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REPORT 2 OF THE COUNCIL ON MEDICAL SERVICE (A-24)
Improving Affordability of Employment-Based Health Coverage
(Resolution 103-A-23)
(Reference Committee A)

EXECUTIVE SUMMARY

To expand coverage to all Americans, the American Medical Association has long advocated for the promotion of individually selected and owned health insurance; the maintenance of the safety net that Medicaid and CHIP provide; and the preservation of employer-sponsored coverage to the extent the market demands it. As highlighted in this report, ESI remains the dominant source of health coverage in this country and most people seem satisfied with it. However, because of shortcomings inherent to the ESI system—namely equity and affordability concerns, and rising costs—it does not work well for everyone. Some workers, especially those with lower incomes, may be contributing more for an employer plan than they would pay for subsidized marketplace coverage because a provision in the Affordable Care Act (ACA), known as the firewall, prohibits workers with affordable ESI offers from receiving premium tax credits to purchase marketplace plans.

The Council's main concerns about eliminating the firewall abruptly and in full include the potential impacts on ESI stability, which may not be wholly understood, and potential costs to the federal government, since allowing all ESI enrollees access to ACA marketplace subsidies might prove to be prohibitively expensive. Instead, the Council supports incrementally reducing the affordability threshold so that it benefits workers most in need, and then monitoring the effects of this change over time. Accordingly, the Council recommends amending Policy H-165.828[1] to support lowering the threshold that determines whether an employee's premium contribution is affordable to the maximum percentage of income they would be required to pay, after accounting for subsidies, towards premiums for an ACA benchmark plan (second-lowest-cost silver plan).

Additional recommendations are intended to strengthen the quality and affordability of ESI. To help address the needs of ESI enrollees with lower incomes, who are more likely to report difficulties covering the costs of medical care and who may not know if they are firewalled, the Council recommends amending Policy H-165.843 to encourage employers to 1) implement programs that improve affordability of ESI premiums and/or cost-sharing; 2) provide employees with user-friendly information regarding their eligibility for subsidized ACA marketplace plans based on their offer of ESI; and 3) provide employees with information regarding available health plan options, including the plans' cost, network breadth, and prior authorization requirements, which will help them choose a plan that meets their needs. The Council also recommends supporting efforts to strengthen employer coverage offerings, such as by requiring a higher minimum actuarial value or more robust benefit standards.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 2-A-24

Subject: Improving Affordability of Employment-Based Health Coverage (Resolution 103-A-23)

Presented by: Sheila Rege, MD, Chair

Referred to: Reference Committee A

At the June 2023 Annual Meeting, the House of Delegates referred Resolution 103, which was sponsored by the Medical Student Section and asked the American Medical Association (AMA) to: (1) recognize the inefficiencies and complexity of the employer-sponsored health insurance system and the existence of alternative models that better align incentives to facilitate access to high quality health care; (2) support movement toward a health care system that does not rely on employer-sponsored health insurance and enables universal access to high quality health care; (3) amend Policy H-165.828[1], "Health Insurance Affordability," by addition and deletion to read as follows:

Health Insurance Affordability H-165.828[1]
~~1. Our AMA supports modifying the eligibility criteria for premium credits and cost-sharing subsidies for those offered employer-sponsored coverage by lowering the threshold that determines whether an employee's premium contribution is affordable to that which applies to the exemption from the individual mandate of the Affordable Care Act (ACA).~~Our AMA advocates for the elimination of the employer-sponsored insurance firewall such that no individual would be ineligible for premium tax credits and cost-sharing assistance for marketplace coverage solely on the basis of having access to employer-sponsored health insurance.

and (4) amend Policy H-165.823[2] by deletion to read as follows:

Options to Maximize Coverage Under the AMA Proposal for Reform H-165.823[2]
2. 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.~~
b~~e~~. 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.
c~~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 participation in Medicare, Medicaid and/or any commercial product to participation in the public option.
d~~e~~. The public option is financially self-sustaining and has uniform solvency requirements.

ef. The public option does not receive advantageous government subsidies in comparison to those provided to other health plans.
fg. 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.

The Board of Trustees assigned this item to the Council on Medical Service for a report back to the House of Delegates. This report discusses policy options for addressing employer-sponsored health insurance (ESI) affordability, summarizes relevant AMA policy, and presents recommendations.

BACKGROUND

Almost a decade and a half after enactment of the ACA, ESI continues to be the dominant source of health coverage for Americans under 65 years of age. In 2023, the Congressional Budget Office (CBO) estimated that 155 million people under age 65—or 57.3 percent of the nonelderly population—had health insurance coverage through their employer, a number the CBO predicts will remain steady through 2025 and increase in the years thereafter.[1] Although ESI is the most common type of health insurance, coverage varies significantly by income as well as race and ethnicity. While nearly all individuals with incomes at or above 400 percent of the federal poverty level (FPL) have ESI, it covers just over half of people with incomes between 150 to 400 percent FPL and fewer than one-quarter of individuals with incomes below 150 percent FPL.[2] Additionally, larger percentages of white and Asian people have ESI while individuals who are African American and Latino are less likely to have employer-based coverage, raising equity concerns.[3,4]

Overall, most Americans appear satisfied with employment-based coverage.[5] According to KFF's survey of consumer experiences with health insurance, in 2023, 80 percent of adults with ESI and 73 percent of those with marketplace coverage rated their health coverage as "excellent" or "good" although people in poorer health gave more negative ratings across all plan types. Regardless of health status, enrollees in marketplace plans were most likely to rate their experiences with health insurance as fair or poor.[6] Ninety-three percent of workers responding to a 2022 poll sponsored by the U.S. Chamber of Commerce expressed high rates of satisfaction with ESI, with a large majority (89 percent) expressing a preference for ESI over other types of coverage.[7] Eighty percent of respondents to this survey ranked health insurance as the most important workplace benefit provided to them, and a majority cited "affordability" and "high quality" as ESI's most critical features.[8]

Although ESI is popular, it has become increasingly costly for employers and employees, especially small firms and lower-income workers. According to 2023 data from the KFF's Employer Health Benefits Survey:

- Fifty-three percent of all firms offered health benefits, down slightly from five years ago (57 percent). Almost all (98 percent) large employers (those with 200 or more workers) offered coverage to at least some workers while just over half (53 percent) of smaller firms (those with three to 199 workers) did so.
- Seventy-five percent of eligible employees took up coverage when it was offered to them, a slight decrease from 2013 (80 percent) and a more sizeable decrease from 2003 (84 percent).[9]
- Annual health insurance premiums averaged $8,435 for individual coverage and $23,968 for family coverage, a seven percent increase over 2022. Notably, premiums for family coverage

have increased on average 22 percent since 2018 and 47 percent since 2013. Workers pay, on average, $6,575 annually toward the cost of family premiums.

- Most (77 percent) firms offered only one type of plan, and PPOs were the most common plan type offered. Large employers were more likely than smaller firms to offer more than one plan.[10]

In addition to premium contributions, most workers with ESI are responsible for cost-sharing expenses, including plan deductibles, copayments, and coinsurance. According to KFF's 2023 Employer Health Benefits Survey, the average annual deductible for employees with single coverage was $1,735, a figure that has increased more than 50 percent over the course of 10 years.[11] Overall, nearly a third of employees had plan deductibles of $2,000 or more, including almost half (47 percent) of workers at small firms, whose average annual deductible was $2,434 compared to $1,478 for employees of larger firms.[12]

ESI Affordability

KFF has also highlighted the lack of affordable family coverage options for workers at smaller firms employing fewer than 200 people. These employees pay on average $8,334 towards family coverage premiums each year with a quarter paying at least $12,000 annually, not including deductibles and other cost-sharing expenses.[13] A KFF analysis of data from its 2023 survey of consumer experiences with health insurance found that adults with incomes below 200 percent FPL who have ESI were significantly more likely than higher-income peers to report difficulties paying for medical care; treatment delays and declines in health due to insurance problems, such as prior authorization; dissatisfaction with the availability and quality of health providers in their plan's network; and more difficulty comparing plans and signing up for coverage.[14]

Several analyses have pointed out that workers with lower incomes are disproportionately burdened by ESI costs and usually pay a greater share of income toward employer plan premiums and other out-of-pocket expenses.[15] [16] [17] KFF research from 2022 found that, on average, families with incomes below 200 percent FPL pay approximately 10.4 percent of income toward health care premiums and out-of-pocket expenses (7.7 percent for premiums) while those with incomes at or above 400 percent FPL pay about 3.5 percent toward premiums and medical expenses (2.3 percent for premiums).[18] More workers (over 20 percent, according to a 2019 KFF survey) [19] are covered by high-deductible plans, which can present additional challenges to lower-income employees even if a health savings account or health reimbursement account option is available to them. Though employers could utilize health benefit design strategies to address affordability issues facing lower-income workers, few seem to do so; in 2022, 10 percent of large firms reportedly had programs that lowered premium costs for lower-income employees while only five percent reported programs to lower their cost-sharing expenses.[20] COBRA coverage may also be too costly for some workers who are leaving a job.

Though many workers mistakenly think otherwise, they—not the firms they work for—pay the majority of ESI costs, both directly through contributions and indirectly through wage adjustments made to cover employers' health care costs.[21] Building on the literature linking growth in health insurance costs to stagnant wages, a 2023 *JAMA* analysis suggests a likely association between increased premium costs for workers with ESI family coverage and decreased earnings and increased income inequality.[22] Because workers earning lower wages contribute a greater share of income toward ESI premiums, the analysis posits that making employer plans more affordable for lower-wage workers could help address earnings inequality. This study also identified large disparities in premium costs as a percentage of income by race (African American and Latino families paid higher percentages of earnings toward premium costs than white families), and found

that over 30 years, families with ESI may have cumulatively lost, on average, more than $125,000 in earnings due to increases in premium costs.[23]

ACA Provisions on Affordability and Employer Shared Responsibility

Under the ACA, individuals are not eligible for marketplace premium tax credits if they are eligible for "minimum essential coverage," which is broadly defined to include Medicare, Medicaid, and other public programs as well as ESI. Accordingly, individuals with offers of coverage from an employer do not qualify for ACA marketplace subsidies unless their ESI offer is deemed either unaffordable or inadequate. In 2023, an employer plan was considered unaffordable if an employee's premium contribution exceeded 9.12 percent of that person's household income. This percentage threshold is adjusted annually for inflation and is 8.39 percent in 2024.[24] To be considered adequate, a plan must cover at least 60 percent of average costs (actuarial value); anything less is deemed inadequate.[25] The ACA provision making workers with affordable and adequate ESI offers ineligible to receive advance premium tax credits to purchase marketplace coverage is colloquially referred to as "the firewall." This affordability threshold was established to address multiple concerns with the landmark legislation; namely, to prevent disruption to the ESI market and prevent prohibitive increases in federal spending (for marketplace subsidies) while preserving ESI's position as the principal source of health coverage in this country.

As explained in a 2014 Council on Medical Service Report on the future of ESI, the ACA aimed to build upon the ESI framework and provide low-income, non-elderly individuals without access to ESI with either Medicaid coverage or subsidized private coverage offered through the nongroup marketplace. As such, provisions in the ACA statute included incentives and penalties intended to prevent disruption to the ESI market. For example, to incentivize employers to continue offering coverage, the ACA contained an "employer shared responsibility" provision, also called the "employer mandate," which requires employers with 50 or more full-time employees to either offer affordable minimum essential coverage to full-time employees and their dependents or pay a penalty to the Internal Revenue Service (IRS).[26] Under this provision, employers face two potential penalties:[27]

- If an employer does not offer minimum essential coverage to at least 95 percent of its full-time employees and dependents, and at least one employee receives a premium tax credit for coverage offered through an ACA exchange, the employer faces a penalty that is based on all full-time employees (except 30), including those who have ESI or coverage from another source. In 2024, the penalty is $2,970 per employee.[28]
- If an employer offers coverage to at least 95 percent of its employees but at least one employee obtains a premium tax credit for ACA coverage due to the employer's coverage not being "affordable" or "adequate," the employer must pay a penalty for each employee who receives the premium tax credit. In 2024, the penalty is $4,460 per employee.[29]

AMA Policy on the ACA Affordability Threshold

In the early years of ACA implementation, a 2015 Council on Medical Service report on health insurance affordability recommended making changes to how affordable coverage is defined under the law in order to provide more workers and their families with access to marketplace plans when those plans are more affordable than employer plans. This report established Policy H-165.828, which included several provisions calling for the ACA's "family glitch" to be fixed and capping the tax exclusion for ESI as a funding stream to improve insurance affordability. Policy H-165.828[1] as originally written (prior to being amended in 2021) established AMA support for:

> … modifying the eligibility criteria for premium credits and cost-sharing subsidies for those offered ESI by lowering the threshold that determines whether an employee's premium contribution is affordable to that which applies to the exemption from the individual mandate of the ACA.

In 2015 when this policy was adopted, individuals were deemed exempt from the ACA's individual mandate—which was repealed in 2017—if the lowest-priced coverage available to them cost more than 8.05 percent of their household income. The same year, individuals with employer coverage offers were eligible for ACA marketplace plan premium tax credits if their ESI premium contributions exceeded 9.56 percent of income. The aforementioned Policy H-165.828[1] was crafted to align the definitions of affordability with respect to being exempt from the individual mandate (>8.05 percent) and premium tax credit eligibility for individuals with ESI offers (>9.56 percent).

Policy H-165.828[1] was amended via adoption of the recommendations in a 2021 Council on Medical Service report to address new inconsistencies between the definition of affordability pertaining to premium tax credit eligibility and provisions in the American Rescue Plan Act of 2021 (ARPA), which extended eligibility for premium subsidies to people with incomes greater than 400 percent FPL and capped premiums for those with the highest incomes at 8.5 percent of their income. ARPA increased the generosity of premium tax credits and lowered the cap on the percentage of income individuals are required to pay for premiums of the benchmark (second-lowest-cost silver) plan for everyone. At the time the report was written, in 2021, employer coverage with an employee share of the premium less than 9.83 percent of income was considered "affordable." To open the door to premium tax credit eligibility to individuals with ESI premiums that were above the maximum affordability threshold applied to subsidized marketplace plans, Policy H-165.828[1] was amended to establish AMA support for:

> … modifying the eligibility criteria for premium credits and cost-sharing subsidies for those offered ESI by lowering the threshold that determines whether an employee's premium contribution is affordable to the level at which premiums are capped for individuals with the highest incomes eligible for subsidized ACA coverage.

Federal Subsidies for ACA Premium Tax Credits/Cost-Sharing and ESI Tax Benefits

In 2023, the federal government subsidized coverage obtained through the ACA marketplaces and the Basic Health Program (BHP) at a cost of $92 billion.[30] This figure includes ARPA federal subsidy enhancements for premium tax credits and cost-sharing reductions that were extended through 2025 by the Inflation Reduction Act (IRA). Prior to ARPA, required premium contribution percentages ranged from about two percent of household income for people with poverty level income to nearly 10 percent of income for people with incomes between 300 to 400 percent FPL; people earning more than 400 percent FPL were not eligible for premium tax credits.[31] This year, as shown in Table 1, required premium contribution percentages range from zero for people with less than 150 percent FPL to 8.5 percent for those making around 400 percent FPL or more.

Table 1: Required Individual Contribution Percentage for 2024[32,33]

Household income percentage of Federal poverty line:	% at start of range	% at top of range
Less than 150%	0.00%	0.00%
At least 150% but less than 200%	0.00%	2.00%
At least 200% but less than 250%	2.00%	4.00%
At least 250% but less than 300%	4.00%	6.00%

At least 300% but less than 400%	6.00%	8.50%
At least 400% and higher	8.50%	8.50%

Premium tax credits for ACA marketplace coverage are calculated by subtracting the required contribution from the actual cost of the "benchmark" plan, though the credit can be applied toward any marketplace plan except catastrophic coverage.[34] People with incomes below 250 percent FPL also receive subsidies for cost-sharing expenses that are based on income, so that people with incomes between 100 and 150 percent FPL receive the most generous subsidies.[35] These cost-sharing reductions are only available to those enrolled in silver plans. According to the CBO, in 2023 the average federal subsidy per ACA marketplace/BHP enrollee was $5,990.[36] The range of subsidy amounts is considerable, with small subsidy amounts provided to people with incomes around 400 or more percent of the FPL and subsidies worth around $15,000 for families with the lowest incomes.

The federal government subsidizes ESI via tax benefits provided to employers and employees that exclude premium contributions from federal income and payroll taxes. The amount of an individual's subsidy depends on that person's marginal tax rate that would be owed if employer-paid premiums were taxed as wages. Accordingly, people with greater incomes and higher marginal tax rates receive larger federal ESI subsidies than people with lower-incomes and lower tax rates.[37] According to the CBO, the average federal subsidy per ESI enrollee in 2023 was $2,170.[38]

In part due to the enhanced subsidies for marketplace enrollees established by ARPA and extended by the IRA, several analysts have observed the growing disparity between federal subsidies that help defray ACA marketplace plan costs, and subsidies for ESI coverage. To illustrate this expanding gap, a 2024 American Enterprise Institute (AEI) paper calculated the value of subsidies that would be received by a family of four with $75,000 in income, depending on whether they purchased ESI or marketplace coverage. According to AEI, if the family enrolled in an employer-based plan, their tax subsidy would be around $4,100, compared to the more than $15,000 in federal premium subsidies the family would be eligible for if enrolled in a marketplace plan.[39] Other analyses have noted that workers with lower incomes may be contributing more for an employer-based plan than they would pay for coverage under a subsidized marketplace plan, and that it would be financially advantageous for these workers to move to the marketplace.[40]

Some employees who would be financially incentivized to enroll in a marketplace plan if the firewall is repealed might opt to retain ESI coverage if they are satisfied with their plan and able to see the physicians they want in a timely manner. The Centers for Medicare & Medicaid Services (CMS) has previously acknowledged the proliferation of narrow networks among ACA exchange plans, and several studies have demonstrated varying degrees of challenges facing marketplace enrollees attempting to access in-network providers, most commonly mental health specialists. A 2020 *JAMA* study found that provider networks were broader in ESI plans and narrower in marketplace plans but that networks may also be limited in lower-quality employer plans.[41] The Council has previously observed that, while marketplace plans may be attractive to some people because their premium prices are lower, purchasers may not be aware that a plan's provider network could be narrower and that they may have trouble getting needed care from in-network physicians, hospitals, and other providers. Therefore, some workers with ESI coverage who would become newly eligible for marketplace subsidies if the firewall is repealed may decide to keep their employer plan to avoid possible care disruptions and to preserve relationships with their treating physicians. Depending on income and a range of other factors, this could be true for some employees who utilize more services and medications or who have a family member on their plan who has a health condition that requires timely access to specialty care.

POLICY OPTIONS ADDRESSING ESI AFFORDABILITY

During the development of this report, the Council reviewed papers from a broad spectrum of organizations and also met with subject matter experts who suggested a range of approaches to improving affordability in ESI and nongroup markets. Review of the literature uncovered a handful of data analyses and a range of conflicting opinions on the best way forward. The studies generally agreed that lifting the firewall would increase access to lower cost insurance for people with low incomes. However, they differed in their assessment of the percent of the population that would move from ESI to the ACA marketplace, the impact of employer behavior, and their willingness to support increased federal health spending. These studies are summarized below in alphabetical order.

American Enterprise Institute (AEI): A 2020 paper published by AEI recognizes both the value of ESI to many Americans as well as its flaws, including rising costs for both employers and employees. AEI asserts that ESI is worth preserving and suggests tax reforms as the centerpiece of a framework for a more stable ESI system, including the provision of a tax benefit for employers that would be applied to employee premiums. According to AEI, such firm-level tax credits could provide greater support to lower-income employees but less support to those with higher incomes.[42]

Bipartisan Policy Center (BPC): A 2022 BPC report recognizes that ESI is less affordable for lower-wage workers but suggests that fully eliminating the firewall would be quite costly for the federal government. Instead, BPC recommends that Congress adjust the affordability threshold to align with the percentage cap on premium contributions for marketplace plans.[43]

Center on Budget and Policy Priorities (CBPP): A 2019 CBPP analysis acknowledged that eliminating the firewall would improve equity but concluded that a full repeal would be too costly to recommend. Instead, the CBPP suggested strengthening the standards for employer coverage offers, such as by raising the minimum value standard (from 60 to 70 percent) or establishing more robust benefit standards for ESI plans.[44]

Commonwealth Fund: A 2020 analysis found that, depending on marketplace subsidy amounts in place, between six and 13 percent of people with ESI would pay lower premium amounts if they were able to switch to marketplace plans. Importantly, the paper pointed out that people with the lowest incomes would benefit the most from lower marketplace premiums, as would African American, Latino, American Indian and Alaska Native individuals. According to the brief, much is unknown about potential employer responses to elimination of the firewall, including whether firms will incentivize sicker workers to move to exchange plans or stop offering coverage altogether.[45]

A 2024 Commonwealth Fund paper on automatic enrollment in health insurance posits that 1.2 million people with incomes below 150 percent of FPL and 6.5 million people with income between 150 percent and 200 percent of FPL would become eligible for marketplace subsidies if the firewall were eliminated. The analysis states that “most” of these newly eligible individuals currently have ESI although some are paying full premiums for nongroup plans.[46]

Congressional Budget Office (CBO): In 2020, the CBO estimated that approximately 25 percent of workers with ESI would become eligible for marketplace subsidies if the firewall was repealed. For 20 percent of those newly eligible, post-subsidy premiums for marketplace plans would be lower than ESI premiums, thus making the nongroup market an attractive option. The CBO maintained

that, although firms would respond differently to a lifting of the firewall, most of the savings incurred would likely be passed on to employees and adverse selection would be minimized.[47]
Urban Institute: Data presented to the Council but not yet published at the time this report was written estimated that eliminating the firewall would decrease ESI coverage by two percent or less, increase federal spending by about $20 billion, decrease the number of uninsured individuals, slightly increase provider revenue, and decrease employer spending and household spending.[48]

RELEVANT AMA POLICY

Policy H-165.829 encourages the development of state waivers to develop and test different models for transforming employer-provided health insurance coverage, including giving employees a choice between employer-sponsored coverage and individual coverage offered through health insurance exchanges, and allowing employers to purchase or subsidize coverage for their employees on the individual exchanges. Among its many provisions, Policy H-165.920 supports:

- A system where individually owned health insurance is the preferred option but employer-provided coverage is still available to the extent the market demands it;
- An individual's right to select his/her health insurance plan and to receive the same tax treatment for individually purchased coverage, for contributions toward employer-provided coverage, and for completely employer-provided coverage; and
- A replacement of the present federal income tax exclusion from employee's taxable income of employer-provided insurance coverage with tax credits for individuals and families.

Under Policy H-165.851, the AMA supports incremental steps toward financing individual tax credits for the purchase of health insurance, including but not limited to capping the tax exclusion for employment-based health insurance. Policy H-165.843 encourages employers to promote greater individual choice and ownership of plans; enhance employee education regarding how to choose health plans that meet their needs; and support increased fairness and uniformity in the health insurance market. Policy H-165.881 advocates for equal-dollar contributions by employers irrespective of an employee's health plan choice. Policy H-165.854 supports Health Reimbursement Arrangements (HRAs)—account-based health plans that employers can offer to reimburse employees for their medical expenses—as one mechanism for empowering patients to have greater control over health care decision-making.

Policy H-165.824 supports improving affordability in health insurance exchanges by expanding eligibility for premium tax credits beyond 400 percent FPL; increasing the generosity of premium tax credits; expanding eligibility for cost-sharing reductions; and increasing the size of cost-sharing reductions. Policy H-165.828, which as previously noted addresses the affordability threshold (firewall), also supports capping the tax exclusion for employment-based health insurance as a funding stream to improve health insurance affordability.

Policy H-165.823 supports a pluralistic health care system and advocates that eligibility for premium tax credit and cost-sharing assistance to purchase a public option be restricted to individuals without access to affordable employer-sponsored coverage that meets standards for minimum value of benefits. This policy sets additional standards for supporting a public option and states that it shall be made available to uninsured individuals who fall into the "coverage gap" in states that do not expand Medicaid at no or nominal cost.

DISCUSSION

The AMA has long supported health system reform alternatives that are consistent with AMA policies concerning pluralism, freedom of choice, freedom of practice, and universal access for patients. To expand coverage to all Americans, the AMA has advocated for the promotion of individually selected and owned health insurance; the maintenance of the safety net that Medicaid and CHIP provide; and the preservation of employer-sponsored coverage to the extent the market demands it. As ESI continues to be the dominant source of health coverage for people under 65 years of age, most people who have employment-based coverage seem satisfied with it. Still, the Council acknowledges that because of shortcomings inherent to the ESI system—including equity and affordability concerns, and rising costs—it does not work well for everyone, especially workers with lower incomes and those at smaller firms paying for costly family coverage.

As explained in this report, people with higher earnings receive larger federal ESI subsidies than their lower-income peers and employees with lower incomes pay a greater share of earnings towards ESI expenses. The Council recognizes that federal tax benefits available to ESI subscribers most in need are not nearly as generous as the enhanced subsidies available to many low- and moderate-income individuals enrolled in ACA marketplace plans. Because the disparity between subsidy amounts for people with ESI and those with marketplace coverage has widened as marketplace subsidies have increased and ESI costs have continued to grow, the Council agrees that it is an appropriate time to revisit AMA policy on the firewall (Policy H-165.828[1]), which supports lowering the affordability threshold to the level at which premiums are capped for individuals with the highest incomes eligible for subsidized coverage (currently 8.5 percent).

During the development of this report, the Council reviewed the literature and heard from experts holding an array of views on the potential impacts of fully eliminating the firewall, which is the policy change requested by referred Resolution 103-A-23. Although the Council cannot estimate with certainty how many people would switch from ESI to exchange plans over time if the firewall was repealed, the impact on coverage patterns could be significant. Even less is known about potential employer responses to a repeal, which cannot be predicted and will likely vary, with some firms possibly shifting certain employees to the marketplace or ceasing to offer health coverage altogether, and without assurances that employer savings would be passed along to workers. Still, we understand that the firewall is problematic for some employees, including lower-income workers who may be contributing more for an employer plan than they would pay for marketplace coverage and those whose firms offer little to no choice of health plans. Even among employees who would benefit financially from transitioning to the marketplace, some may opt to retain ESI coverage if they are satisfied with that plan, concerned about the network breadth of exchange plans, or interested in preserving relationships with their treating physicians.

The impact of eliminating the firewall on physician payment rates is also difficult to predict, since payment rates in the nongroup market tend to vary, though they are generally lower than rates paid in the ESI market. The Council's main concerns about eliminating the firewall abruptly and in full include the potential impacts on ESI stability, which may not be wholly understood, and the potential substantial costs that would be incurred by the federal government, which already spends upwards of $1.8 trillion on health insurance subsidies—across all coverage programs—each year.[49] Allowing all ESI enrollees access to ACA marketplace subsidies might prove to be prohibitively expensive. We cannot estimate the exact costs of eliminating the firewall, which would depend on how many workers ultimately move to exchange plans but the costs easily total tens of billions of dollars or more per year, especially if enhanced federal marketplace subsidies remain in place after

2025. We believe that budgetary considerations may make the full repeal option unrealistic, financially, and also politically since it would be unpopular with ESI proponents, including employers using health coverage offers as recruiting tools. For these reasons, the Council supports incrementally reducing the affordability threshold so that it benefits workers most in need, and then monitoring the effects of this change on coverage patterns, federal and consumer health spending, and employer behavior. Accordingly, the Council recommends amending Policy H-165.828[1] to support lowering the threshold that determines whether an employee's premium contribution is affordable to the maximum percentage of income they would be required to pay, after accounting for subsidies, towards premiums for an ACA benchmark plan (second-lowest-cost silver plan). The Council is optimistic that this change, if enacted, may also encourage some employers to offer more affordable coverage in order to keep attracting workers.

The Council also suggests additional recommendations that are intended to strengthen the quality and affordability of ESI. To help address the needs of ESI enrollees with lower incomes, who are more likely to report difficulties covering the costs of medical care and who may not know if they are firewalled, the Council recommends amending Policy H-165.843 to encourage employers to: 1) implement programs that improve affordability of ESI premiums and/or cost-sharing; 2) provide employees with user-friendly information regarding their eligibility for subsidized ACA marketplace plans based on their offer of ESI; and 3) provide employees with information regarding available health plan options, including the plans' cost, network breadth, and prior authorization requirements, which will help them choose a plan that meets their needs. The Council recognizes that employers are already required to provide employees with notice about the ACA marketplace and that, depending on income and ESI offer, they may be eligible for lower-cost coverage in the marketplace. However, it may be challenging for some employees to determine whether they are eligible for marketplace subsidies without tools to help them do so.

The Council also notes that large employers are subject to a 60 percent actuarial value standard compared to the 70 percent standard required of silver plans on the marketplace (an 80 percent actuarial standard is required for gold plans; 60 percent for bronze). Notably, marketplace plans are also subject to more rigorous essential health benefits standards. To address these disparities in standards, the Council recommends general support for efforts to strengthen employer coverage offerings, such as by requiring a higher minimum actuarial value or more robust benefit standards. Finally, the Council recommends reaffirmation of AMA policies most relevant to this report: Policy H-165.881, which directs the AMA to pursue strategies for expanding patient choice in the private sector by advocating for greater choice of health plans by consumers, equal-dollar contributions by employers irrespective of an employee's health plan choice, and expanded individual selection and ownership of health insurance; and Policy H-165.920, which supports principles related to individually purchased and owned health insurance coverage as the preferred option, although employer-provided coverage is still available to the extent the market demands it.

RECOMMENDATIONS

The Council on Medical Service recommends that the following recommendations be adopted in lieu of Resolution 103-A-23, and that the remainder of the report be filed.

1. That our American Medical Association (AMA) amend Policy H-165.828[1] by addition and deletion to read:

   Our AMA supports modifying the eligibility criteria for premium credits and cost-sharing subsidies for those offered employer-sponsored coverage by lowering the threshold that determines whether an employee's premium contribution is affordable to the ~~level at which~~

~~premiums are capped for individuals with the highest incomes eligible for subsidized coverage~~ maximum percentage of income they would be required to pay towards premiums after accounting for subsidies ~~in~~ for an Affordable Care Act (ACA) marketplace~~s~~ benchmark plan. (Modify HOD Policy)

2. That our AMA amend Policy H-165.843 by addition and deletion to read:

Our AMA encourages employers to:
a) promote greater individual choice and ownership of plans;
b) implement plans to improve affordability of premiums and/or cost-sharing, especially expenses for employees with lower incomes and those who may qualify for Affordable Care Act marketplace plans based on affordability criteria;
c) ~~help employees determine if their employer coverage offer makes them ineligible or eligible for federal marketplace subsidies~~ provide employees with user-friendly information regarding their eligibility for subsidized ACA marketplace plans based on their offer of employer-sponsored insurance;
~~b~~d) ~~enhance employee education regarding available health plan options and how to choose health plans that meet their needs~~ provide employees with information regarding available health plan options, including the plan's cost, network breadth, and prior authorization requirements, which will help them choose a plan that meets their needs;
~~c~~e) offer information and decision-making tools to assist employees in developing and managing their individual health care choices;
~~d~~f) support increased fairness and uniformity in the health insurance market; and
~~e~~g) promote mechanisms that encourage their employees to pre-fund future costs related to retiree health care and long-term care. (Modify HOD Policy)

3. That our AMA support efforts to strengthen employer coverage offerings, such as by requiring a higher minimum actuarial value or more robust benefit standards, like those required of nongroup marketplace plans. (New HOD Policy)

4. That our AMA reaffirm Policy H-165.881, which directs the AMA to pursue strategies for expanding patient choice in the private sector by advocating for greater choice of health plans by consumers, equal-dollar contributions by employers irrespective of an employee's health plan choice and expanded individual selection and ownership of health insurance. (Reaffirm HOD Policy)

5. That our AMA reaffirm Policy H-165.920, which supports individually purchased and owned health insurance coverage as the preferred option, although employer-provided coverage is still available to the extent the market demands it, and other principles related to health insurance. (Reaffirm HOD Policy)

Fiscal Note: Less than $500.

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Appendix

Policies Recommended for Amendment and Reaffirmation

Health Insurance Affordability H-165.828
1. Our AMA supports modifying the eligibility criteria for premium credits and cost-sharing subsidies for those offered employer-sponsored coverage by lowering the threshold that determines whether an employee's premium contribution is affordable to the level at which premiums are capped for individuals with the highest incomes eligible for subsidized coverage in Affordable Care Act (ACA) marketplaces.
2. Our AMA supports legislation or regulation, whichever is relevant, to fix the ACA's "family glitch," thus determining the eligibility of family members of workers for premium tax credits and cost-sharing reductions based on the affordability of family employer-sponsored coverage and household income.
3. Our AMA encourages the development of demonstration projects to allow individuals eligible for cost-sharing subsidies, who forego these subsidies by enrolling in a bronze plan, to have access to a health savings account (HSA) partially funded by an amount determined to be equivalent to the cost-sharing subsidy.
4. Our AMA supports capping the tax exclusion for employment-based health insurance as a funding stream to improve health insurance affordability, including for individuals impacted by the inconsistency in affordability definitions, individuals impacted by the "family glitch," and individuals who forego cost-sharing subsidies despite being eligible.
5. Our AMA supports additional education regarding deductibles and cost-sharing at the time of health plan enrollment, including through the use of online prompts and the provision of examples of patient cost-sharing responsibilities for common procedures and services.
6. Our AMA supports efforts to ensure clear and meaningful differences between plans offered on health insurance exchanges.
7. Our AMA supports clear labeling of exchange plans that are eligible to be paired with a Health Savings Account (HSA) with information on how to set up an HSA.
8. Our AMA supports the inclusion of pregnancy as a qualifying life event for special enrollment in the health insurance marketplace. (CMS Rep. 8, I-15 Reaffirmed in lieu of: Res. 121, A-16 Reaffirmation: A-17 Reaffirmed: CMS Rep. 09, A-19 Reaffirmed: CMS Rep. 02, A-19 Reaffirmed in lieu of: Res. 101, A-19 Reaffirmed: CMS Rep. 01, I-20 Reaffirmed: CMS Rep. 2, I-20 Modified: CMS Rep. 3, I-21 Appended: Res. 701, I-21)

Trends in Employer-Sponsored Health Insurance H-165.843
Our AMA encourages employers to:
a) promote greater individual choice and ownership of plans;
b) enhance employee education regarding how to choose health plans that meet their needs;
c) offer information and decision-making tools to assist employees in developing and managing their individual health care choices;
d) support increased fairness and uniformity in the health insurance market; and
e) promote mechanisms that encourage their employees to pre-fund future costs related to retiree health care and long-term care. (CMS Rep. 4, I-07 Reaffirmed: CMS Rep. 01, A-17)

Expanding Choice in the Private Sector H-165.881
Our AMA will continue to actively pursue strategies for expanding patient choice in the private sector by advocating for greater choice of health plans by consumers, equal-dollar contributions by

employers irrespective of an employee's health plan choice and mexpanded individual selection and ownership of health insurance where plans are truly accountable to patients. (BOT Rep. 23, A-97 Reaffirmed BOT Rep. 6, A-98 Reaffirmation A-02 Reaffirmed: CMS Rep. 4, A-12 Reaffirmation: A-19)

Individual Health Insurance H-165.920
Our AMA:
(1) affirms its support for pluralism of health care delivery systems and financing mechanisms in obtaining universal coverage and access to health care services;
(2) recognizes incremental levels of coverage for different groups of the uninsured, consistent with finite resources, as a necessary interim step toward universal access;
(3) actively supports the principle of the individual's right to select his/her health insurance plan and actively support ways in which the concept of individually selected and individually owned health insurance can be appropriately integrated, in a complementary position, into the Association's position on achieving universal coverage and access to health care services. To do this, our AMA will:
(a) Continue to support equal tax treatment for payment of health insurance coverage whether the employer provides the coverage for the employee or whether the employer provides a financial contribution to the employee to purchase individually selected and individually owned health insurance coverage, including the exemption of both employer and employee contributions toward the individually owned insurance from FICA (Social Security and Medicare) and federal and state unemployment taxes;
(b) Support the concept that the tax treatment would be the same as long as the employer's contribution toward the cost of the employee's health insurance is at least equivalent to the same dollar amount that the employer would pay when purchasing the employee's insurance directly;
(c) Study the viability of provisions that would allow individual employees to opt out of group plans without jeopardizing the ability of the group to continue their employer sponsored group coverage; and
(d) Work toward establishment of safeguards, such as a health care voucher system, to ensure that to the extent that employer direct contributions made to the employee for the purchase of individually selected and individually owned health insurance coverage continue, such contributions are used only for that purpose when the employer direct contributions are less than the cost of the specified minimum level of coverage. Any excess of the direct contribution over the cost of such coverage could be used by the individual for other purposes;
(4) will identify any further means through which universal coverage and access can be achieved;
(5) supports individually selected and individually-owned health insurance as the preferred method for people to obtain health insurance coverage; and supports and advocates a system where individually-purchased and owned health insurance coverage is the preferred option, but employer-provided coverage is still available to the extent the market demands it;
(6) supports the individual's right to select his/her health insurance plan and to receive the same tax treatment for individually purchased coverage, for contributions toward employer-provided coverage, and for completely employer provided coverage;
(7) supports immediate tax equity for health insurance costs of self-employed and unemployed persons;
(8) supports legislation to remove paragraph (4) of Section 162(l) of the US tax code, which discriminates against the self-employed by requiring them to pay federal payroll (FICA) tax on health insurance premium expenditures;
(9) supports legislation requiring a “maintenance of effort” period, such as one or two years, during which employers would be required to add to the employee's salary the cash value of any health insurance coverage they directly provide if they discontinue that coverage or if the employee opts out of the employer-provided plan;

(10) encourages through all appropriate channels the development of educational programs to assist consumers in making informed choices as to sources of individual health insurance coverage;
(11) encourages employers, unions, and other employee groups to consider the merits of risk-adjusting the amount of the employer direct contributions toward individually purchased coverage. Under such an approach, useful risk adjustment measures such as age, sex, and family status would be used to provide higher-risk employees with a larger contribution and lower-risk employees with a lesser one;
(12) supports a replacement of the present federal income tax exclusion from employees' taxable income of employer-provided health insurance coverage with tax credits for individuals and families, while allowing all health insurance expenditures to be exempt from federal and state payroll taxes, including FICA (Social Security and Medicare) payroll tax, FUTA (federal unemployment tax act) payroll tax, and SUTA (state unemployment tax act) payroll tax;
(13) advocates that, upon replacement, with tax credits, of the exclusion of employer-sponsored health insurance from employees' federal income tax, any states and municipalities conforming to this federal tax change be required to use the resulting increase in state and local tax revenues to finance health insurance tax credits, vouchers or other coverage subsidies; and
(14) believes that refundable, advanceable tax credits inversely related to income are preferred over public sector expansions as a means of providing coverage to the uninsured.
(15) Our AMA reaffirms our policies committed to our patients and their individual responsibility and freedoms consistent with our United States Constitution. (BOT Rep. 41, I-93 CMS Rep. 11, I-94 Reaffirmed by Sub. Res. 125 and Sub. Res. 109, A-95 Amended by CMS Rep. 2, I-96 Amended and Reaffirmed by CMS Rep. 7, A-97 Reaffirmation A-97 Reaffirmed: CMS Rep. 5, I-97 Res. 212, I-97 Appended and Amended by CMS Rep. 9, A-98 Reaffirmation I-98 Reaffirmation I-98 Res. 105 & 108, A-99 Reaffirmation A-99 Reaffirmed: CMS Rep. 5 and 7, I-99 Modified: CMS Rep. 4, CMS Rep. 5, and Appended by Res. 220, A-00 Reaffirmation I-00 Reaffirmed: CMS Rep. 2, I-01 Reaffirmed CMS Rep. 5, A-02 Reaffirmation A-03 Reaffirmed: CMS Rep. 1 and 3,
A-02 Reaffirmed: CMS Rep. 3, I-02 Reaffirmed: CMS Rep. 3, A-03 Reaffirmation I-03 Reaffirmation A-04 Consolidated: CMS Rep. 7, I-05 Modified: CMS Rep. 3, A-06 Reaffirmed in lieu of Res. 105, A-06 Reaffirmation A-07 Appended and Modified: CMS Rep. 5, A-08 Modified: CMS Rep. 8, A-08 Reaffirmation A-10 Reaffirmed: CMS Rep. 9, A-11 Reaffirmation A-11 Reaffirmed: Res. 239, A-12 Appended: Res. 239, A-12 Reaffirmed: CMS Rep. 6, A-12 Reaffirmed: CMS Rep. 9, A-14 Reaffirmed in lieu of: Res. 805, I-17)

REPORT 3 OF THE COUNCIL ON MEDICAL SERVICE (A-24)
Review of Payment Options for Traditional Healing Services
(Resolution 106-A-23)
(Reference Committee A)

EXECUTIVE SUMMARY

At the 2023 Annual Meeting, the House of Delegates referred Resolution 106, which was sponsored by the Medical Student Section and asked for the American Medical Association to "study the impact of Medicaid waivers for managed care demonstration projects regarding implementation and reimbursement for traditional American Indian and Alaska Native healing practices provided in concert with physician-led healthcare teams."

In 1883, the federal government established the Code of Indian Offenses to prosecute American Indians who participated in traditional ceremonies. The cultural identity of American Indian Tribes was restricted by such methods until 1978, when the American Indian Religious Freedom Act legalized traditional spirituality and ceremonies. As the cornerstone legal authority for the provision of health care to American Indians and Alaska Natives (AI/AN), the Indian Health Care Improvement Act (IHCIA) was permanently authorized in 2010 to promote traditional health care practices, fulfill special trust responsibilities, and ensure the highest possible health status by providing all resources necessary to implement that policy.

Federal officials have called for Medicaid to improve its ability to provide culturally competent services to AI/AN beneficiaries and many Tribes have incorporated traditional healing services into their health care delivery. While Congress granted the Indian Health Service the ability to bill Medicaid, traditional healing services are not currently a Medicaid covered service. Accordingly, Section 1115 waivers provide a path forward. Currently, four states are pursuing Medicaid Section 1115 demonstration authority to cover traditional healing services furnished by Indian health providers to AI/AN Medicaid beneficiaries. The waiver requests seek the maximum amount of discretion to be given to Native and Indigenous communities to establish relevant programs for each community, while incorporating minimal federal requirements upon approval of the requests. The Council supports monitoring of Medicaid Section 1115 waivers that recognize the value of traditional AI/AN healing services as a mechanism for improving patient-centered care and health equity among AI/AN populations when coordinated with physician-led care.

For AI/AN communities, traditional healing practices are a fundamental element of Indian health care that helps individuals achieve wellness and restores emotional balance and one's relationship with the environment. While traditional healing services are recognized by the IHCIA, there is no statutory definition for traditional healing services, as they vary considerably among Tribes. The Council supports consultation with Tribes to facilitate the development of best practices and coordination of AI/AN traditional healing providers with the physician-led care team.

The value of traditional healing services is not easily quantified by a culture grounded in conventional medicine as it represents a spiritual tradition tied to lifestyle, community, sovereignty issues, and land and culture preservation. The history of AI/AN Tribes in the US involves dislocation and upheaval followed by sustained disregard for effective Indigenous practices based on a historic preference for conventional evidence-based medicine. As a result, barriers to traditional care services have been created by a lack of cultural competence among systems of care that fail to question how evidence has historically been defined.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 3-A-24

Subject:	Review of Payment Options for Traditional Healing Services (Resolution 106-A-23)
Presented by:	Sheila Rege, MD, Chair
Referred to:	Reference Committee A

At the 2023 Annual Meeting, the House of Delegates referred Resolution 106, which was sponsored by the Medical Student Section. Resolution 106-A-23 asked for the American Medical Association (AMA) to "study the impact of Medicaid waivers for managed care demonstration projects regarding implementation and reimbursement for traditional American Indian and Alaska Native (AI/AN) healing practices provided in concert with physician-led healthcare teams." Testimony was mixed for Resolution 106, with some recommending alternate language asking our AMA to support Medicaid payment for traditional healing services and encourage involved communities to adhere to a series of principles addressing traditional provider/facility arrangements, covered services, and qualified providers. Others supported the resolution as written, albeit with further study to recognize the need for cultural relevance while ensuring patient safety. This report focuses on health equity and cultural competence in providing care for AI/AN populations, examines coverage considerations, summarizes relevant Medicaid Section 1115 waiver requests, and presents new policy recommendations.

BACKGROUND

The Office of Management and Budget (OMB) defines an AI/AN individual as "a person having origins in any of the original peoples of North and South America (including Central America) and who maintains Tribal affiliation or community attachment." American Indians and Alaska Natives are a United States (US) census-defined racial group that also has a specific political and legal classification. From 1778 to 1871, US relations with individual American Indian Nations indigenous to what is now the US were established through the treaty-making process. The treaties recognized unique sets of rights, benefits, and conditions for the Tribes who agreed to surrender millions of acres to the U.S. in return for its protection. The US-American Indian treaties are considered to be the foundation upon which federal Indian law and the federal Indian trust responsibility is based. In *Seminole Nation v. United States (1942)*, the US "charged itself with moral obligations of the highest responsibility and trust" toward Indian Tribes and accepted a legally enforceable fiduciary obligation to protect Tribal treaty rights, lands, assets, and resources, as well as a duty to carry out the mandates of federal law with respect to AI/AN Tribes and villages.[1]

In 1954, the Transfer Act moved responsibility for Indian health care from the Bureau of Indian Affairs to the United States Public Health Service in the former Department of Health, Education, and Welfare, currently known as the Department of Health and Human Services (HHS), creating the Indian Health Service (IHS). The IHS was formed to provide federal health care services to

AI/AN populations based on the unique government-to-government relationship between the federal government and the Tribes established by treaties and codified in Article I, Section 8 of the US Constitution. IHS funds and delivers health services through a network of programs and facilities, providing services free of charge to eligible individuals. IHS provides an array of direct health care services at its facilities and also refers beneficiaries to private providers for care through the Purchased/Referred Care Program when needed services are not available at IHS facilities. Eligibility is generally restricted to members of federally recognized Tribes and their descendants who live within the geographic service area of an IHS or Tribally operated facility, typically on or near a reservation or other trust land area.

The Snyder Act of 1921 provided explicit legislative authorization for federal health programs for AI/AN individuals by mandating the expenditure of funds for "the relief of distress and conservation of health…(and) for the employment of…physicians…for Indian Tribes." The 1976 Indian Health Care Improvement Act (IHCIA) is the cornerstone legal authority for the provision of health care to AI/AN populations. It was permanently authorized in March 2010 as part of the Patient Protection and Affordable Care Act (ACA) with the goal to "promote traditional health care practices of the Indian Tribes served consistent with the Service standards for the provision of health care, health promotion, and disease prevention" and "fulfill special trust responsibilities and legal obligations to Indians…to ensure the highest possible health status for Indians and urban Indians and to provide all resources necessary to effect that policy."[2] The ACA included many AI/AN-specific provisions, such as greater flexibility in health insurance enrollment in the individual marketplace exchanges, limited or elimination of cost-sharing for health plans based on income, improved payment to IHS hospitals through Medicare, and promotion of traditional healing services. The legislation additionally facilitated the expansion of Medicaid, to the benefit of many AI/AN individuals. The Snyder Act and the permanent authorization of the IHCIA provide legislative authority for Congress to appropriate funds specifically for the health care of Indian people.

Since Indian Tribes are political entities, they are considered sovereign nations participating in a government-to-government relationship with the US separate from the state regulatory structure. The federal government honors this unique relationship by adhering to 2021 Executive Order 13175, which requires federal agencies to engage in meaningful Tribal consultation. As a result of the Executive Order, HHS and the Centers for Medicare & Medicaid Services (CMS) each have a Tribal consultation policy. Depending on the nature of the policy at issue, states are subject to varying levels of Tribal consultation requirements. For example, Section 5006 of the American Recovery and Reinvestment Act requires that states must seek advice from designees of Indian health programs and urban Indian organizations in the state when Medicaid and Children's Health Insurance Program (CHIP) matters have a direct effect on Indians, Indian health programs, or urban Indian programs. States are also required to describe the process for seeking advice from Indian health programs and urban Indian organizations in the Medicaid and CHIP state plans.

IHS does not provide insurance coverage or offer a defined benefit package. Further, because it is not an entitlement program, IHS offers services to the extent permitted by its annual federal appropriation and a limited amount of revenue from other sources (e.g., payment from insurers such as Medicaid). While IHS was previously the only federal health program without advance appropriations, HHS successfully secured advance appropriations for IHS starting in 2024, which means that the majority of IHS-funded programs, including Tribal health programs and urban Indian organizations, will remain funded and operational in the event of an expiration of appropriations. The Indian Health Manual sets forth the policies, standards, and procedures for determining who falls within the scope of the IHS health care program. Generally, in order to receive IHS services, an individual must be a member of a federally recognized Tribe or an Alaska

Native Claims Settlement Act shareholder. Health care services unavailable at an IHS/Tribal/Urban facility can be provided by non-IHS health care facilities through the Purchased/Referred Care (PRC) program. Since PRC payments are authorized based on clearly defined guidelines subject to availability of funds, services obtained under PRC must be prioritized, with life-threatening illnesses or injuries being given highest priority. Although there are no deductibles, coinsurance, or copayments for IHS services, insurance allows coverage for things such as specialty care, services without IHS PRC authorization, and care when away from home.

AI/AN individuals who are eligible for health care through the IHS are also entitled to Medicaid/CHIP coverage if they meet the categorical and financial eligibility requirements of the Medicaid/CHIP program in the state in which they reside. When AI/AN individuals enroll in Medicaid/CHIP or a qualified health plan (QHP) available through the Marketplace, they can continue to receive services from their local Indian health care provider and can also access services from non-IHS providers that are participating providers in Medicaid/CHIP or the QHP provider network, respectively. IHS and Tribal providers can generally bill QHP issuers or Medicaid/CHIP for services provided to their patients, and these revenues can be used to pay for costs such as hiring health professionals, purchasing equipment, and meeting accreditation requirements. Medicaid plays a secondary but significant role in financing health services for the AI/AN population, as it provides health insurance coverage for many AI/AN people.[3] In 2020, over 1.8 million AI/AN individuals were enrolled in Medicaid, meaning almost one-fifth of the AI/AN population was covered by Medicaid.[4] Services provided by IHS and Tribal physicians are also subject to a 100 percent Federal Medical Assistance Percentage. As such, Medicaid is an essential source of revenue for the facilities and programs that make up the IHS health care delivery system.

AMERICAN INDIAN/ALASKA NATIVE TRADITIONAL HEALING SERVICES

The value of AI/AN traditional healing services is often measured against modern medicine, or allopathy. Allopathy is the treatment of disease by conventional means and translates to “other than the disease.” Traditional healing is holistic and spiritual, with a focus on well-being and the promotion of health through ceremony-assisted treatments. Many modern medicines and treatments have Indigenous equivalents (e.g., aspirin is closely related to salicin found in willow bark) and studies have found that traditional healing is currently in wide-spread use,[5] with documented effectiveness in diabetes mellitus populations.[6]

A scoping review of the literature provides robust data regarding the utilization of AI/AN traditional healing services, integration of traditional and Western medicine systems, ceremonial practice for healing, and traditional healer perspectives.[7] However, published systematic reviews appear limited to determining the effectiveness of AI/AN traditional healing in treating mental illness or substance use disorders. A 2016 systematic review searched four databases and reference lists for papers that explicitly measured the effectiveness of traditional healers on mental illness and psychological distress. While there was some evidence that traditional healers can provide an effective psychosocial intervention by helping to relieve distress and improve mild symptoms in common mental disorders such as depression and anxiety, they found little evidence to suggest that traditional healers change the course of severe mental illnesses such as bipolar and psychotic disorders.[8] A 2023 systematic review assessed the feasibility of AI/AN traditional ceremonial practices to address substance use disorders in both reservation and urban settings. Between September 2021, and January 2022, culturally specific review protocols were applied to articles retrieved from over 160 electronic databases, with 10 studies meeting the criteria for inclusion in the review. While all 10 studies reported some type of quantitative data showing a reduction of substance use associated with traditional ceremonial practices, the fact that the current status of the literature is emerging did not allow for meta-analysis of existing studies.[9]

For AI/AN communities, traditional healing practices are a fundamental element of Indian health care that helps individuals achieve wellness and restores emotional balance and one's relationship with the environment. While traditional healing services are recognized by the IHCIA, there is no statutory definition for traditional healing services. Some Tribes believe that a health problem is an imbalance between an individual and the community and there are seven natural ways of emotional discharge and healing to address that imbalance: shaking, crying, laughing, sweating, voicing (i.e., talking, singing, hollering, yelling, screaming), kicking, and hitting, all of which must be done in a constructive manner so as to not harm another spirit.[10] Accordingly, Traditional AI/AN healing services might include a range of services such as (but not limited to):

- Sweat lodges
- Healing hands
- Prayer
- Smudging and purification rituals
- Song and dance
- Use of herbal remedies
- Culturally sensitive and supportive counseling
- Shamanism

Traditional healers are often identified in their Tribal community by their innate gift of healing. They typically work informally but may continue to uncover their unique gift through apprenticeship and by observing more experienced healers. Many traditional healers do not charge for their services but are given gifts as an expression of gratitude. Some healers will not accept payment at all, especially when originating from a third-party.

HEALTH EQUITY CONSIDERATIONS

In 1883, the federal government established the Code of Indian Offenses to prosecute American Indians who participated in traditional ceremonies in order to replace them with Christianity.[11] This was one of several methods utilized to restrict the cultural identity of American Indian Tribes throughout US history. In 1978, the American Indian Religious Freedom Act (AIRFA) was a pivotal turning point in addressing concerns regarding separation of church and state, legalizing traditional spirituality and ceremonies, and overturning local and state regulations that had banned AI/AN spiritual practices. In 1994, AIRFA was expanded to increase access to traditional healing services such that "when an Indian Health Service patient requests assistance in obtaining the services of a native practitioner, every effort will be made to comply…such efforts might include contacting a native practitioner, providing space or privacy within a hospital room for a ceremony, and/or the authorization of contract health care funds to pay for native healer consultation when necessary."

More recently, Congress recognized "provid[ing] the resources, processes, and structure that will enable Indian Tribes and Tribal members to obtain the quantity and quality of health care services and opportunities to eradicating health disparities between Indians and the general population of the United States," as a top national priority. After President Biden issued Executive Order 13985 in 2021 to establish equity as a cornerstone of Administration policy, the National Indian Health Board (NIHB), supported by CMS and the CMS Tribal Technical Advisory Group (TTAG), convened AI/AN leaders to consider what health equity means from a Tribal perspective. The resulting 2022 NIHB report similarly concluded that traditional healing is essential to advancing health equity. The federal government issued a second Executive Order in 2023, to further build equity into the business of government.

The 2022 NIHB report established that in pursuit of honoring Indigenous knowledge, traditional healing services should be paid utilizing paths to credentialing and billing that are Tribally led and approached with sensitivity and cultural humility. In September 2023, the CMS TTAG wrote to the CMS Administrator urging the Biden-Harris Administration to develop CMS policy in support of funding and payment for traditional healing, which would "allow Tribes to use the additional third-party revenue to expand traditional healing services, coordinate the services within the facility, hire additional healers as appropriate, and create a space for ceremonial practices."

LESSONS LEARNED IN FOSTERING CULTURAL COMPETENCE

In January 1952, two anthropologists and a physician from Cornell Medical College learned that tuberculosis raged untreated on the Navajo Reservation in Arizona. Recognizing a valuable opportunity for medical research, they designed and administered a ten-year demonstration to evaluate the efficacy of new antibiotics and test the power of modern medicine to improve the health conditions of a marginalized rural society. In 1970, they published a book detailing the demonstration and deeming the project a success, as it established a mechanism for effective, continued community control and elicited full participation by community members who expressed satisfaction with the care they received.[12] A 2002 analysis of the demonstration drew different conclusions, where "researchers exploited the opportunities made possible by the ill-health of a marginalized population…(and) erected an intrusive system of outpatient surveillance that failed to reduce the dominant causes of morbidity and mortality…(where) every act of treatment became an experiment (and) risked undermining the trust on which research and clinical care depended."[13] However, the demonstration's exploration of AI/AN traditional healing is perhaps the only semiquantitative approach to the subject and provides insights that remain useful today, as the demonstration recognized that "First, it must be realized that this is not a situation of compromising alternatives. Rather, there is belief on the part of patients that both systems have something to offer, they both 'work.'"[14]

Humility, which is at the core of AI/AN traditional healing, requires commitment to cultural connectedness, particularly when traditional healing services are provided in concert with allopathic/osteopathic care. While validated cultural connectedness measurement scales are available,[15] there are tenets of traditional healing that can be successfully incorporated into any care coordination paradigm, such as providing multigenerational visits and home visits to reinforce the value of community-and family-based care or supporting a holistic approach to care through hands-on healing, physical body manipulation, and use of Indigenous diets to promote food as medicine. More AI/AN patients are embracing the opportunity to benefit from coordination between traditional healing and allopathic/osteopathic care. For example, in the Navajo Tribe, use of healers overlaps with use of medical providers for common medical conditions and patients rarely perceive conflict between the Native healer and conventional medicine.[16] If traditional healing services are allied with the health system, care can be coordinated to accommodate individuals' needs, leading to improved health outcomes.[17] Furthermore, coordination, open communication, and transparency are critical to overcoming medical mistrust in modern medicine among AI/AN individuals.

There are two areas where it is particularly important to further cultural sensitivity in the provision of traditional healing services:

(1) Collecting data: While Indigenous Peoples need health data to help identify populations at risk and monitor the effectiveness of programs, health care centers and public health institutions regularly overlook the AI/AN community when collecting data and conducting research. Because some AI/AN patients are hesitant to allow the collection of their health care data by non-Indigenous individuals due to a lack of trust in how it might be used, this underrepresentation can

be magnified. Additionally, because Western research protocols do not prioritize providing benefits to the entire community, randomized clinical trials are often perceived as unacceptable and unfair as true randomization is difficult to apply when investigators have legacy relationships with certain individuals over others. The perception that control-group communities are receiving a lesser intervention, or none at all, can result in an ethical and cultural, and often stressful, struggle for both academic and community investigators.[18]

(2) Credentialing traditional healers: As non-AI/AN protocols cannot be easily applied in determining necessary qualifications when it comes to traditional healing services, many Tribes have established distinct processes for credentialing traditional healers. A Tribal credentialing process might involve a multi-level training program where applications are reviewed by Tribal Elders, who then interview candidates before being considered by the Council of Elders. Given the wide variation among Tribes, many agree that it would be impractical to standardize the credentialing process. Furthermore, if traditional healing is governmentally regulated and licensed, then licensing boards will tell traditional healers what conditions they can and cannot treat, what methods are acceptable, and determine who is qualified, possibly challenging Tribal sovereignty.

EFFORTS TO INTEGRATE TRADITIONAL HEALING SERVICES AND CONVENTIONAL MEDICINE

Due to the fact that traditional healing services exist outside the paradigm of conventional medicine and vary across Tribes, they do not necessarily adhere to a conventional evidence-based standard of care. Ensuring patient safety and quality of care through the delivery of evidence-based medicine remains a top priority for the AMA. Accordingly, when it comes to traditional healing services or integrative medicine services, it is important to distinguish between welcoming the benefits of culturally competent/sensitive care as adjunctive or supportive and full acceptance of non-evidence-based medicine practices as substitutes for evidence-based medicine-derived treatments. In Canada and the US, there is a growing movement toward combining traditional healing services with conventional medicine. The "wise practices" model incorporates local knowledge, culture, language, and values into program design, implementation, and evaluation. This ensures that the local context is a formal component of determining program success, allowing for improved community engagement and increased community acceptance of programs. Wise practices allow Indigenous knowledge and principles to be incorporated into public health, academic, and policy settings.

In 2020, the University of North Dakota launched the first of its kind doctoral program in Indigenous health, offering students a deeper understanding of the unique health challenges faced by Indigenous communities. The training is focused on getting to know the community and its history to allow the provision of health care on reservations that is both evidence-based and culturally competent. That same year, KFF reported that IHS facilities were actively seeking job applicants for traditional healers toward rebuilding trust and recouping Indigenous expertise. In 2022, a Federal Indian Health Insurance Plan was proposed in *Preventive Medicine Reports* that would offer a culturally competent, comprehensive health insurance product that would include payment for traditional healing services and eliminate premiums and all other forms of cost-sharing regardless of income.[19] To-date, its legislative status is unknown.

LEARNING FROM PAST CONSIDERATIONS OF ALTERNATIVE TREATMENT OPTIONS

Developing an infrastructure to allow coverage for AI/AN traditional healing services could be informed by coverage considerations for other types of traditional healing services or integrative

medicine services, which have varying degrees of success in being covered by insurance and differing evidence bases, many of which are still evolving as coverage expands.

Considerations surrounding coverage and payment for other types of alternative treatment include:

- Patient safety/quality and outcomes oversight
- Training, licensing, credentialing of providers
- Benefit design and payment structure
- Utilization uptake

Due to these and other considerations, insurance plans often have measures in place to ensure patient safety and clinical effectiveness in exchange for payment. For example, many plans only cover these services if prescribed by a physician or licensed practitioner as a demonstration of clinical benefit to the patient. Most insurance plans utilize a team of clinical experts to review which services meet their requirements for safety and effectiveness before offering coverage.

PURSUING PAYMENT FOR AI/AN TRADITIONAL HEALING SERVICES

Payment for the provision of AI/AN traditional healing services offers pathways for complementary practices, improvements in safety of care coordination, and trust-building between physicians and patients rooted in cultural sensitivity. Allowing payment for traditional healing services will likely increase access for AI/AN patients. In situations where traditional healers are unable to accept payment directly from patients, the payment can be given to the IHS facility, which can utilize the funds to procure medical supplies, invest in capital (e.g., build a Navajo Hogan), and pay the healers and other health care providers employed by the IHS.

During the August 2023 Traditional Medicine Global Summit, the World Health Organization (WHO) presented results from the third global survey on traditional medicine, which included questions on financing of traditional medicine, health of Indigenous Peoples, evidence-based traditional medicine, integration, and patient safety. In addition to informing the development of WHO's 2025-2034 traditional medicine strategy, these findings outline how standardization of traditional medicine condition documentation and coding in routine health information systems is a pre-requisite for effective implementation of traditional medicine in health care systems.

Payment for any health service usually requires establishing a coding infrastructure to allow reporting in a standardized manner. The infrastructure includes both procedural and diagnosis codes to answer the "what" and "why" of patient encounters, respectively. While there are currently no procedure codes for AI/AN traditional healing services, in May 2023, Blue Cross Blue Shield of Minnesota (BCBS MN) submitted an application for a Healthcare Common Procedural Coding System (HCPCS) Level II code to allow AI/AN Medicaid and dual-eligible members to receive and bill the health plan for traditional healing services. While approval of the code is currently pending a decision by CMS, BCBS MN will plan to pilot it with four Native-led clinics using an Indigenous evaluator to determine patient satisfaction, leaving it up to each clinic as to the level of physician involvement. Each Native-led clinic will validate the traditional healing services through its Elder in Residence, Elders Council, or Elders Advisory Board. The HCPCS Level II code will be used to pay a capitated fee, viewed as administrative remuneration to offset the grant amount. BCBS MN is currently required to use an unlisted Current Procedural Terminology (CPT®) code to allow reporting of traditional healing services, which necessitates review of each paper claim submission. The HCPCS Level II nomenclature includes code *S9900, Services by a journal-listed Christian science practitioner for the purpose of healing, per diem*, which may serve as a precedent to assist CMS in its decision. Another option could be a standard encounter fee, such

as the IHS All Inclusive Rate (AIR), which is the amount paid to IHS and Tribal facilities by CMS for Medicaid covered services per encounter (not per specific service). IHS reviews annual cost reports before submitting recommended rates to OMB for final approval through HHS. The approved AIRs are published in the *Federal Register* to allow annual updates to IHS systems. In lieu of a discrete HCPCS/CPT code, traditional healing services could be paid using an AIR.

The WHO's *International Classification of Diseases, 11th Edition* (ICD-11) allows reporting of traditional medicine diagnoses, representing a formative step for the integration of traditional medicine conditions into a classification standard used in conventional medicine. As a tool for counting and comparing traditional medicine conditions, the ICD-11 *Traditional Medicine Chapter* can provide the means for doing research and evaluation to establish efficacy of traditional medicine and collect morbidity data (e.g., payment, patient safety, research).[20]

Additionally, the *International Classification of Diseases, 10th Edition, Clinical Modification* (ICD-10-CM), which is the Health Insurance Portability & Accountability Act diagnosis code set standard, includes social determinants of health (SDOH)-related Z codes (Z55-Z65). The Z codes can be reported when documentation specifies that a patient has an associated problem or risk factor that influences their health (e.g., housing insecurity or extreme poverty), thereby helping to improve equity in health care delivery and research by:

- Empowering physicians to identify and address health disparities (e.g., care coordination and referrals)
- Supporting planning and implementation of social needs interventions
- Identifying community and population needs
- Monitoring SDOH intervention effectiveness for patient outcomes
- Utilizing data to advocate for updating and creating new policies

Payment processes for traditional healing services should be culturally sensitive, to allow individuals to "recover one's wholeness." The Anti-Deficiency Act prevents the IHS from participating in risk-based contracts, as it prohibits expenditures in excess of amounts available in appropriations. Furthermore, a bundled payment model would not be logical as healers cannot be put at risk based on outcomes in an environment where collection of demographic-based outcome data is suspect. There are several possible options for a payment model, including:

- Standard Encounter Fee: IHS, Tribal, or Urban Indian health facilities paid at the AIR per encounter rate available for Medicaid inpatient and outpatient hospital services for covered traditional healing services, with hospital services billed on a Uniform Billing Form (UB-04) at the OMB AIR using with the current rate published in the *Federal Register*.
- Fee-for-Service: Payment based on traditional healing services provided to an individual AI/AN patient and reported by a HCPCS/CPT code(s) (e.g., BCBS MN pilot)
- Member Benefit Allowance: Each eligible AI/AN patient receives an added value benefit to be spent on traditional healing services at their determination. This option could circumvent some Tribes' inability to accept payment from a third party. The self-directed community benefit is currently utilized by the New Mexico Centennial Care 2.0 Medicaid Section 1115 waiver. Native American Healers is among the specialized therapies under the member-managed annual $2,000 budget, allowing Tribal members to have access to an annual sum to use for traditional healing services.
- Medicaid Section 1115 Waivers.

MEDICAID SECTION 1115 WAIVER REQUESTS

Medicaid Section 1115 waivers may provide another path forward for payment of traditional healing services through conventional health care systems. While federal officials have called for state Medicaid programs to improve their ability to provide culturally competent services to AI/AN beneficiaries[21] and Congress granted IHS the ability to bill Medicaid, traditional healing services are not currently a Medicaid nationally covered service. However, Section 1115(a) of the Social Security Act (SSA) authorizes the Secretary of HHS to waive provisions of Section 1902 of the SSA and grant expenditure authority to treat demonstration costs as federally matchable expenditures under Section 1903 of the SSA. The Secretary's approval of experimental, pilot, or demonstration projects is discretionary and must be based on a finding that the demonstration is likely to assist in promoting the objectives of the Medicaid program.

Medicaid Section 1115 waivers are initially approved for five years and renewable for three years at a time. The waivers are required to be budget-neutral, meaning that federal spending under the waiver cannot exceed what it would have been in absence of the waiver. Although not defined by federal statue or regulations, this requirement has been in practice for many years. Over time, CMS has allowed states to calculate budget neutrality in multiple ways, although in 2018 it provided states with additional information on agency policies regarding calculating budget neutrality.

To date, four states (i.e., Arizona, California, New Mexico, and Oregon) have pursued Medicaid Section 1115 demonstration authority to cover traditional healing services furnished by Indian health providers to AI/AN Medicaid beneficiaries. In general, the waiver requests seek that the maximum amount of discretion be given to Native and Indigenous communities to establish relevant programs for each community, while allowing HHS to enact certain federal oversight requirements to ensure patient safety and program requirements are being met (e.g., background checks, verification of training, etc.) upon approval of the requests. The Center for Medicaid & CHIP Services (CMCS) is the agency charged with reviewing the state waiver requests with the goal of supporting cultural alignment of providers and patients toward reducing health disparities in the AI/AN community. CMCS has acknowledged the importance of incorporating Tribal leadership into the review process since traditional healing services vary across Tribes. Below is a summary of the current status of each state's waiver application request.

Arizona

It is expected that the Arizona waiver application will be considered by CMCS first – and then serve as the template for the other three states. The Arizona Health Care Cost Containment System (AHCCCS) initially submitted its waiver request in 2015 and then again in 2020, consulting with Tribal leadership prior to each submission. AHCCCS is requesting permission to pay for traditional healing services using Title 19 dollars, maximizing individual Tribal communities' discretion to define traditional healing services and qualifications for traditional healers. The request limits services to individuals served by the IHS and urban Indian facilities and proposes paying the AIR, which is annually established by the federal government. It also includes specific service parameters toward maximizing patient benefit and safety.

California

The California Department of Health Care Services (DHCS) has requested authority to cover Traditional Healer and Natural Helper services under the Drug Medi-Cal Organized Delivery System (DMC-ODS) in 2017, 2020, and again in 2021. The most recent request includes Traditional Healer and Natural Helper services under the DMC-ODS as part of the comprehensive California Advancing and Innovating Medi-Cal initiative. The purpose of the request is to provide culturally appropriate options and improve access to substance use disorder (SUD) treatment for

AI/AN Medi-Cal members receiving SUD treatment services through Indian health care providers. Meanwhile, DHCS provides funding and technical assistance resources to Tribal and urban Indian health programs through the Tribal MAT Project, including the Tribal and Urban Indian Community Defined Best Practices program. Described by its lead entities as "a unified response to the opioid crisis in California Indian Country," the Tribal MAT Project was designed to meet the specific opioid use disorder prevention, treatment, and recovery needs of California's Tribal and Urban Indian communities with special consideration for Tribal and urban Indian values, culture, and treatments.

New Mexico

Since 2019, New Mexico's Centennial Care 2.0 Section 1115 demonstration has provided a self-directed community budget for specialized therapies to members with a nursing-facility level of care need (NF LOC) and who receive home and community-based services (HCBS). Native American Healing is among the specialized therapies under the member-managed annual $2,000/member budget. All Tribal members with an NF LOC need are mandatorily enrolled in a health plan. Tribal members ineligible for HCBS and who have enrolled in a health plan may have access to an annual sum to use for traditional healing services; this arrangement is considered a "value-added service"[22] subject to the health plan to provide or place parameters on the benefit. In 2022, the New Mexico Human Services Department (HSD) submitted a waiver renewal application seeking federal approval to renew and enhance the Centennial Care 2.0 waiver to expand the availability of culturally competent, traditional healing benefits to AI/AN members enrolled in managed care, up to $500/member for traditional healing services to each Tribal member enrolled in managed care and lacking an NF LOC need. HSD has hosted Tribal Listening Sessions to gather feedback on the new Member-Directed Traditional Healing Benefits for Native Americans.

Oregon

In 2022, the Oregon Health Plan (OHP) submitted a Section 1115 waiver request to continue foundational elements of the OHP with a substantial refocus on addressing health inequities, including expanding benefits for AI/AN OHP members to include Tribal-based practices as a covered service, and waive prior authorization criteria for Tribal members. The Oregon Health Authority and the Oregon Tribes implemented a process by which Tribal-based practices are developed and approved by the Tribal-Based Practice Review Panel, which is comprised of Tribal representatives.

In reviewing the applications across the four states, CMCS' goal is to identify commonality of services that can be covered under Medicaid, provided by traditional healers who have been credentialed within their communities. CMCS plans to pay for traditional healing services through certified IHS facilities, who will then decide how the traditional healers are paid. It is not anticipated that traditional healing will require a referral or prior authorization, as this limits access to the service. CMCS is currently undergoing robust consultation with Tribes and IHS to identify common traditional healing services, facilities where those services are being provided, and providers who will provide them. Pending approval of the waivers, CMCS has expressed that it would require each state to develop and report on benchmarks to demonstrate how it is improving outcomes and reducing disparities, thereby requiring demonstration of value while allowing for variation by state and by Tribe.

AMA POLICY

AMA Policy H-290.987 generally supports Section 1115 waivers that assist in promoting the goals of the Medicaid program and have sufficient payment levels to secure adequate access to providers.

Policy H-350.949 encourages Medicaid managed care organizations to follow the CMS TTAG's recommendations to improve care coordination and payment agreements with Indian health care providers.

The AMA has several policies outlining the integral and culturally necessary role that traditional healing services play in delivering health care to AI/AN individuals, including:

- Policy H-350.948, which advocates for increased funding to the IHS Purchased/Referred Care Program and the Urban Indian Health Program to enable the programs to fully meet the health care needs of AI/AN patients;
- Policy H-350.976, which recognizes the "medicine man" as an integral and culturally necessary individual in delivering health care to American Indians and Alaska Natives; and
- Policy H-350.977, which supports expanding the role of the American Indian in their own health care and increased involvement of private practitioners and facilities in American Indian care.

The AMA has long-standing policy identifying, evaluating, and working to close health care disparities, including:

- Policy D-350.995, which calls for a study of health system opportunities and barriers to eliminating racial and ethnic disparities in health care;
- Policy D-350.996, which calls for the AMA to continue to identify and incorporate strategies specific to the elimination of minority health care disparities in its ongoing advocacy and public health efforts;
- Policy H-200.954, which supports efforts to quantify the geographic maldistribution of physicians and encourages medical schools and residency programs to consider developing admissions policies and practices and targeted educational efforts aimed at attracting physicians to practice in underserved areas and to provide care to underserved populations; and
- Policy H-350.974, which encourages the development of evidence-based performance measures that adequately identify socioeconomic and racial/ethnic disparities in quality and supports the use of evidence-based guidelines to promote the consistency and equity of care for all persons.

Further, Policy H-480.973 encourages the National Center for Complementary and Integrative Health to determine by objective and scientific evaluation the efficacy and safety of practices and procedures of unconventional medicine.

DISCUSSION

Resolution 106-A-23 calls for the AMA to study the impact of using Medicaid Section 1115 waivers for demonstration projects regarding payment for AI/AN traditional healing services. The Council recognizes the value of traditional healing services for AI/AN patients and understands the need for state flexibility to design Medicaid programs that best respond to the health care needs of their enrollees. The purpose of Section 1115 waivers, which give states additional flexibility to design and improve their Medicaid programs, is to demonstrate and evaluate state-specific policy approaches to better serving that state's unique population of Medicaid enrollees, including AI/AN individuals. The Council acknowledges the importance of cultural competence, particularly with regard to understanding traditional healing and its economic impact in the Section 1115 waiver program, as it requires regular monitoring and independent evaluation of outcomes, which is

challenging to do while respecting Tribal data sovereignty. Additionally, it is uncertain how generalizable outcomes might be given the vast differences among Tribes.
The Council understands the importance of distinguishing between culturally competent/sensitive care as adjunctive or supportive and full acceptance of non-evidence-based medicine practices as substitutes for evidence-based medicine-derived treatments. Further, with the Medicaid Section 1115 waiver demonstrations, we may find novel programs that are based on evidence. While support of guidelines for coordinating traditional healing services as part of the physician-led health care team was requested by Resolution 106-A-23 and is consistent with AMA policy, decisions should be made in concert with Tribes in order to ensure inclusive and culturally relevant care. Experts with whom the Council agrees have recommended that each Tribe be responsible for verifying that valid traditional healing services have been performed by credentialed healers, taking into account the "medical necessity" of the service along with the appropriate site of service (e.g., hogan versus hospital).

With many AI/AN patients utilizing traditional healing services,[23] patient safety will be maximized if there is care coordination between Indigenous healers and physicians. The Council appreciates the value of traditional healing services for AI/AN patients when provided in coordination with evidence-based conventional medicine, and believes such coordination may allow the culturally competent physician-led health care team to address Tribal social determinants of health while building trust in conventional care systems among the AI/AN community. What cannot be overlooked, however, is the substantial shortage of physicians identifying as AI/AN. As of 2021, fewer than 3,000 physicians – or 0.4 percent of total physicians – identified as American Indian or Alaska Native, according to the latest statistics from the Association of American Medical Colleges Physician Specialty Data Report. The US Government Accountability Office published a report outlining an average vacancy rate for IHS physicians, nurses, and other care providers of 25 percent. There would need to be more physicians who identify as AI/AN if the U.S. is to provide culturally sensitive care implemented by a physician-led team utilizing a traditional healing model.

AI/AN traditional healing represents a spiritual tradition tied to lifestyle, community, sovereignty issues, and land and culture preservation not easily explained by Western medicine. The history of AI/AN Tribes in the US involves dislocation and upheaval followed by sustained disregard for effective Indigenous practices based on a historic preference for conventional evidence-based medicine. Barriers to care have been created by a lack of cultural competence among systems of care that fail to question how evidence is defined.

It is critically important to remember that the US has a special responsibility to AI/AN populations due to treaty obligations and sovereign nation status which differentiate AI/AN traditional healing from other forms of traditional healing. The IHCIA and resulting creation of the IHS establish clear federal law plus a mandate to ensure the highest possible health status and to provide all resources necessary for AI/AN populations.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 106-A-23, and the remainder of the report be filed:

1. That our American Medical Association (AMA) amend Policy H-350.976 by addition and deletion, and modify the title by addition, as follows:

   Improving Health Care of American Indians and Alaska Natives H-350.976

(1) Our AMA recommends that: (1) All individuals, special interest groups, and levels of government recognize the American Indian and Alaska Native people as full citizens of the US, entitled to the same equal rights and privileges as other US citizens.
(2) The federal government provide sufficient funds to support needed health services for American Indians and Alaska Natives.
(3) State and local governments give special attention to the health and health-related needs of nonreservation American Indians and Alaska Natives in an effort to improve their quality of life.
(4) American Indian and Alaska Native religious and cultural beliefs be recognized and respected by those responsible for planning and providing services in Indian health programs.
(5) Our AMA recognize practitioners of Indigenous medicine as an integral and culturally necessary individual in delivering health care to American Indians and Alaska Natives.
(6) Our AMA support monitoring of Medicaid Section 1115 waivers that recognize the value of traditional American Indian and Alaska Native healing services as a mechanism for improving patient-centered care and health equity among American Indian and Alaska Native populations when coordinated with physician-led care.
(7) Our AMA support consultation with Tribes to facilitate the development of best practices, including but not limited to culturally sensitive data collection, safety monitoring, the development of payment methodologies, healer credentialing, and tracking of traditional healing services utilization at Indian Health Service, Tribal, and Urban Indian Health Programs.
(~~6~~8) Strong emphasis be given to mental health programs for American Indians and Alaska Natives in an effort to reduce the high incidence of alcoholism, homicide, suicide, and accidents.
(~~7~~9) A team approach drawing from traditional health providers supplemented by psychiatric social workers, health aides, visiting nurses, and health educators be utilized in solving these problems.
(~~8~~10) Our AMA continue its liaison with the Indian Health Service and the National Indian Health Board and establish a liaison with the Association of American Indian Physicians.
(~~9~~11) State and county medical associations establish liaisons with intertribal health councils in those states where American Indians and Alaska Natives reside.
(~~10~~12) Our AMA supports and encourages further development and use of innovative delivery systems and staffing configurations to meet American Indian and Alaska Native health needs but opposes overemphasis on research for the sake of research, particularly if needed federal funds are diverted from direct services for American Indians and Alaska Natives.
(~~11~~13) Our AMA strongly supports those bills before Congressional committees that aim to improve the health of and health-related services provided to American Indians and Alaska Natives and further recommends that members of appropriate AMA councils and committees provide testimony in favor of effective legislation and proposed regulations. (Modify HOD Policy)

2. That our AMA reaffirm Policy D-350.996, which states that the AMA will continue to identify and incorporate strategies specific to the elimination of minority health care disparities in its ongoing advocacy and public health efforts. (Reaffirm HOD Policy)

3. That our AMA reaffirm Policy H-200.954, which supports efforts to quantify the geographic maldistribution of physicians and encourages medical schools and residency programs to consider developing admissions policies and practices and targeted educational efforts aimed at attracting physicians to practice in underserved areas and to provide care to underserved populations. (Reaffirm HOD Policy)

4. That our AMA reaffirm Policy H-350.949, which encourages state Medicaid agencies to follow the Centers for Medicare & Medicaid Services Tribal Technical Advisory Group's recommendations to improve care coordination and payment agreements between Medicaid managed care organizations and Indian health care providers. (Reaffirm HOD Policy)

5. That our AMA reaffirm Policy H-350.977, which supports expanding the American Indian role in their own health care and increased involvement of private practitioners and facilities in American Indian health care through such mechanisms as agreements with Tribal leaders or Indian Health Service contracts, as well as normal private practice relationships. (Reaffirm HOD Policy)

Fiscal Note: Less than $500.

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Council on Medical Service Report 3-A-24
Review of Payment Options for Traditional Healing Services
Policy Appendix

Strategies for Eliminating Minority Health Care Disparities D-350.996
Our American Medical Association (AMA) will continue to identify and incorporate strategies specific to the elimination of minority health care disparities in its ongoing advocacy and public health efforts, as appropriate.
Res. 731, I-02 Modified: CCB/CLRPD Rep. 4, A-12 Reaffirmed: CCB/CLRPD Rep. 1, A-22

US Physician Shortage H-200.954
Our AMA:
(1) explicitly recognizes the existing shortage of physicians in many specialties and areas of the US;
(2) supports efforts to quantify the geographic maldistribution and physician shortage in many specialties;
(3) supports current programs to alleviate the shortages in many specialties and the maldistribution of physicians in the US;
(4) encourages medical schools and residency programs to consider developing admissions policies and practices and targeted educational efforts aimed at attracting physicians to practice in underserved areas and to provide care to underserved populations;
(5) encourages medical schools and residency programs to continue to provide courses, clerkships, and longitudinal experiences in rural and other underserved areas as a means to support educational program objectives and to influence choice of graduates' practice locations;
(6) encourages medical schools to include criteria and processes in admission of medical students that are predictive of graduates' eventual practice in underserved areas and with underserved populations;
(7) will continue to advocate for funding from public and private payers for educational programs that provide experiences for medical students in rural and other underserved areas;
(8) will continue to advocate for funding from all payers (public and private sector) to increase the number of graduate medical education positions in specialties leading to first certification;
(9) will work with other groups to explore additional innovative strategies for funding graduate medical education positions, including positions tied to geographic or specialty need;
(10) continues to work with the Association of American Medical Colleges (AAMC) and other relevant groups to monitor the outcomes of the National Resident Matching Program; and
(11) continues to work with the AAMC and other relevant groups to develop strategies to address the current and potential shortages in clinical training sites for medical students.
(12) will: (a) promote greater awareness and implementation of the Project ECHO (Extension for Community Healthcare Outcomes) and Child Psychiatry Access Project models among academic health centers and community-based primary care physicians; (b) work with stakeholders to identify and mitigate barriers to broader implementation of these models in the United States; and (c) monitor whether health care payers offer additional payment or incentive payments for physicians who engage in clinical practice improvement activities as a result of their participation in programs such as Project ECHO and the Child Psychiatry Access Project; and if confirmed, promote awareness of these benefits among physicians.
(13) will work to augment the impact of initiatives to address rural physician workforce shortages.

(14) supports opportunities to incentivize physicians to select specialties and practice settings which involve delivery of health services to populations experiencing a shortage of providers, such as women, LGBTQ+ patients, children, elder adults, and patients with disabilities, including populations of such patients who do not live in underserved geographic areas
Res. 807, I-03 Reaffirmation I-06 Reaffirmed: CME Rep. 7, A-08 Appended: CME Rep. 4, A-10 Appended: CME Rep. 16, A-10 Reaffirmation: I-12 Reaffirmation A-13 Appended: Res. 922, I-13 Modified: CME Rep. 7, A-14 Reaffirmed: CME Rep. 03, A-16 Appended: Res. 323, A-19 Appended: CME Rep. 3, I-21 Reaffirmation: I-22 Appended: Res. 105, A-23 Reaffirmed: BOT Rep. 11, A-23

Medicaid Waivers for Managed Care Demonstration Projects H-290.987
(1) Our AMA adopts the position that the Secretary of Health and Human Services should determine as a condition for granting waivers for demonstration projects under Section 1115(a) of the Medicaid Act that the proposed project: (i) assist in promoting the Medicaid Act's objective of improving access to quality medical care, (ii) has been preceded by a fair and open process for receiving public comment on the program, (iii) is properly funded, (iv) has sufficient provider reimbursement levels to secure adequate access to providers, (v) does not include provisions designed to coerce physicians and other providers into participation, such as those that link participation in private health plans with participation in Medicaid, and (vi) maintains adequate funding for graduate medical education. (2) Our AMA advocates that CMS establish a procedure which state Medicaid agencies can implement to monitor managed care plans to ensure that (a) they are aware of their responsibilities under EPSDT, (b) they inform patients of entitlement to these services, and (c) they institute internal review mechanisms to ensure that children have access to medically necessary services not specified in the plan's benefit package. (BOT Rep. 24, A-95; Reaffirmation A-99; Reaffirmation A-00; Reaffirmation I-04; Modified: CMS Rep. 1, A-14)

Medicaid Managed Care for Indian Health Care Providers H-350.949
Our AMA will: (1) support stronger federal enforcement of Indian Health Care Medicaid Managed Care Provisions and other relevant laws to ensure state Medicaid agencies and their Medicaid managed care organizations (MCO) are in compliance with their legal obligations to Indian health care providers; and (2) encourage state Medicaid agencies to follow the Centers for Medicare and Medicaid Services Tribal Technical Advisory Group’s recommendations to improve care coordination and payment agreements between Medicaid managed care organizations and Indian health care providers.
Res. 208, A-23

Improving Health Care of American Indians H-350.976
Our AMA recommends that: (1) All individuals, special interest groups, and levels of government recognize the American Indian people as full citizens of the US, entitled to the same equal rights and privileges as other U.S. citizens.
(2) The federal government provide sufficient funds to support needed health services for American Indians.
(3) State and local governments give special attention to the health and health-related needs of nonreservation American Indians in an effort to improve their quality of life.
(4) American Indian religious and cultural beliefs be recognized and respected by those responsible for planning and providing services in Indian health programs.
(5) Our AMA recognize the “medicine man” as an integral and culturally necessary individual in delivering health care to American Indians.
(6) Strong emphasis be given to mental health programs for American Indians in an effort to reduce

the high incidence of alcoholism, homicide, suicide, and accidents.
(7) A team approach drawing from traditional health providers supplemented by psychiatric social workers, health aides, visiting nurses, and health educators be utilized in solving these problems.
(8) Our AMA continue its liaison with the Indian Health Service and the National Indian Health Board and establish a liaison with the Association of American Indian Physicians.
(9) State and county medical associations establish liaisons with intertribal health councils in those states where American Indians reside.
(10) Our AMA supports and encourages further development and use of innovative delivery systems and staffing configurations to meet American Indian health needs but opposes overemphasis on research for the sake of research, particularly if needed federal funds are diverted from direct services for American Indians.
(11) Our AMA strongly supports those bills before Congressional committees that aim to improve the health of and health-related services provided to American Indians and further recommends that members of appropriate AMA councils and committees provide testimony in favor of effective legislation and proposed regulations.
CLRPD Rep. 3, I-98 Reaffirmed: Res. 221, A-07 Reaffirmation A-12 Reaffirmed: Res. 233, A-13 Reaffirmed: BOT Rep. 09, A-23

Indian Health Service H-350.977
The policy of the AMA is to support efforts in Congress to enable the Indian Health Service to meet its obligation to bring American Indian health up to the general population level. The AMA specifically recommends: (1) Indian Population: (a) In current education programs, and in the expansion of educational activities suggested below, special consideration be given to involving the American Indian and Alaska native population in training for the various health professions, in the expectation that such professionals, if provided with adequate professional resources, facilities, and income, will be more likely to serve the tribal areas permanently; (b) Exploration with American Indian leaders of the possibility of increased numbers of nonfederal American Indian health centers, under tribal sponsorship, to expand the American Indian role in its own health care; (c) Increased involvement of private practitioners and facilities in American Indian care, through such mechanisms as agreements with tribal leaders or Indian Health Service contracts, as well as normal private practice relationships; and (d) Improvement in transportation to make access to existing private care easier for the American Indian population.
(2) Federal Facilities: Based on the distribution of the eligible population, transportation facilities and roads, and the availability of alternative nonfederal resources, the AMA recommends that those Indian Health Service facilities currently necessary for American Indian care be identified and that an immediate construction and modernization program be initiated to bring these facilities up to current standards of practice and accreditation.
(3) Manpower: (a) Compensation for Indian Health Service physicians be increased to a level competitive with other Federal agencies and nongovernmental service; (b) Consideration should be given to increased compensation for service in remote areas; (c) In conjunction with improvement of Service facilities, efforts should be made to establish closer ties with teaching centers, thus increasing both the available manpower and the level of professional expertise available for consultation; (d) Allied health professional staffing of Service facilities should be maintained at a level appropriate to the special needs of the population served; (e) Continuing education opportunities should be provided for those health professionals serving these communities, and especially those in remote areas, and, increased peer contact, both to maintain the quality of care and to avert professional isolation; and (f) Consideration should be given to a federal statement of policy supporting continuation of the Public Health Service to reduce the great uncertainty now felt by many career officers of the corps.

(4) Medical Societies: In those states where Indian Health Service facilities are located, and in counties containing or adjacent to Service facilities, that the appropriate medical societies should explore the possibility of increased formal liaison with local Indian Health Service physicians. Increased support from organized medicine for improvement of health care provided under their direction, including professional consultation and involvement in society activities should be pursued.
(5) Our AMA also support the removal of any requirement for competitive bidding in the Indian Health Service that compromises proper care for the American Indian population.
(6) Our AMA will advocate that the Indian Health Service (IHS) establish an Office of Academic Affiliations responsible for coordinating partnerships with LCME- and COCA-accredited medical schools and ACGME-accredited residency programs.
(7) Our AMA will encourage the development of funding streams to promote rotations and learning opportunities at Indian Health Service, Tribal, and Urban Indian Health Programs.
CLRPD Rep. 3, I-98 Reaffirmed: CLRPD Rep. 1, A-08 Reaffirmation A-12 Reaffirmed: Res. 233, A-13 Appended: Res. 305, A-23 Reaffirmed: BOT Rep. 09, A-23

REPORT 7 OF THE COUNCIL ON MEDICAL SERVICE (A-24)
Ensuring Privacy in Retail Health Care Settings
(Reference Committee A)

EXECUTIVE SUMMARY

At the 2023 Annual Meeting, the House of Delegates adopted Policy H-315.960, which asks our American Medical Association to "study privacy protections, privacy consent practices, the potential for data breaches, and the use of health data for non-clinical purposes in retail health care settings."

The growth in retail health care clinics makes them a significant player in the $4 trillion US health care system. Retail health care is a term used to describe two discrete models of care: 1) walk-in clinics that provide treatment from employed non-physician practitioners; or 2) services that connect patients with participating online clinics. This distinction is important as it has implications in deciphering responsibilities of covered entities and business associates, respectively.

While the Health Insurance Portability and Accountability Act (HIPAA) has been in place since 1996, misconceptions have muddied the waters around what is and is not a covered entity or business associate, and what is or is not protected health information (PHI). Furthermore, there is confusion surrounding retail health care companies' HIPAA status, as they require patients to read and comprehend several documents together in order to understand their rights. For these reasons, the Council has developed recommended guardrails surrounding retail health care companies' handling of PHI.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 7-A-24

Subject: Ensuring Privacy in Retail Health Care Settings

Presented by: Sheila Rege, MD, Chair

Referred to: Reference Committee A

At the 2023 Annual Meeting, the House of Delegates adopted Policy H-315.960, which asks our American Medical Association (AMA) to "study privacy protections, privacy consent practices, the potential for data breaches, and the use of health data for non-clinical purposes in retail health care settings." Testimony at the 2023 Annual Meeting regarding the resolution was unanimously supportive, highlighting a strong commitment to patient privacy as well as expansion to include health data for nonclinical purposes and all retail health care settings. This report focuses on current privacy practices in retail health care settings, highlights AMA advocacy efforts and essential policy, and presents new policy recommendations.

BACKGROUND

As of March 2023, there were 1,801 active retail health care clinics in 44 states, predominantly in major metropolitan areas. While only two percent of retail health care clinics are in rural areas, CVS Health owns half of those as well as 63 percent of all retail health care clinics. Kroger Health is the second largest, at 12 percent market share, with more than 220 retail clinics in 35 states, and Walgreens is the third largest at eight percent.[1] Other participants include Walmart, Amazon, Best Buy, and Dollar General. Most retail clinics are in the Southeast and the Midwest, which account for 62 percent of locations. Nearly half (49.1 percent) of all retail clinics are concentrated in seven states: Texas, Florida, Ohio, California, Georgia, Illinois, and Tennessee, which can be attributed to population density. Retail health care clinics have seen a 202 percent increase in utilization from 2021 to 2022,[2] which is a greater growth percentage than seen by urgent care centers, primary care practices, and hospital emergency departments. While retail health care has been around since the early 2000s, it is now a significant player in the $4 trillion U.S. health care system.[3] Retailers' substantial financial resources and far reach allow them to push a customized consumer experience focused on convenience and driven by digital health products, permitting them to get closer to consumers as e-commerce erodes their traditional business. Companies such as CVS Health, Walgreens, Costco, and Amazon continue to expand their services, pulling together different technology-enabled services such as urgent, primary, home, and specialty care along with pharmacy and, in some cases, full integration with an insurer, prompting anti-trust and privacy concerns.

A 2022 AMA survey found that while 92 percent of people believe that privacy of their health data is a right, most are unclear about the rules relevant to their privacy. The AMA is concerned that health data are increasingly vulnerable and has called for regulations for an individual's right to control, access, and delete personal data collected about them. The issue is further exacerbated by the Supreme Court's decision to overturn *Roe v. Wade*, which challenges the right to privacy by

potentially enabling law enforcement to gain access to health data related to abortion care and pregnancy.[4] As such, the AMA has outlined five privacy principles for a national privacy framework, including:

- Individual rights
- Equity
- Entity responsibility
- Applicability
- Enforcement

SNAPSHOT OF CURRENT RETAIL HEALTH CARE MARKET

Walmart is reportedly in negotiations with ChenMed, which touts itself as "family-owned, family-oriented organization committed to bringing superior health care to moderate-to-low-income seniors." Walgreens recently announced that it is teaming up with technology company Pearl Health, which has a platform to enable value-based care. The collaboration will merge Pearl's operating system capabilities with Walgreens' care delivery assets, allowing Walgreens to function as a management services organization for physicians and hospitals. Costco is partnering with the online platform Sesame, which operates outside of insurance networks in order to cater to patients with high-deductible health plans and to the uninsured. Costco will be able to offer same-day telehealth primary care visits for $29, as well as video prescription refills, mental health consults, and in-person visits for urgent care, among other services. In 2018, Amazon acquired start-up PillPack, which later became Amazon Pharmacy. In November 2022, the company launched Amazon Clinic, a virtual health service that provides users with 24/7 access to physicians and nurse practitioners on Amazon's website and mobile application (app). In February 2023, Amazon purchased One Medical, which is a membership-based, tech-integrated primary care platform. Amazon is now piloting delivery of medications via drone, airlifting certain common medicines to homes within 60 minutes.[5] Most recently, Amazon introduced its Health Conditions Programs, an initiative that enables customers to discover digital health benefits to help manage chronic conditions such as diabetes and hypertension. Customers answer questions to determine if their insurance covers a program and if they are clinically eligible for that program, for which they gain access to specific services (e.g., virtual health coaching) and devices (e.g., continuous glucose monitors) covered by their plan. CVS Health owns Aetna, Oak Street Health, and Caremark. In December 2017, CVS announced its merger with Aetna, representing the biggest health care merger in US history, involving both a horizontal and a vertical merger. While the AMA led advocacy efforts to block the union, it was eventually approved.

FEDERAL DATA PRIVACY LAWS

The Health Insurance Portability and Accountability Act (HIPAA) was enacted in 1996, establishing a comprehensive set of standards for protecting sensitive patient health information. The HIPAA Privacy Rule establishes national standards to protect individuals' medical records and other individually identifiable patient health information (collectively defined as "protected health information" or PHI). It requires appropriate safeguards to protect the privacy of PHI and sets limits and conditions on the uses and disclosures that may be made of such information without an individual's authorization.

PHI is any individually identifiable health information created, received, maintained, or transmitted by a covered entity or business associate that:

- Relates to the past, present, or future physical or mental health or condition of an individual,
- The provision of health care to an individual, or
- The past, present, or future payment for the provision of health care to an individual.

The United States does not have a federal law that affirms who owns medical records. Under HIPAA, patients have the right to access data medical information in their medical records. The HIPAA Privacy Rule requires appropriate safeguards to protect the privacy of PHI and sets limits and conditions on the uses and disclosures that may be made of such information without an individual's authorization. The HIPAA Privacy Rule also gives individuals rights over their PHI, including rights to examine and obtain a copy of their health records, to direct a covered entity to transmit to a third-party an electronic copy of their protected health information in an electronic health record, and to request corrections. It applies to all entities that fall within the definition of a "covered entity," which includes health plans, health care clearinghouses, and those health care providers that conduct certain health care transactions electronically. Third-party organizations that provide a service for or on behalf of a covered entity are referred to as "business associates" when the service they provide requires that the covered entity disclose PHI to them; common examples of a business associate are a claims processing entity or appointment scheduling service. All business associates are required to comply with HIPAA privacy protections to the same extent as the covered entity for which the services are performed.

Retail health care is a term used to describe two discrete models of care: 1) walk-in clinics that provide treatment from employed non-physician practitioners (e.g., CVS Minute Clinic); or 2) services that connect patients with participating online clinics (e.g., Amazon Clinic). This distinction is important as it has implications in deciphering responsibilities of covered entities (e.g., CVS Affiliated Covered Entity, which designates itself as a single covered entity made up of covered entities and health care providers owned or controlled by CVS) and business associates, respectively. In order to help health care providers and organizations determine their HIPAA status, the Centers for Medicare & Medicaid Services has developed a *Covered Entity Decision Tool*.

While HIPAA has been in place since 1996, misconceptions persist regarding what is and is not a covered entity or business associate, and what is or is not PHI. Fortunately, in this regard, the HIPAA regulations have not changed in 10 years, since the 2013 HIPAA and Health Information Technology for Economic Clinical Health Act (HITECH) Omnibus Rule. Therefore, the following still hold true:

- A legally compliant business associate (BA) status can only be achieved by signing a BA agreement (BAA) with a covered entity (CE).
- The minimum terms of each business association agreement (BAA) are mandated by regulations, which have also not changed since 2013.
- The Privacy Rule provides that a BAA must require a BA to return all PHI to the CE or destroy the PHI at the termination of the BAA where feasible.

Legally, the HIPAA Privacy Rule applies to covered entities and business associates. Covered entities are also responsible for guaranteeing their business associates are safeguarding PHI under contract. The contract between the covered entity and its business associate must be HIPAA compliant. If a business associate breaches its contract, then it is up to the covered entity to correct that breach or terminate the contract. In the event of a loss of PHI by a BA, a CE can be responsible for their loss of data.

Health care data that are not created, received, maintained, or transmitted by a CE or BA are referred to as "health care adjacent data" and are not protected by the HIPAA Privacy Rule, nor subject to the safeguards of the HIPAA Security Rule. The HIPAA Security Rule requires CEs and BAs to maintain reasonable and appropriate administrative, technical, and physical safeguards for protecting electronically stored PHI (ePHI). However, health care entities that collect, use, store, and share personal health data from digital health platforms, apps, and other similar software programs (e.g., Fitbit) are not CEs or BAs and are, therefore, beyond the reach of HIPAA. These apps may be held legally accountable by federal regulators for inappropriate disclosures or data breaches by the Federal Trade Commission (FTC).

RETAIL HEALTH CARE ORGANIZATIONS' HIPAA STATUS

In some cases, there is confusion regarding a retail health care company's HIPAA status, requiring patients to read and comprehend several documents together in order to understand their rights. Determining which organizations HIPAA protections apply is a complex question, as HIPAA regulates not only the three types of covered entities (health plans, health care clearinghouses, and health care providers who transmit health information electronically in connection with a covered transaction), but also their business associates, which can be difficult for the layperson to identify. Additionally, while retail health companies often contend that they have stringent customer privacy policies, they may still require customers to sign away some data protection rights. For example, Amazon's privacy page explains that the Clinic is not a health care provider – in other words, it is not a HIPAA covered entity. It goes on to explain that Amazon Clinic is a service provider to health care providers – thereby classifying it as a HIPAA business associate, retaining patient PHI in order to "coordinate health care services and update customer information to facilitate services from other providers." However, the Amazon Clinic HIPAA Authorization webpage states that it is "in compliance with federal privacy laws, including HIPAA" and includes FAQs that reference its use of "HIPAA compliant technology." The challenge is that the Amazon Clinic HIPAA Authorization needs to be read together with the intricate terms of several other Amazon legal policies, including its Amazon Clinic Terms of Use, Amazon.com Conditions of Use, and Amazon.com Privacy Notice in order for patients to understand all their privacy rights. While retail health companies contend that they have stringent customer privacy policies, there have been accounts of companies requiring customers to sign away some data protection rights. In May 2023, the *Washington Post* reported that when enrolling for Amazon Clinic, users are required to provide consent to allow the use and disclosure of their PHI. The form that patients are asked to complete states that after providing consent, Amazon will be authorized to have access to the complete patient file, may re-disclose information contained in that file, and that the information disclosed will no longer be subject to HIPAA Rules.[6] While the terms are voluntary, individuals have no option of using Amazon Clinic if they do not agree to the terms and conditions.[7] The fundamental problem is that once patients agree to the Amazon Clinic authorization, they agree their health information may no longer be protected by HIPAA.[8] How retail health care companies decide to manipulate data and use it may not become apparent for many years.

CONSUMER PROTECTION & PRIVACY LAWS

Retail health care organizations that electronically transmit standard transactions (e.g., payment, enrollment, eligibility) are covered entities subject to HIPAA. They are also subject to other consumer protection and privacy laws for non-HIPAA covered entities. Privacy rights are included in the FTC's authority to protect consumers from deceptive or unfair business practices. The FTC Health Breach Notification Rule specifically applies to non-HIPAA covered entities who are required to notify their customers, the FTC, and, in some instances, the media if there is a breach of unsecured, individually identifiable health information.[9]

The State of Washington recently passed a privacy-focused law to protect PHI that falls outside HIPAA. The My Health My Data Act makes it illegal to sell or offer to sell PHI without first obtaining authorization from the consumer.[10] Several other states (i.e., California, Colorado, Connecticut, Utah, and Virginia) have enacted general privacy laws with varying applicability to retail health care companies. The latter laws include various exemptions for PHI, HIPAA de-identified information, health care providers, HIPAA covered entities, HIPAA business associates, and non-profits. While all of the latter laws exempt PHI, retail health care companies may have obligations under these laws with respect to other personal information, such as website data.[11]

RETAIL HEALTH PRIVACY PROTECTIONS & CONSENT PRACTICES

In a privacy notice, retail health care companies outline how HIPAA allows them to use and share PHI for treatment, payment, and health care operations. Their privacy notices also describe the circumstances where uses and disclosures of PHI do not require patient approval, including certain uses and disclosures by business associates (i.e., service providers to health care providers), designated patient caregivers, workers' compensation claims, law enforcement, judicial or administrative proceedings, public health purposes, health oversight activities (e.g., audits), institutional review board-approved research, coroners, medical examiners and funeral directors, organ procurement organizations, correctional institutions, and military/national security activities. Retail health care companies are prohibited from disclosing PHI for purposes other than those described in their notices or for marketing purposes of any kind without written patient consent. Additionally, patients are notified that they may revoke their approval at any time, although most companies require submission of formal written notice, explaining that revocation cannot undo any use or sharing of PHI that has already happened based on previously granted permission.

It is important to note that Amazon Clinic is not required to secure any additional waiver or "authorization" from prospective patients in order for Amazon Clinic to provide the services it promises to perform in regard to matching the patient with an available medical provider. This type of scheduling and care coordination is one aspect of "health care operations" under HIPAA, and falls within the Treatment, Payment, and Health Care Operations permissible disclosures under HIPAA, for which no patient authorization is required.* Per Department of Health & Human Services-Office of Civil Rights (OCR) guidance, "A business associate agreement may authorize a business associate to make uses and disclosures of PHI the covered entity itself is permitted by the HIPAA Privacy Rule to make. See 45 C.F.R. § 164.504(e)." Patients are asked to sign a voluntary Amazon Clinic HIPAA authorization. The superfluous nature of Amazon's HIPAA authorization form seems to be a tactic aimed at obtaining valuable PHI. This strategy not only allows Amazon access to use and disclose the PHI relevant to its patient matching services, it secures Amazon's ability to collect, use, and disclose each patient's "complete patient file" – far exceeding the amount of information needed to match a patient with a medical provider.

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* See 45 C.F.R. §164.506(a) Standard: Permitted uses and disclosures. A covered entity may use or disclose protected health information for treatment, payment, or health care operations provided that such use or disclosure is consistent with other applicable requirements of this subpart. (emphasis in original). See also, "Health care operations are any of the following activities: (a) quality assessment and improvement activities, including case management and care coordination . . ." (emphasis in original) https://www.hhs.gov/hipaa/for-professionals/privacy/laws-regulations/index.html#:~:text=Health %20care %20operations%20are%20any,c)%20conducting%20or%20arranging%20for. See finally, 45 C.F.R. §164.506 (c)(2): "A covered entity may disclose protected health information for treatment activities of a health care provider." In the case of Amazon Clinic, Amazon discloses patient PHI to its participating providers to facilitate the patient's treatment, in addition to care coordination.

The breadth of retail health care companies' coast-to-coast networks can amplify privacy concerns. In December 2023, the Senate Committee on Finance found that eight of the nation's largest pharmacy chains had routinely turned over customers' PHI to law enforcement agencies, even without a warrant, concluding that, "these companies' privacy practices vary widely, in ways that seriously impact patient privacy." None of the companies required a warrant before turning over requested data, as HIPAA does not require law enforcement to obtain a warrant or judge-issued subpoena before they make a lawful request for records containing PHI.

ETHICAL & COMPETITIVE CONSIDERATIONS

The investment banking industry utilizes a virtual information barrier between those who have material, non-public information and those who do not, to prevent conflicts of interest, sometimes referred to as an "ethical wall" or privacy wall. The legal services industry utilizes a similar firewall to protect clients by restraining access to information in order to prevent conflicts of interest among law firm attorneys who may have represented a now adverse party in their prior legal work. Establishing a privacy wall between the health business and non-health business of retail health care companies could eliminate sharing of identifiable PHI or re-identifiable PHI for uses not directly related to patients' medical care.

Amazon's acquisition of One Medical is a cautionary example. The union allows Amazon to collect a large cache of PHI to further cement its dominance as an online intermediary for goods and services. Amazon's cross-industry reach allows it to use data to develop detailed insights about individuals, without much risk of violating privacy laws. In order to protect the privacy of patients, it will be important for Amazon to commit to having a privacy wall between its patient data and its other areas. Amazon notes that it "will never share One Medical PHI outside of One Medical for advertising or marketing purposes of other Amazon products and services without clear permission from the customer."[12] However, Amazon makes patients accept its conditions of use prior to treatment, which signs away their PHI protections.[13] The combination of a vast product distributor and marketer with sensitive PHI sets the stage for unfettered targeted advertising.

The implications of horizonal-vertical health care mergers, such as the one between CVS and Aetna, cannot be overlooked. An AMA evidence-based analysis showed how the merger would reduce competition in five key health care markets: Medicare Part D; health insurance; pharmacy benefit management; retail pharmacy; and specialty pharmacy, leading to higher premiums and lower-quality insurance products. Such mergers may lead to increased access to PHI, leveraging data on individual biology, medical history, level of well-being, shopping habits, sleep hygiene, nicotine consumption, and exercise routines to shape patients' digital health IDs. This can allow health insurers to reduce their risks and, therefore, their costs by restricting access to health care services for high-risk patients and vulnerable populations.

POTENTIAL FOR DATA BREACHES

On February 21, 2024, a cyberattack against UnitedHealth Group's Change Healthcare disrupted operations for physicians, hospitals, insurers, and pharmacies. Change Healthcare uses Amazon Web Services (AWS) to submit and process insurance claims, handling close to 14 billion transactions a year. As of March 1, 2024, Change Healthcare reported that it was working with Microsoft and AWS to perform an additional scan of its cloud environment. This breach highlights the potential for cyberattacks to affect patient privacy in the retail health care setting.

The four most common reasons for data breaches include cyberattacks, unauthorized disclosure, theft, and improper disposal of PHI.[14] As retail health care companies expand their reach, the risk

of a data breach increases exponentially, especially if they fail to establish the technical controls, training, and employee sanctions necessary to isolate retail health care business from other lines of business. Legal and technical firewalls are essential in preventing retail health care data breaches because they serve as the first line of defense in protecting ePHI from external threats such as hacking, as well as unauthorized or unintended disclosures across business lines.

Once a covered entity knows or by reasonable diligence should have known (referred to as the "date of discovery") that a breach of PHI has occurred, the entity has an obligation to notify the relevant parties "without unreasonable delay" or up to 60 calendar days following the date of discovery, even if upon discovery the entity was unsure as to whether PHI had been compromised. If the breach involves the unsecured PHI of more than 500 individuals, a covered entity must notify a prominent media outlet serving the state or jurisdiction in which the breach occurred, in addition to notifying the Department of Health & Human Services (HHS). For breaches involving fewer than 500 individuals, covered entities are permitted to maintain a log of the relevant information and notify HHS within 60 days after the end of the calendar year via the HHS website. Additionally, covered entities may offer affected individuals free identity restoration services or credit reports for a defined period of time. While such offerings are well intended, they do not necessarily allow reparations commensurate with the degree of harm experienced by the affected individuals.

USE OF HEALTH DATA FOR NON-CLINICAL PURPOSES

Secondary use of PHI includes activities such as analysis, research, quality and safety measurement, public health, payment, physician accreditation, marketing, risk stratifying to limit care to high-risk patients and vulnerable populations, and other business applications. As retail health care companies continue to expand their reach, the potential for them to use PHI for non-clinical purposes grows. The FTC sent a letter to Amazon in anticipation of its acquisition of One Medical, reminding it of the obligation to protect sensitive health information and inquiring as to how the integrated entity will use One Medical PHI for purposes beyond the provision of health care. Amazon's acquisition of One Medical was finalized in February 2023 without a regulatory challenge. While the FTC could file a lawsuit to unwind the transaction in the future, experts agree that if regulators had found a reason to block the deal, they already would have. Granting retail health care companies enormous tranches of PHI is viewed by some as a mistake, given that loopholes exist in every legal framework.

THE ROLE OF AUGMENTED INTELLIGENCE IN DATA PRIVACY

De-identifying PHI enables HIPAA covered entities to share health data for large-scale medical research studies, policy assessments, comparative effectiveness studies, and other studies and assessments without violating the privacy of patients or requiring authorizations to be obtained from each patient prior to data being disclosed. Once PHI is de-identified and theoretically can no longer be traced back to an individual, it is no longer protected by the HIPAA Privacy Rule.[15] HIPAA-compliant de-identification of PHI is possible using one of two methods – Safe Harbor or Expert Determination. While neither method will remove all risk of re-identification of patients, both can reduce risk. In essence, almost all de-identified PHI is re-identifiable.

A covered entity may assign a code or other means of record identification to allow information de-identified to be re-identified by the covered entity. However, as long as the covered entity does not use or disclose the code or other means of record identification for any other purpose or does not disclose the mechanism for re-identification, they remain compliant with HIPAA.

The complexity and rise of data in health care means that augmented intelligence (AI) will increasingly be applied within the field. Several types of AI are already employed by payers, health plans, and life sciences companies. At the present time, the key categories of applications involve diagnosis and treatment recommendations, patient engagement and adherence, and administrative activities.[16] Health care adjacent data, such as data collected by wearables and health care applications, are commonly transmitted to an AI-driven health care solution – for example, for the early diagnosis of a heart condition. Accordingly, there is rising concern about the ability of AI to facilitate the re-identification of PHI with relative ease. AI algorithms are sophisticated enough to "learn" new strategies from data, such as how to discern patterns in the data. Through this detection, an algorithm may be able to effect PHI re-identification. The HIPAA Privacy Rule outlines specific requirements to adhere to when de-identifying health data, but there is currently no standardized approach for using de-identified data or validating best practices. While current laws do not address the role AI might play in data privacy, regulators are continually enacting and revising their policies, such as the European Union's General Data Protection Regulation (GDPR) and California's Consumer Privacy Act (CCPA). Under the GDPR, there must be a legal basis for collecting personal data, while the CCPA requires that users have the ability to opt out of any personal information collection practices. At the federal level, National Institute of Standards and Technology AI Standards are currently under development, while the Government Accountability Office report, Artificial Intelligence in Health Care provides guidance for future legislation. In the interim, AI vendors and software developers are advised to follow the Xcertia mHealth Guidelines, which align with many of HIPAA's standards and are backed by the AMA, one of the founding members. The Joint Commission recently launched the Responsible Use of Health Data Certification (RUHD), a voluntary program aimed at providing health care entities with an objective evaluation of how well they maintain health data privacy best practices in their secondary use of data for endeavors such as operations improvement or AI development. The RUHD will evaluate whether an organization de-identifies data in accordance with HIPAA, whether it has established a governance structure for the use of de-identified data, and how the organization communicates with key stakeholders about the secondary use of de-identified data. The AMA has also recently created a set of AI Principles which identify and advocate for enhanced protections for de-identified data when used in conjunction with generative AI and large language models.

ROADBLOCKS TO PRIVACY PROTECTION

As HIPAA only covers CEs and BAs, concerns arise in the regulation of entities currently beyond the scope of HIPAA, such as digital health platforms, apps, and other similar software programs that collect, use, store, and share personal health data. Under federal law there is no floor – no minimum threshold at all – for an organization's privacy policy. Thus, any health app or digital health platform can word their stated privacy policy in a weak, evasive, easy-to-comply-with manner that will sound reassuring to the consumers who choose to read it. Unfair and deceptive acts and practices affective commerce are a required basis of an FTC action. This is in stark contrast to the HIPAA Notice of Privacy Practices, which must include specific representations as to a CE's privacy practices.

Entities such as Amazon Clinic have taken a savvy approach by positioning themselves as BAs and thus subject to HIPAA, which reassures consumers. Amazon Clinic's BA status appears to have been achieved by entering into a BAA with each of the medical providers (i.e., CEs) who participate with Amazon Clinic. Amazon Clinic collects data from consumers and matches them with the Clinic's participating providers. Amazon is able to avoid most of the compliance burden and privacy protections that HIPAA requires of BAs, by requiring consumers to click through a screen whereby they effectively waive their HIPAA protections. Under HIPAA, a BA may not use or disclose PHI in a manner that would violate the Privacy Rule if done by the CE, but HIPAA

does allow patients to effectively waive their rights against disclosure by the CE by giving an authorization, which is how Amazon characterizes its waiver/click-through screen. While amending HIPAA to provide that BAs may not get a waiver from consumers might be helpful, sophisticated companies such as Amazon would likely devise a strategy so the patient "authorization for disclosure" appears to come from the medical provider, and patient authorizations to disclose their PHI are a necessary feature of HIPAA. When patients sign up for treatment through Amazon Clinic, they also authorize all those involved (physicians, pharmacies, laboratories) to share their PHI with Amazon. Amazon then has the right to "retain, use, and disclose" PHI to facilitate services from "other providers." It is unclear who these other providers are, leading some to believe it could include businesses looking to target patients with ads related to their condition. A substantial hurdle to privacy protection seems to be the willingness of consumers to click through screens.

CHALLENGING PRIVACY ROADBLOCKS

To ensure robust privacy protections, the Council believes that retail health care companies should be prohibited from utilizing "clickwrap" agreements, which are online agreements where the user indicates their acceptance by clicking a button or checking a box that states, "I agree." While the purpose of a clickwrap agreement is to digitally capture acceptance of a contract, they permit patients to access a service without specific affirmative consent to data sharing. Common uses include asking website visitors to acknowledge that the website they are visiting uses cookies, installing a mobile app, or connecting to a wireless network.

The Council also believes it is important that retail health care companies' Terms of Use do not require data sharing for uses not directly related to patients' medical care in order to receive care – unless required by law (e.g., reporting of infectious diseases). Operationally, this means that the Terms of Use should be distinct from the Notice of Privacy Practices, with clear indication that patients are not required to sign the latter in order to receive care. Retail health care companies should provide education on this concept to reduce patient vulnerability and achieve meaningful consent.

There are four types of consent: express consent, implied consent, opt-in consent and opt-out consent. Several retail health care companies utilize opt-out consent, which assumes user consent unless they act to withdraw it. Opt-out consent requires users to take action to indicate non-consent, placing the responsibility on users to actively protect their data. When opt-out consent is coupled with deceptive wording, it may lead patients to agree to something without meaningful consent. Meaningful consent requires a patient to be given sufficient and understandable knowledge to make a valid decision. Requiring retail health care companies to use a default opt-in consent plus plain language is essential toward protecting patients' privacy and fostering health literacy. Once consent is given, it then becomes important to provide clear direction on how patients can withdraw consent. Section 1798.105(a) of the California Consumer Privacy Act grants consumers the right to request that a business delete any personal information about the consumer which the business has collected from the consumer. While the CCPA "right to be forgotten" has many exceptions that allow businesses to keep personal information, it could serve as a prototype for regulations in the retail health care arena.

RELEVANT AMA POLICY, ADVOCACY, & RESOURCES

The AMA Privacy Principles, derived primarily from AMA House of Delegates policy, serve as the foundation for AMA advocacy on privacy extrinsic to HIPAA covered entities. In addition to shifting the responsibility for privacy from individuals to data holders, the principles implore that

individuals have the right to know whether their data will be used to develop and/or train AI algorithms and hold entities accountable toward making their de-identification processes and techniques publicly available. These Principles were developed based on an identified need to extend AMA advocacy efforts beyond protections for HIPAA covered entities to (1) provide individuals with rights and protections from discrimination; (2) shift the responsibility for privacy from individuals to data holders other than HIPAA covered entities; and (3) create principles for robust enforcement, individual rights, equity, applicability, and entity responsibility. The AMA Privacy Principles advocate for the expansion of FTC oversight to consumer data that is accessed, used, or exchanged by technology companies and vendors not classified as covered entities under HIPAA. The Principles contend that "health care data" is a subjective term and one that should be evaluated by a federal agency with broad expertise in data privacy. Accordingly, the AMA Privacy Principles' use of the term "data" includes information that can be used to identify an individual, even if it is not descriptive on its face, such as IP addresses and advertising identifiers from mobile phones.

While the AMA Privacy Principles recognize a role for the FTC, it is important to note why the OCR is absent from the discussion. The OCR administers and enforces HIPAA regulations with a focus on PHI, and, therefore, expanding OCR's HIPAA legislative umbrella to include technology companies and vendors not classified as covered entities was a consideration. However, it was recognized that (1) OCR lacks the structure, resources, and expertise to regulate technology companies and vendors, who are themselves new entrants into the health care arena, and (2) an existing federal agency is better equipped to regulate health data that flows outside the traditional HIPAA covered entity arena. Furthermore, extending HIPAA protections for PHI to non-HIPAA covered technology companies and vendors could create a gap in needed privacy policies.

Although the Office of the National Coordinator for Health Information Technology (ONC) is not mentioned in the AMA Privacy Principles, it has a role in ensuring that sensitive medical information regarding reproductive health, sexual orientation, gender identity, and substance use disorder is placed behind a firewall in the electronic health record as well as when it is requested and shared with others using national health information exchanges, such as under ONC's Trusted Exchange Framework and Common Agreement. The 21st Century Cures Act lifted limitations on the scope of ePHI, allowing information blocking regulations to go into full effect. Physicians who interfere with the access, exchange, or use of ePHI could be considered "information blockers" and subject to financial penalties, making it difficult for them to protect sensitive information.

The AMA's longstanding goal to support strong protections for patient privacy is reinforced by several policies, including those that:

- Advocate for legislation that aligns mobile health apps and other digital health tools with the AMA Privacy Principles (Policy D-315.968);
- Oppose the sale or transfer of medical history data and contact information for use in marketing or advertising (Policy D-315.973);
- Engage with stakeholders to identify relevant guiding principles to promote a vibrant, useful, and trustworthy mHealth market (Policy D-480.972);
- Advocate for narrowing the definition of "health care operations" to include only those activities that are routine and critical for general business operations and that cannot be reasonably undertaken with de-identified health information (Policy H-315.975);
- Support strong protections for patient privacy and, in general, require that patient medical records be kept strictly confidential unless waived by the patient in a meaningful way, de-

identified, or in rare instances when strong countervailing interests in public health or safety justify invasions of patient privacy or breaches of confidentiality (Policy H-315.983);

- Work to ensure that computer-based patient record systems and networks, and the legislation and regulations governing their use, include adequate technical and legal safeguards for protecting the confidentiality, integrity, and security of patient data (Policy H-315.989); and
- Support that mHealth apps and associated devices, trackers and sensors must abide by applicable laws addressing the privacy and security of patients' medical information (Policy
- H-480.943).

AMA policy has been developed related to the potential complications introduced by the intersection of AI and patient privacy, including those that:

- Re-examine existing guidance relevant to the confidentiality of patient information, striving to preserve the benefits of widespread use of de-identified patient data for purposes of promoting quality improvement, research, and public health while mitigating the risks of re-identification of such data (Policy D-315.969);
- Support efforts to promote transparency in the use of de-identified patient data and to protect patient privacy by developing methods of, and technologies for, de-identification of patient information that reduce the risk of re-identification of such data (Policy H-315.962); and
- Promote development of thoughtfully designed, high-quality, clinically validated health care AI that safeguards patients' privacy interests and preserves the security and integrity of personal information (Policy H-480.940).

The AMA has written several comment letters addressing the issue of patient privacy, including a December 2018 letter to NIST which references the tenets of Policy H-315.983, noting that when breaches of confidentiality are compelled by concerns for public health and safety, those breaches must be as narrow in scope and content as possible, must contain the least identifiable and sensitive information possible, and must be disclosed to the fewest possible to achieve the necessary end. In a February 2019 letter to the Office for Civil Rights, the AMA offers suggestions on a Request for Information about modifying HIPAA Rules to improve coordinated care, including how the regulations can be revised to promote the goals of value-based care and care coordination while preserving and protecting the privacy and security of a patient's health information. In May 2019, the AMA submitted patient privacy comments to several recipients, including the Office of the National Coordinator for Health Information Technology and the Centers for Medicare & Medicaid Services, and the FTC. While slightly different audiences, the message for each was similar, with a focus on the AMA approach to privacy. The AMA outlined how data segmentation is critical for health information exchange, regardless of where the data resides, how it is used, or with whom it is exchanged. Consistent with that approach, patient consent and privacy, data provenance, governance, and state and federal law compliance must be inherent in the development of technology. A June 2023 letter to the National Governors Association urged that comprehensive state legislative privacy proposals provide adequate protections for consumer health data, especially health data obtained by apps and other devices or organizations that do not fall within HIPAA or state privacy laws. In August 2023, the AMA submitted written comments to the FTC regarding the Health Breach Notification Rule, noting the deficiencies in regulation of health apps. A September 2023 AMA letter to Senator Bill Cassidy in response to his request for information outlines the distinction between PHI and health information outside of HIPAA, and the potential for harm to individuals caused by confusion between the two.

In addition to advocacy, the AMA provides members with robust resources on the issue of patient privacy. The AMA health data privacy framework surveyed patient perspectives to shed light on

fundamental data privacy issues that can impact individuals nationwide, while the AMA patient privacy webpage provides resources to ensure that patients have meaningful controls over their PHI. As part of the AMA Patient Access Playbook, the AMA has developed a case for privacy by design in app development. The 2023 AMA Principles for Augmented Intelligence Development, Deployment, and Use address privacy and cybersecurity as well as establish guardrails around payer use of AI in automated denials.

DISCUSSION

While HIPAA was enacted in 1996, misconceptions have muddied the waters around what is and is not a covered entity or business associate, and what is or is not PHI. Given that HIPAA only governs covered entities and business associates, concerns arise in the regulation of entities currently beyond the scope of HIPAA, such as digital health platforms, apps, and other similar software programs that collect, use, store, and share personal health data. Under federal law there is no floor – no minimum threshold – for an organization's privacy policy other than it cannot be unfair or deceptive. Thus, any health app or digital health platform can word their stated privacy policy in a weak, evasive, easy-to-comply-with manner that will sound reassuring to the consumers who choose to read it. Furthermore, there is confusion surrounding retail health care companies' HIPAA status, as they require patients to read and comprehend several documents together in order to understand their rights. Determining which organizations HIPAA applies to can be difficult for the layperson.

The Council therefore recommends a series of principles to address retail health care companies' handling of PHI. Any health care providing entity, or one that is facilitating the referral of patients for care, regardless of whether it provides the care directly, must be held to the standard of a HIPAA covered entity, complete with a privacy wall between the health and non-health lines of business to eliminate sharing of PHI for uses not directly related to patients' medical care. Retail health care companies should be prohibited from utilizing "clickwrap" agreements, which permit patients to use a service without affirmatively consenting to the data sharing. It is also important that retail health care companies' Terms of Use do not require data sharing for uses not directly related to patients' medical care in order to receive care unless required by law. Operationally, this means that the Terms of Use should be distinct from the Notice of Privacy Practices, with clear indication that patients are not required to sign the latter in order to receive care. Requiring retail health care companies to use a default opt-in consent plus plain language is essential toward protecting patients' privacy and fostering health literacy. Opt-in user consent requires patients to acknowledge the proposed data activity, understand the purposes for collection, and agree to have their data collected, processed, and stored. Once consent is given, it then becomes important to provide clear direction on how patients can withdraw consent.

The Council also recommends reaffirmation of policies that advocate for legislation that aligns mobile health apps and other digital health tools with the AMA Privacy Principles, supports efforts to promote transparency in the use of de-identified patient data, and promotes development of thoughtfully designed, high-quality, clinically validated health care AI that safeguards patients' privacy interests and preserves the security and integrity of personal information.

RECOMMENDATIONS

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

1. That our American Medical Association (AMA) will:
   (a) support regulatory guidance to establish a privacy wall between the health business and non-health business of retail health care companies to eliminate sharing of protected health information, re-identifiable patient data, or data that could be reasonably be used to re-identify a patient when combined with other data for uses not directly related to patients' medical care;
   (b) support the prohibition of Terms of Use that require data sharing for uses not directly related to patients' medical care in order to receive care, while still allowing data sharing where required by law (e.g., infectious disease reporting);
   (c) support the separation of consents required to receive care from any consents to share data for non-medical care reasons, with clear indication that patients do not need to sign the data-sharing agreements in order to receive care;
   (d) support the prohibition of "clickwrap" contracts for use of a health care service without affirmative patient consent to data sharing;
   (e) support the requirement that retail health care companies must use an active opt-in selection for obtaining meaningful consent for data use and disclosure, otherwise the default should be that the patient does not consent to disclosure;
   (f) support the requirement that retail health care companies clearly indicate how patients can withdraw consent and request deletion of data retained by the non-health care providing units, which should be by a means no more onerous than providing the initial consent. (New HOD Policy)

2. That our AMA reaffirm Policy D-315.968, which advocates for legislation that aligns mobile health apps and other digital health tools with the AMA Privacy Principles. (Reaffirm HOD Policy)

3. That our AMA reaffirm Policy H-315.962, which supports efforts to promote transparency in the use of de-identified patient data and to protect patient privacy by developing methods of, and technologies for, de-identification of patient information that reduce the risk of re-identification of such data. (Reaffirm HOD Policy)

4. That our AMA reaffirm Policy H-480.940, which promotes development of thoughtfully designed, high-quality, clinically validated health care AI that safeguards patients' privacy interests and preserves the security and integrity of personal information. (Reaffirm HOD Policy)

5. Rescind Policy H-315.960, as having been completed with this report. (Rescind HOD Policy)

Fiscal Note: Less than $500.

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Council on Medical Service Report 7-A-24
Ensuring Privacy in Retail Health Care Settings
Policy Appendix

Supporting Improvements to Patient Data Privacy D-315.968
Our AMA will (1) strengthen patient and physician data privacy protections by advocating for legislation that reflects the AMA's Privacy Principles with particular focus on mobile health apps and other digital health tools, in addition to non-health apps and software capable of generating patient data and (2) will work with appropriate stakeholders to oppose using any personally identifiable data to identify patients, potential patients who have yet to seek care, physicians, and any other health care providers who are providing or receiving health care that may be criminalized in a given jurisdiction.
Res. 227, A-22 Modified: Res. 230, I-22 Reaffirmation: A-23

Research Handling of De-Identified Patient Information D-315.969
The Council on Ethical and Judicial Affairs will consider re-examining existing guidance relevant to the confidentiality of patient information, striving to preserve the benefits of widespread use of de-identified patient data for purposes of promoting quality improvement, research, and public health while mitigating the risks of re-identification of such data.
BOT Rep. 16, I-21

Preventing Inappropriate Use of Patient Protected Medical Information in the Vaccination Process D-315.973
Our AMA will: (1) advocate to prohibit the use of patient/customer information collected by retail pharmacies for COVID-19 vaccination scheduling and/or the vaccine administration process for commercial marketing or future patient recruiting purposes, especially any targeting based on medical history or conditions; and (2) oppose the sale or transfer of medical history data and contact information accumulated through the scheduling or provision of government-funded vaccinations to third parties for use in marketing or advertising.
Res. 232, A-21

Guidelines for Mobile Medical Applications and Devices D-480.972
1. Our AMA will monitor market developments in mobile health (mHealth), including the development and uptake of mHealth apps, in order to identify developing consensus that provides opportunities for AMA involvement.
2. Our AMA will continue to engage with stakeholders to identify relevant guiding principles to promote a vibrant, useful and trustworthy mHealth market.
3. Our AMA will make an effort to educate physicians on mHealth apps that can be used to facilitate patient communication, advice, and clinical decision support, as well as resources that can assist physicians in becoming familiar with mHealth apps that are clinically useful and evidence based.
4. Our AMA will develop and publicly disseminate a list of best practices guiding the development and use of mobile medical applications.
5. Our AMA encourages further research integrating mobile devices into clinical care, particularly to address challenges of reducing work burden while maintaining clinical autonomy for residents and fellows.
6. Our AMA will collaborate with the Liaison Committee on Medical Education and Accreditation Council for Graduate Medical Education to develop germane policies, especially with

consideration of potential financial burden and personal privacy of trainees, to ensure more uniform regulation for use of mobile devices in medical education and clinical training.
7. Our AMA encourages medical schools and residency programs to educate all trainees on proper hygiene and professional guidelines for using personal mobile devices in clinical environments.
8. Our AMA encourages the development of mobile health applications that employ linguistically appropriate and culturally informed health content tailored to linguistically and/or culturally diverse backgrounds, with emphasis on underserved and low-income populations.
CSAPH Rep. 5, A-14 Appended: Res. 201, A-15 Appended: Res. 305, I-16 Modified: Res. 903, I-19

Research Handling of De-Identified Patient Information H-315.962
Our AMA supports efforts to promote transparency in the use of de-identified patient data and to protect patient privacy by developing methods of, and technologies for, de-identification of patient information that reduce the risk of re-identification of such information.
BOT Rep. 16, I-21 Reaffirmation: A-22

Police, Payer, and Government Access to Patient Health Information H-315.975
(1) Our AMA advocates vigorously, with respect to the final privacy rule or other privacy legislation, to define "health care operations" narrowly to include only those activities and functions that are routine and critical for general business operations and that cannot reasonably be undertaken with de-identified information.
(2) Our AMA advocates vigorously, with respect to the final privacy rule or other privacy legislation, that the Centers for Medicare & Medicaid Services (CMS) and other payers shall have access to medical records and individually identifiable health information solely for billing and payment purposes, and routine and critical health care operations that cannot reasonably be undertaken with de-identified health information.
(3) Our AMA advocates vigorously, with respect to the final privacy rule or other privacy legislation, that CMS and other payers may access and use medical records and individually identifiable health information for non-billing, non-payment purposes and non-routine, non-critical health care operations that cannot reasonably be undertaken with de-identified health information, only with the express written consent of the patient or the patient's authorized representative, each and every time, separate and apart from blanket consent at time of enrollment.
(4) Our AMA advocates vigorously, with respect to the final privacy rule or other privacy legislation that no government agency, including law enforcement agencies, be permitted access to medical records or individually identifiable health information (except for any discretionary or mandatory disclosures made by physicians and other health care providers pursuant to ethical guidelines or to comply with applicable state or federal reporting laws) without the express written consent of the patient, or a court order or warrant permitting such access.
(5) Our AMA continues to strongly support and advocate a minimum necessary standard of disclosure of individually identifiable health information requested by payers, so that the information necessary to accomplish the intended purpose of the request be determined by physicians and other health care providers, as permitted under the final privacy rule.
Res. 246, A-01 Reaffirmation I-01 Reaffirmation A-02 Reaffirmed: BOT Rep. 19, I-06 Reaffirmation A-07 Reaffirmed: BOT Rep. 19, A-07 Reaffirmed: BOT Rep. 22, A-17 Reaffirmed: BOT Rep. 16, I-21

Patient Privacy and Confidentiality H-315.983
1. Our AMA affirms the following key principles that should be consistently implemented to evaluate any proposal regarding patient privacy and the confidentiality of medical information: (a)

That there exists a basic right of patients to privacy of their medical information and records, and that this right should be explicitly acknowledged; (b) That patients' privacy should be honored unless waived by the patient in a meaningful way or in rare instances when strong countervailing interests in public health or safety justify invasions of patient privacy or breaches of confidentiality, and then only when such invasions or breaches are subject to stringent safeguards enforced by appropriate standards of accountability; (c) That patients' privacy should be honored in the context of gathering and disclosing information for clinical research and quality improvement activities, and that any necessary departures from the preferred practices of obtaining patients' informed consent and of de-identifying all data be strictly controlled; (d) That any information disclosed should be limited to that information, portion of the medical record, or abstract necessary to fulfill the immediate and specific purpose of disclosure; and (e) That the Health Insurance Portability and Accountability Act of 1996 (HIPAA) be the minimal standard for protecting clinician-patient privilege, regardless of where care is received.

2. Our AMA affirms: (a) that physicians and medical students who are patients are entitled to the same right to privacy and confidentiality of personal medical information and medical records as other patients, (b) that when patients exercise their right to keep their personal medical histories confidential, such action should not be regarded as fraudulent or inappropriate concealment, and (c) that physicians and medical students should not be required to report any aspects of their patients' medical history to governmental agencies or other entities, beyond that which would be required by law.

3. Employers and insurers should be barred from unconsented access to identifiable medical information lest knowledge of sensitive facts form the basis of adverse decisions against individuals. (a) Release forms that authorize access should be explicit about to whom access is being granted and for what purpose and should be as narrowly tailored as possible. (b) Patients, physicians, and medical students should be educated about the consequences of signing overly-broad consent forms. (c) Employers and insurers should adopt explicit and public policies to assure the security and confidentiality of patients' medical information. (d) A patient's ability to join or a physician's participation in an insurance plan should not be contingent on signing a broad and indefinite consent for release and disclosure.

4. Whenever possible, medical records should be de-identified for purposes of use in connection with utilization review, panel credentialing, quality assurance, and peer review.

5. The fundamental values and duties that guide the safekeeping of medical information should remain constant in this era of computerization. Whether they are in computerized or paper form, it is critical that medical information be accurate, secure, and free from unauthorized access and improper use.

6. Our AMA recommends that the confidentiality of data collected by race and ethnicity as part of the medical record, be maintained.

7. Genetic information should be kept confidential and should not be disclosed to third parties without the explicit informed consent of the tested individual.

8. When breaches of confidentiality are compelled by concerns for public health and safety, those breaches must be as narrow in scope and content as possible, must contain the least identifiable and sensitive information possible, and must be disclosed to the fewest possible to achieve the necessary end.

9. Law enforcement agencies requesting private medical information should be given access to such information only through a court order. This court order for disclosure should be granted only if the law enforcement entity has shown, by clear and convincing evidence, that the information sought is necessary to a legitimate law enforcement inquiry; that the needs of the law enforcement authority cannot be satisfied by non-identifiable health information or by any other information; and that the law enforcement need for the information outweighs the privacy interest of the

individual to whom the information pertains. These records should be subject to stringent security measures.
10. Our AMA must guard against the imposition of unduly restrictive barriers to patient records that would impede or prevent access to data needed for medical or public health research or quality improvement and accreditation activities. Whenever possible, de-identified data should be used for these purposes. In those contexts where personal identification is essential for the collation of data, review of identifiable data should not take place without an institutional review board (IRB) approved justification for the retention of identifiers and the consent of the patient. In those cases where obtaining patient consent for disclosure is impracticable, our AMA endorses the oversight and accountability provided by an IRB.
11. Marketing and commercial uses of identifiable patients' medical information may violate principles of informed consent and patient confidentiality. Patients divulge information to their physicians only for purposes of diagnosis and treatment. If other uses are to be made of the information, patients must first give their uncoerced permission after being fully informed about the purpose of such disclosures
12. Our AMA, in collaboration with other professional organizations, patient advocacy groups and the public health community, should continue its advocacy for privacy and confidentiality regulations, including: (a) The establishment of rules allocating liability for disclosure of identifiable patient medical information between physicians and the health plans of which they are a part, and securing appropriate physicians' control over the disposition of information from their patients' medical records. (b) The establishment of rules to prevent disclosure of identifiable patient medical information for commercial and marketing purposes; and (c) The establishment of penalties for negligent or deliberate breach of confidentiality or violation of patient privacy rights.
13. Our AMA will pursue an aggressive agenda to educate patients, the public, physicians and policymakers at all levels of government about concerns and complexities of patient privacy and confidentiality in the variety of contexts mentioned.
14. Disclosure of personally identifiable patient information to public health physicians and departments is appropriate for the purpose of addressing public health emergencies or to comply with laws regarding public health reporting for the purpose of disease surveillance.
15. In the event of the sale or discontinuation of a medical practice, patients should be notified whenever possible and asked for authorization to transfer the medical record to a new physician or care provider. Only de-identified and/or aggregate data should be used for "business decisions," including sales, mergers, and similar business transactions when ownership or control of medical records changes hands.
16. The most appropriate jurisdiction for considering physician breaches of patient confidentiality is the relevant state medical practice act. Knowing and intentional breaches of patient confidentiality, particularly under false pretenses, for malicious harm, or for monetary gain, represents a violation of the professional practice of medicine.
17. Our AMA Board of Trustees will actively monitor and support legislation at the federal level that will afford patients protection against discrimination on the basis of genetic testing.
18. Our AMA supports privacy standards that would require pharmacies to obtain a prior written and signed consent from patients to use their personal data for marketing purposes.
19. Our AMA supports privacy standards that require pharmacies and drug store chains to disclose the source of financial support for drug mailings or phone calls.
20. Our AMA supports privacy standards that would prohibit pharmacies from using prescription refill reminders or disease management programs as an opportunity for marketing purposes.
21. Our AMA will draft model state legislation requiring consent of all parties to the recording of a physician-patient conversation.

BOT Rep. 9, A-98 Reaffirmation I-98 Appended: Res. 4, and Reaffirmed: BOT Rep. 36, A-99 Appended: BOT Rep. 16 and Reaffirmed: CSA Rep. 13, I-99 Reaffirmation A-00 Reaffirmed: Res. 246 and 504 and Appended Res. 504 and 509, A-01 Reaffirmed: BOT Rep. 19, I-01 Appended: Res. 524, A-02 Reaffirmed: Sub. Res. 206, A-04 Reaffirmed: BOT Rep. 24, I-04 Reaffirmed: BOT Rep. 19, I-06 Reaffirmation A-07 Reaffirmed: BOT Rep. 19, A-07 Reaffirmed: CEJA Rep. 6, A-11 Reaffirmed in lieu of Res. 705, A-12 Reaffirmed: BOT Rep. 17, A-13 Modified: Res. 2, I-14 Reaffirmation: A-17 Modified: BOT Rep. 16, A-18 Appended: Res. 232, A-18 Reaffirmation: I-18 Reaffirmed: Res. 219, A-21 Reaffirmed: Res. 229, A-21 Reaffirmed: BOT Rep. 12, I-21 Reaffirmed: BOT Rep. 22, A-22 Reaffirmation: A-23

Confidentiality of Computerized Patient Records H-315.989
The AMA will continue its leadership in protecting the confidentiality, integrity, and security of patient-specific data; and will continue working to ensure that computer-based patient record systems and networks, and the legislation and regulations governing their use, include adequate technical and legal safeguards for protecting the confidentiality, integrity, and security of patient data.
BOT Rep. F, A-93 Reaffirmation I-99 Reaffirmed: BOT Rep. 19, I-06 Reaffirmed: BOT Rep. 19, A-07 Reaffirmed in lieu of Res. 818, I-07 Reaffirmation I-08 Reaffirmation A-10 Reaffirmed: BOT Rep. 17, A-13

Augmented Intelligence in Health Care H-480.940
As a leader in American medicine, our AMA has a unique opportunity to ensure that the evolution of augmented intelligence (AI) in medicine benefits patients, physicians, and the health care community.
To that end our AMA will seek to:
1. Leverage its ongoing engagement in digital health and other priority areas for improving patient outcomes and physicians' professional satisfaction to help set priorities for health care AI.
2. Identify opportunities to integrate the perspective of practicing physicians into the development, design, validation, and implementation of health care AI.
3. Promote development of thoughtfully designed, high-quality, clinically validated health care AI that:
a. is designed and evaluated in keeping with best practices in user-centered design, particularly for physicians and other members of the health care team;
b. is transparent;
c. conforms to leading standards for reproducibility;
d. identifies and takes steps to address bias and avoids introducing or exacerbating health care disparities including when testing or deploying new AI tools on vulnerable populations; and
e. safeguards patients and other individuals privacy interests and preserves the security and integrity of personal information.
4. Encourage education for patients, physicians, medical students, other health care professionals, and health administrators to promote greater understanding of the promise and limitations of health care AI.
5. Explore the legal implications of health care AI, such as issues of liability or intellectual property, and advocate for appropriate professional and governmental oversight for safe, effective, and equitable use of and access to health care AI.
BOT Rep. 41, A-18

Integration of Mobile Health Applications and Devices into Practice H-480.943
1. Our AMA supports the establishment of coverage, payment and financial incentive mechanisms to support the use of mobile health applications (mHealth apps) and associated devices, trackers and sensors by patients, physicians and other providers that: (a) support the establishment or continuation of a valid patient-physician relationship; (b) have a high-quality clinical evidence base to support their use in order to ensure mHealth app safety and effectiveness; (c) follow evidence-based practice guidelines, especially those developed and produced by national medical specialty societies and based on systematic reviews, to ensure patient safety, quality of care and positive health outcomes; (d) support care delivery that is patient-centered, promotes care coordination and facilitates team-based communication; (e) support data portability and interoperability in order to promote care coordination through medical home and accountable care models; (f) abide by state licensure laws and state medical practice laws and requirements in the state in which the patient receives services facilitated by the app; (g) require that physicians and other health practitioners delivering services through the app be licensed in the state where the patient receives services, or be providing these services as otherwise authorized by that state's medical board; and (h) ensure that the delivery of any services via the app be consistent with state scope of practice laws.
2. Our AMA supports that mHealth apps and associated devices, trackers and sensors must abide by applicable laws addressing the privacy and security of patients' medical information.
3. Our AMA encourages the mobile app industry and other relevant stakeholders to conduct industry-wide outreach and provide necessary educational materials to patients to promote increased awareness of the varying levels of privacy and security of their information and data afforded by mHealth apps, and how their information and data can potentially be collected and used.
4. Our AMA encourages the mHealth app community to work with the AMA, national medical specialty societies, and other interested physician groups to develop app transparency principles, including the provision of a standard privacy notice to patients if apps collect, store and/or transmit protected health information.
5. Our AMA encourages physicians to consult with qualified legal counsel if unsure of whether an mHealth app meets Health Insurance Portability and Accountability Act standards and also inquire about any applicable state privacy and security laws.
6. Our AMA encourages physicians to alert patients to the potential privacy and security risks of any mHealth apps that he or she prescribes or recommends, and document the patient's understanding of such risks
7. Our AMA supports further development of research and evidence regarding the impact that mHealth apps have on quality, costs, patient safety and patient privacy.
8. Our AMA encourages national medical specialty societies to develop guidelines for the integration of mHealth apps and associated devices into care delivery.
CMS Rep. 06, I-16 Reaffirmation: A-17 Reaffirmation: A-23

REPORT 8 OF THE COUNCIL ON MEDICAL SERVICE (A-24)
Sustainable Payment for Community Practices
(Resolution 108-A-23)
(Reference Committee A)

EXECUTIVE SUMMARY

At the 2023 Annual Meeting, the House of Delegates referred Resolution 108-A-23, which asked the American Medical Association (AMA) to assess the prevalence of insurance payments to small medical practices that are below Medicare rates and the impact of these payment levels on the ability of practices to provide care. The resolution also asked the AMA to consider the impact on small and medium-sized practices of being excluded from population health management, outcome evidence-based care, and value-based purchasing arrangements, as well as to consider model legislation to address payment rates below the cost of practicing. Council on Medical Service Report 7-I-23 was referred back to the Council to allow reconsideration of a) non-Medicare benchmarks for private payers; b) a minimum government rate, including Medicaid; and c) the impact that rates below these benchmarks have on small community practices.

Despite the current trend toward larger practices, more than half of physicians still work in small practices of 10 or fewer physicians, a percentage that has fallen continuously since 2012. While small practices have some advantages that cannot be matched by larger practices, they are not necessarily well equipped to succeed in value-based purchasing arrangements, which require financial investment and regulatory, technological, and analytic expertise. Given that the single most important factor in ensuring a sustainable level of payment for small practices is leverage, collaboration to form alliances may provide the scale needed to negotiate value-based contracts and to spread the risk across multiple practices. Strong network adequacy requirements and fair out-of-network rules are also essential for the sustainability of small practices.

While research shows that private insurance payment rates are, on average, higher than Medicare payment rates for the same medical services, it also indicates that Medicaid payment rates are substantially below Medicare payment rates. Small practices have a higher percentage of private health insurance patients than larger practices, which should benefit them. However, not all private insurance payments are reflective of the full cost of practice, the value of the care provided, or include inflation-based updates. These inadequate payment levels are exacerbated by the fact that in 2019, Medicaid fee-for-service payments for physician services were nearly 30 percent below Medicare payment levels, with an even larger differential for primary care physician services.

While AMA policy does not endorse a specific payment mechanism such as the Medicare Resource-Based Relative Value Scale (RBRVS), it does support payment at no less than 100 percent of RBRVS Medicare allowable as one option that could provide the basis for both public and private physician payment systems.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 8-A-24

Subject: Sustainable Payment for Community Practices (Resolution 108-A-23)

Presented by: Sheila Rege, MD, Chair

Referred to: Reference Committee A

At the 2023 Annual Meeting, the House of Delegates (HOD) referred Resolution 108, which was sponsored by the District of Columbia Delegation. Resolution 108-A-23 asked for the American Medical Association (AMA) to:

> "(1) study small medical practices to assess the prevalence of insurance payments to these practices that are below Medicare rates and to assess the effects of these payment levels on practices' ability to provide care, and report back by the 2024 Annual Meeting; (2) study and report back on remedies for such reimbursement rates for physician practices; (3) study the impact on small and medium-sized physician practices of being excluded from population health management, outcome evidence-based care, and value-based purchasing arrangements; and study and report back to the House of Delegates options for model legislation for states and municipalities seeking to correct reimbursement rates for medical practices that are below those required to meet fixed costs."

The Council on Medical Service developed Report 7-I-23, Sustainable Payment for Community Practices, which was referred to allow reconsideration of a) non-Medicare benchmarks for private payers; b) a minimum government rate, including Medicaid; and c) the impact that rates below these benchmarks have on small community practices.

In this report, the Council expands on the discussion included in Council Report 7-I-23 to include Medicaid payment schedules and how they compare to Medicare and private insurance payment rates, while acknowledging the costs of providing care to the Medicaid population as well as the challenges of tying payment schedules to a Medicare benchmark. Our focus is on non-hospital owned small practices, which are typically not eligible for facility fees nor possess the market power inherent in larger, hospital-owned practices. We compare Medicare, Medicaid, and private insurance payment rates, outline collaborative and negotiating resources available to small practices, highlight essential AMA policy and resources, and present new policy recommendations.

BACKGROUND

Despite the current trend toward larger practices, more than half of physicians (51.8 percent) still work in small practices of 10 or fewer physicians, a percentage that has fallen continuously from 61.4 percent in 2012.[1] Contributing factors to the shift include mergers and acquisitions, practice closures, physician job changes, and the different practice settings chosen by younger physicians compared to those of retiring physicians. The "cohort effect"[2] demonstrates that younger

physicians appear to prefer larger practices for the more predictable income and work-life balance they can offer.[3] They also may be hesitant to assume the business and entrepreneurial responsibilities demanded by smaller practices.[4]

However, small practices have some advantages that cannot be matched by larger practices, most notably patients of small practices have lower rates of preventable readmissions than those in larger practices.[5] The autonomy of small practices and preservation of the traditional patient-physician relationship provide reassurance to patients that the physician is acting in their best interests. It is thought that the patient-physician bond generates trust, which leads to better adherence to a treatment plan.[6] As small practices become patient-centered medical homes, their decisions can control downstream costs, highlighting the importance of trusted, engaged, and financially aligned physicians in value-based payment systems. Although the medical home model suggests that physicians in small practices are uniquely positioned to succeed in value-based purchasing arrangements, they are not necessarily well equipped to do so given the financial investment and regulatory, technological, and analytic expertise necessary to enter these arrangements. In addition to these inherent limitations of small practices, extrinsic factors can play a role in creating an uneven playing field, including the fact that independent primary care physicians more often fill gaps in care in low-income, rural, and other underserved communities.[7]

Assessing the current level of sustainability for small community practices requires appreciating the current limitations of governmental authority, understanding the impact of Medicare, Medicaid, and private insurance payment rates, acknowledging relevant AMA policy and advocacy, and exploring the resources available for small practices that want to engage more fully in an evolving value-based health care system.

FAIR LABOR STANDARDS ACT OF 1938

The Fair Labor Standards Act of 1938 (FLSA) protects workers against unfair employment practices. FLSA rules specify when workers are considered "on the clock" and when they should be paid overtime, along with a minimum wage. Employees are deemed either exempt or nonexempt under the FLSA.

Resolution 108-A-23 postulates that the FLSA confers governmental authority to establish minimum levels of payment for medical practices. However, Section 13(a)(1) of the FLSA provides an exemption from both minimum wage and overtime pay for employees employed as "bona fide executive, administrative, professional, and outside sales employees." Physicians are exempted from FLSA protection since they are considered "Learned Professionals," as their primary duty requires advanced knowledge, defined as work that is predominantly intellectual in character and that includes work requiring the consistent exercise of discretion and judgment, in a field of science or learning; and customarily acquired by a prolonged course of specialized intellectual instruction.[8] As such, the FLSA cannot provide protection for small medical practices regarding minimum levels of payment.

MEDICARE PHYSICIAN PAYMENT SCHEDULE

Medicare is a federal insurance program where coverage is generally offered to individuals who are 65 years or older, have certain disabilities, or suffer from end-stage renal disease or amyotrophic lateral sclerosis. In 1992, the federal government established a standardized Medicare Physician Payment Schedule (MPPS) based on a resource-based relative value scale (RBRVS). Prior to that, the federal government paid physicians using a system of "customary, prevailing, and reasonable" (CPR) charges, which was based on the "usual, customary, and reasonable" system used by many

private insurers. The Medicare CPR system allowed for wide variation in the amount paid for the same service, resulting in unfounded discrepancies in Medicare payment levels among geographic service areas and physician specialties.

In an RBRVS system, payments for services are determined by the standardized resource costs needed to provide them, which are then adjusted to account for differences in work, practice expense, and professional liability insurance costs across national geographic service areas. The RBRVS publishes relative value units (RVUs) for each service, which are then converted to a payment amount using geographical practice cost indices and an annually updated Medicare Conversion Factor to establish the MPPS. The AMA/Specialty Society Relative Value Scale Update Committee (RUC) identifies the resources required to provide physician services, which the Centers for Medicare & Medicaid Services (CMS) then considers in developing RBRVS RVUs. While, historically, 90 percent or more of RUC recommendations have been accepted,[9] CMS makes all final Medicare payment decisions.

MEDICAID PAYMENT SCHEDULES

The Department of Health and Human Services describes Medicare as an insurance program, whereas Medicaid is an assistance program. Medicaid is a federal and state-sponsored program that assists low-income individuals with paying for their health care costs. Each state defines who is eligible for Medicaid coverage, but the program generally covers individuals who have limited income, including:

- Individuals 65 years or older
- Children under 19 years old
- Pregnant women
- Individuals living with a disability
- Parents or adults caring for a child
- Adults without dependent children
- Eligible immigrants

States have the option to charge premiums and determine cost sharing requirements for Medicaid beneficiaries. While maximum out-of-pocket costs are limited, states can impose higher charges for targeted groups of somewhat higher income individuals. Certain vulnerable groups, such as children and pregnant women, are exempt from most out-of-pocket costs and copayments and coinsurance cannot be charged for some services. The federal government funds a percentage of the operating costs for each state through the federal medical assistance percentage (FMAP). The FMAP varies from state to state and is inversely related to state per capita income. The matching rate for a state can range from 50 percent to 83 percent. On average, the federal government nominally pays 57 percent of the cost of the program.[10] Medicaid payment rates are determined by the state for each service in accordance with its approved Medicaid state plan.

PRIVATE INSURANCE PAYMENT SCHEDULES

For small community practices, payment schedules are typically negotiated between the payer and the practice as part of a network of preferred physicians. Practices agree to these payment schedules to permit inclusion in the network, since being in-network is generally more appealing to patients, allows access to in-network referrals, and reduces the chance of unexpectedly low payment to the practice.

When negotiating payment schedules, it is important that the practice is aware of its fixed and variable costs for a given service so that the long-term break-even point can be determined. The smaller the practice, the more important it is to negotiate with as much data and defined value proposition as possible, because a smaller practice has less leverage. Given that private insurance payment schedules are negotiated between two parties, they can vary by state, region, payer, specialty, and/or practice. Thus, it is likely that most small practices accept multiple different payment schedules from different payers.

Private insurance payments are variable across physician specialties. The Urban Institute conducted an analysis of FAIR Health professional claims from March 2019 to February 2020, comparing them to the MPPS for the same time period. The analysis included 17 physician specialties and approximately 20 services per specialty, which represented about 40 percent of total professional spending. The Urban Institute found significant variation in relative prices across specialties, with commercial-to-Medicare payment ratio across all selected services for the 17 specialties averaging 1.6 using an expenditure-weighted approach.[11]

Areas where there is greater market concentration among physicians tend to have higher payment amounts from private insurance.[12] The Health Care Cost Institute's Health Care Cost and Utilization Report found that there was substantial variation in private insurance payments across states, with average commercial prices ranging from 98 percent to 188 percent of Medicare rates. Seven states had payments that were, on average, higher than 150 percent of Medicare rates while 11 states had average payments within 10 percent of Medicare. The states with the highest private insurance payments relative to Medicare tended to be in the northwest of the country and along the Great Plains.[13]

MEDICARE VERSUS PRIVATE INSURANCE PAYMENT RATES

A 2020 KFF literature review discovered that private insurance paid 143 percent of Medicare rates for physician services, on average, ranging from 118 percent to 179 percent of Medicare rates across studies.[14] Estimates from a more recent Milliman white paper closely align, finding that 2022 commercial payment for professional medical services to be approximately 141 percent of Medicare fee-for-service rates.[15] A 2022 Congressional Budget Office report identified "rapid increases in the prices that commercial insurers pay for hospitals' and physicians' services,"[16] leading to further divergence between private and public insurance payment rates, a trend that has proven consistent over time. A 2003 Office of the Inspector General review determined that of 217 procedures, 119 were valued lower by Medicare than by private insurers[17] and a 2017 Health Care Cost Institute report found that commercial payments for the average professional service were 122 percent of what would have been paid under Medicare.[18] The 2022 AMA Physician Practice Benchmark Survey found that small practices of 1 to 15 physicians have a higher percentage of private health insurance patients than larger practices (45.9 percent vs 40.9 percent).[19] Since research shows that private insurance payment rates are, on average, higher than Medicare payment rates for the same health services, this may benefit small practices.

While the Council was unable to identify a survey focused on small practice Medicare to private insurance rate ratios, anecdotal reports indicate that some small practices are seeing private insurers offer payment below 100 percent of Medicare, which may be further depressed when insurers utilize a prior year Medicare rate. A Washington, DC two-physician clinic reported receiving private insurance payment rates ranging from 16-43 percent lower than Medicare, despite becoming a Patient-Centered Medical Home and entering into a local accountable care organization (ACO). Similarly, a solo endocrinologist who left a university-affiliated practice

reported being disadvantaged by no longer being able to collect facility fees to generate higher billing, forcing him to opt out of all insurance plans due to inadequate payment.

MEDICAID PAYMENT COMPARISON AND HEALTH EQUITY IMPLICATIONS

In 2019, Medicaid fee-for-service payments for physician services were nearly 30 percent below Medicare payment levels, with an even larger differential for primary care physician services.[20] A 2017 study found that total payments for physician office visits under Medicaid averaged 62.2 percent of payment amounts under private insurance and 73.7 percent of those under Medicare.[21] As the largest public health insurance provider in the United States, Medicaid policy has significant health equity implications. Low payment rates may limit access to quality care and contribute to poor health outcomes for Medicaid beneficiaries. Research has found that increasing Medicaid primary care rates by $45 per service would reduce access-to-care inequities by at least 70 percent.[22]

While Medicaid state flexibility is intended to preserve state operational autonomy and programming, it has fostered wide variability and geographic inequities, particularly between Medicaid expansion states and non-expansion states,[23] further enabling health disparities. Substantial dependence on state revenues has led to low payment rates that effectively limit access, as it disincentivizes providing care to the often minoritized populations the program serves. As small practices must absorb costs required to provide care to the Medicaid population, such as compliance with regulations and addressing Social Determinants of Health toward equitable care, lower payment makes it almost impossible to recover those costs. Small practices experience higher burdens for translation services in regions where Medicaid patients may have limited English proficiency. Small practices also have challenges in assuring adequate patient follow-up due to a lack of reliable communications (e.g., lack of working phone numbers or inability to reach patients during the daytime while they are working, lack of access to a computer/internet) and transportation challenges.

PAYMENT BENCHMARKS

An ideal payment benchmark will reflect the cost of providing care both in the short term and long term while acknowledging risk, variable expenses, an appropriate allocation of fixed costs, and physician work. It is essential that the benchmark reflect the full cost of practice and the value of the care provided, as well as include inflation-based updates. The benchmark should disclose payment amounts and the methodology used to calculate them, as these are fundamental to establishing trust between physicians and insurers and promoting sound decision making by all participants in the health care system. As the Medicare RBRVS values and methodology are fully transparent, a payment benchmark uncoupled from the RBRVS must be accompanied by commensurate transparency in payment methodology.

A general measurement of a payment schedule is its relative payment rate compared to the MPPS or “benchmarking” to Medicare. Payment schedules that are less than the MPPS are considered beneficial for the payer, whereas payment schedules that match or are greater than the MPPS are considered beneficial for the practice. The percentage of MPPS rates is one of the most widely accepted payment benchmarks when evaluating physician payment level and comparing contracts in the health care industry. It can reflect the mix of services across physicians and plans while removing impacts from billed charges that can vary widely across providers and regions. Additionally, Medicare RBRVS values remain the foundation for many Alternative Payment Models (APMs) as they can produce more or less value by influencing how physicians spend their time and the mix of services provided to patients.

However, there are challenges presented by tying payment to a Medicare benchmark. Some payers may adopt only a portion of the Medicare RBRVS (e.g., use RVU) but utilize a lower conversion factor) or use an outdated RBRVS where the RVUs are no longer reflective of current resource costs. Other payers may implement time-limited or temporary arrangements or apply the RBRVS to only certain specialties, leading to disruption in care or difficulties with patient referrals. Most importantly, continuing to tether payment to a Medicare payment rate that has been reduced by almost 10 percent in four years presents an untenable situation for small practices. After adjusting for inflation, Medicare physician payment has effectively declined 29 percent from 2001 to 2024.

Some have suggested the development of a "minimum government rate" as a payment benchmark. However, it is challenging to identify a rate and methodology defensible across the six major government health care programs:

1) Medicare
2) Medicaid
3) The Children's Insurance Program (CHIP)
4) The Department of Defense TRICARE and TRICARE for Life Programs
5) The Veterans Health Administration program
6) The Indian Health Service

While these programs collectively provide health care services to one-third of Americans, they differ extensively in terms of size, scope, financing, and program design, making it unfeasible to establish an equitable minimum payment rate appropriate for all. Furthermore, it would be impracticable to establish a minimum payment rate in the private physician market, which is currently riding a consolidation wave, transforming health insurers into much larger and more powerful conglomerates. Helping small practices escape the vice grip of unfair market rates from consolidated insurers begs the need for strong antitrust reform. While reference prices and price floors have been used in various sectors of the economy, they appear to have a low likelihood of being adopted in health care, as demonstrated by the Economic Stabilization Program of the early 1970s.[24] Programs that provide for low income and rural patient populations already struggle to obtain adequate funding. As demonstrated in the oil and agricultural sectors, policymakers are not likely to set a payment floor unless they are granted influence over the distribution of health care prices in return.

SUSTAINABLE PAYMENT FOR SMALL COMMUNITY PRACTICES

Small practices are disproportionately affected by payment rates that fall below an ideal benchmark. One of the most notable changes has been the redistribution of physicians from small to large practices. The share of physicians who worked in practices that had 10 or fewer physicians decreased from 61.4 percent in 2012 to 51.8 percent in 2022, with the need to better negotiate favorable (higher) payment rates with payers as one of the most important motivations for private practices selling to hospitals or health systems.[25]

The term "sustainable" denotes that something is bearable and capable of being continued at a certain level over a period of time. For small community practices, sustainable payment reflects the full cost of practice and the value of the care provided. Additionally, it includes annual inflation-based payment updates, which are essential to measure practice cost inflation and account for changes in physicians' operating costs. Annual updates enable small practices to better absorb other payment redistributions triggered by budget neutrality rules and performance adjustments, as well as periods of high inflation and rising staffing costs; they also help physicians invest in their practices and implement new strategies to provide high-value care.

The single most influential factor in ensuring a sustainable level of payment for small practices is leverage. Strong network adequacy requirements that expect all health plans to contract with sufficient numbers and types of physicians bestow bargaining power by making it difficult for insurers to dismiss negotiation on an in-network payment schedule. Alternatively, when small practices are able to drop onerous insurance contracts and achieve out-of-network status, their leverage is amplified, most markedly when underwritten by fair out-of-network rules that require out-of-network physicians be eligible to be paid at rates higher than in-network physicians would otherwise receive for those services.

Physicians have been moving to larger group practices in order to gain leverage as well as access to more resources to effectively implement value-based care and risk-based payment models.[26] In this era of consolidation, there is an expectation of progression from solo or small physician practices to groups and multispecialty practices and, finally, to fully integrated delivery systems that employ the physicians, own the hospitals, and use a single information system. In this limited view, the earlier forms of practice organization are assumed to be incapable of implementing the supporting systems needed for population health (e.g., registries, electronic medical records, care management, team-based care) and are therefore unable to compete in value-based payment systems. A 2011 report of the Massachusetts Attorney General concluded that while bearing financial risk through value-based payments encourages coordinated care, it also requires significant investment to develop the capacity to effectively manage risk, which is more difficult for most physicians who practice in small groups and have historically been paid less than larger practices.[27] The report also found that physicians who transitioned to larger groups received professional payment that was approximately 30 percent higher, which accelerated the number of physicians leaving small practices and joining larger groups.

However, small practices are able to compete if they join forces to create profitable economies of scale without forfeiting the advantages of being small.[28] When small practices collaborate, they form a network of peers to learn from and to glean deeper insights from population health models. Alliances can provide the scale needed to negotiate value-based contracts and to spread the risk across multiple practices, so that a handful of unavoidable hospitalizations does not destroy a single practice. Collaboration allows each practice access to the necessary technologies to draw actionable insights from data and regulatory and coding expertise to maximize revenue, while laying the groundwork for future savings.

Independent practice associations (IPAs), if structured in compliance with antitrust laws, allow contracting between independent physicians and payers and can succeed in value-based purchasing arrangements if they are able to achieve results equal to more highly capitalized and tightly structured large medical groups and hospital-owned practices. Traditionally, most IPAs have been networks of small practices organized for the purpose of negotiating fee-for-service contracts with health insurers. While small practices considering participating in an IPA should be aware of the potential risks, such as underfunded capitation revenue, IPAs can act as a platform for sharing resources and negotiating risk-bearing medical services agreements on behalf of participating practices. Many IPAs, especially those that are clinically integrated, have already converted to an ACO, or provide the infrastructure for their members to organize as one. Because many of these organizations have already operated as risk-bearing provider networks, IPAs are well positioned to take leading roles in developing ACOs or acting as sustaining member organizations. Even if the physician organization has operated in a fee-for-service environment, an IPA can bring expertise regarding contracting, analytics, and management. For example, the Greater Rochester IPA (GRIPA) has over 1,500 physician members who benefit from data analytics services to stratify and manage patients, as well as care management support, pharmacists, visiting home nurses, and diabetes educators. GRIPA has its own ACO, which distributed 83 percent of its 2020 shared

savings to participants. ACOs can also benefit from participation by small practices. A 2022 study found that small practices in ACOs reduced their beneficiaries' spending more than large practices in ACOs, thereby generating higher savings for the ACOs consisting of small practices.[29]

CMS structures several of its initiatives in an effort to support small practices in value-based participation, such as the Small, Underserved, and Rural Support initiative, which provides free, customized technical assistance to practices with 15 or fewer physicians. Small practices can contact selected organizations in their state to receive help with choosing quality measures, strategic planning, education and outreach, and health information technology optimization. CMS also includes several reporting flexibilities and rewards, specifically targeting solo and small practices under the Quality Payment Program's Merit-Based Incentive Payment System, most notably by varying submission methods and allowing special scoring consideration. The CMS ACO Investment Model built on the experience with the Alternative Payment Model (APM) to test the use of pre-paid shared savings to encourage new ACOs to form in rural and underserved areas and to encourage current Medicare Shared Savings Program ACOs to transition to arrangements with greater financial risk. It resulted in more physicians in rural and underserved communities signing on to participate in ACOs. These new ACOs invested in better care coordination, and savings have been attributed to fewer unnecessary acute hospitalizations, fewer emergency department visits, and fewer days in skilled nursing facilities among beneficiaries. The ACO Investment Model generated $381.5 million in net Medicare savings between 2016 and 2018.[30] In June 2024, CMS will launch the Making Care Primary program to allow practices to build a value-based infrastructure by "improving care management and care coordination, equipping primary care clinicians with tools to form partnerships with health care specialists, and leveraging community-based connections to address patients' health needs as well as their health-related social needs such as housing and nutrition." The program will offer three progressive tracks to recognize participants' varying experience in value-based care, including one reserved for practices with no prior value-based care experience.

RESOURCES FOR SMALL PRACTICES

There has been a recent emergence of payer-sponsored arrangements, such as the one sponsored by Acuitas Health. It is a partnership between a nonprofit health plan and a large multispecialty group that offers a range of services to small practices, including billing and coding assistance, practice transformation consulting, and patient aggregation, thereby allowing practices to achieve the scale needed for value-based contracts. Through its work with Acuitas, the NYC Population Health Improvement Program was able to "answer important questions about what skills small practices need in order to succeed in the new environment and how small practices might work together to share the services necessary to develop those skills…(as well as) break new ground by presenting a financial model for the cost of shared services and probing the legal and regulatory issues raised by such arrangements."[31] Other private companies have created shared service infrastructures to allow small, independent practices to participate in APMs, offering low-cost shared resources in return for a portion of downstream savings.

Regardless of the payment rates, small practices can increase profit margins if they are able to keep their costs down. Group purchasing organizations (GPOs) and physician buying groups (PBGs) can offer independent practices a chance to access lower costs by using the power of many practices to benefit all. Some GPOs do not require purchases from a given supplier yet still offer leverage with other suppliers to grant small practices reduced rates. As most community-based practices offer vaccines, PBGs can play an important role in keeping costs down. Vaccines are one of the most costly and important investments a practice makes, and PBGs can offer practices lower contract pricing and rebates from the vaccine manufacturer. Practices can save five to 25 percent on the cost

of supplies by joining a GPO or PBG, most of which have no fee and often allow practices to join several organizations.[32]

Small practices typically sign "evergreen" contracts with payers, which continuously renew automatically until one party terminates the agreement. A payment schedule is part of the contract and will not be updated unless one party opens the contract for negotiation. In most cases, this must be the practice since it is not usually in the payer's best financial interest to negotiate a new contract. As such, practices need to be prepared to contact the payer multiple times in order to actually get a contract negotiated – and then come to the table with as much data and population health metrics (e.g., A1C numbers for patients with diabetes) as possible. A practice able to successfully manage complex patients will have costs within a relatively narrow range without many outliers, thereby increasing negotiating leverage. Small practices can also gain a negotiating advantage if they have extended office hours, are considered the "only show in town," provide specialized care for an underserved patient population, have obtained quality accreditation recognition (e.g., National Committee for Quality Assurance), or can share positive patient testimonials.

The AMA has several resources dedicated to support physicians in private practice, such as the AMA Private Practice Simple Solutions series, which are "free, open access rapid learning cycles designed to provide opportunities to implement actionable changes that can immediately increase efficiency in private practices." Session topics range from marketing to recruitment to reducing administrative burden. The AMA Practice Management Center developed the Evaluating and Negotiating Emerging Payment Options manual to assist members who are considering transitioning to risk-based payment, while the AMA Value Based Care Toolkit is being updated for 2023 to provide a step-by-step guide to designing, adopting, and optimizing the value-based care model. The 2016 adoption of AMA Policy D-160.926, which calls for the development of a guide to provide information to physicians in or considering solo and small practice on how they can align through Independent Practice Associations, Accountable Care Organizations, Physician Hospital Organizations, and other models to help them with the imminent movement to risk-based contracting and value-based care, resulted in the development of the Joining or Aligning with a Physician-Led Integrated Health System guide, which was updated in June 2020. The AMA also offers a Private Practice Group Membership Program to drive sustainability and accelerate innovation for members in private practice, as well as a Voluntary Best Practices to Advance Data Sharing Playbook to address the future of sustainable value-based payment.

AMA POLICY

The AMA's longstanding goal to promote the sustainability of solo, small, and primary care practices is reflected in numerous AMA policies, including those that:

- Call for the development of a guide to provide information to physicians in or considering solo and small practice on how they can align through IPAs, ACOs, Physician Hospital Organizations, and other models to help them with the imminent movement to risk-based contracting and value-based care (Policy D-160.926);
- Advocate in Congress to ensure adequate payment for services rendered by private practicing physicians, create and maintain a reference document establishing principles for entering into and sustaining a private practice, and issue a report in collaboration with the Private Practice Physicians Section at least every two years communicating efforts to support independent medical practices (Policy D-405.988);
- Support development of administrative mechanisms to assist primary care physicians in the logistics of their practices to help ensure professional satisfaction and practice

sustainability, support increased financial incentives for physicians practicing primary care, especially those in rural and urban underserved areas, and advocate for public and private payers to develop physician payment systems to promote primary care and specialty practices in progressive, community-based models of integrated care focused on quality and outcomes (Policy H-200.949);

- Reinforce the freedom of physicians to choose their method of earning a living and the right of physicians to charge their patients their usual fee that is fair, irrespective of insurance/coverage arrangements between the patient and the insurers (Policy H-385.926);
- Support insurance payment rates that are established through meaningful negotiations and contracts (Policy H-165.838);
- Call for a formal, legal review of ongoing grievous behaviors of the health insurance industry (Policy D-385.949);
- Advocate for payment rates that are sufficient to cover the full cost of sustainable medical practice, continue to monitor health care delivery and physician payment reform activities, and provide resources to help physicians understand and participate in payment reform initiatives (Policy H-390.849);
- Seek positive inflation-adjusted annual physician payment updates that keep pace with rising practice costs to ensure payment rates cover the full cost of sustainable medical practice (D-390.946); and
- Support fair out-of-network payment rules coupled with strong network adequacy requirements for all physicians (H-285.904).

The AMA has policy that addresses the challenges presented by the evolving value-based health care system, such as those that:

- Provide guidance and support infrastructure that allows independent physicians to join with other physicians in clinically integrated networks independent of any hospital system, identify financially viable prospective payment models, and develop educational opportunities for physicians to learn and collaborate on best practices for such payment models for physician practice, including but not limited to independent private practice (Policy H-385.904);
- Support a pluralistic approach to third-party payment methodology, promoting flexibility in payment arrangements (Policy H-385.989);
- Reaffirm the AMA's support for a neutral public policy and fair market competition among alternative health care delivery and financing systems (Policy H-385.990); and
- Emphasize the AMA's dedication to seeking payment reform, supporting independent physicians in joining clinically integrated networks, and refining relative values for services based on valid and reliable data (Policy H-400.972).

AMA policy does not endorse a specific payment mechanism such as Medicare RBRVS, but instead, states that use of RBRVS relative values is one option that could provide the basis for both public and private physician payment systems. Among the most relevant policies are those that:

- Oppose any type of national mandatory fee schedule (Policy H-385.986);
- Support uncoupling of commercial fee schedules from Medicare conversion factors and seek legislation and/or regulation to prevent insurance companies from utilizing a physician payment schedule below the updated Medicare professional fee schedule (Policy D-400.990); and

- Support a pluralistic approach to third-party payment methodology under fee-for-service, and do not support a preference for usual and customary or reasonable or any other specific payment methodology (Policy H-385.989).

Finally, AMA policies establish a minimum physician payment of 100 percent of the RBRVS Medicare allowable for CHIP and Medicaid (Policy H-290.976) as well as for TRICARE and any other publicly funded insurance plan (Policy H-385.921).

DISCUSSION

Research has found that small community practices are able to deliver more personalized patient care and have lower rates of preventable hospital admissions. They are able to detect potential conditions before they result in hospital admissions and accordingly play a vital role in keeping patients healthier. However, small community practices may be challenged in implementing the support systems needed for participation in population health management and value-based purchasing arrangements. As such, the Council believes that bonuses for population-based programs must be accessible to small community practices, taking into consideration the size of the populations they manage and with a specific focus on improving care and payment for children, pregnant people, and people with mental health conditions, as these groups are often disproportionately covered by Medicaid.

Small practices are typically not eligible to collect facility fees or utilize various addresses or facility types to generate higher billing for similar procedures depending on contracts and incentives, thereby creating a revenue differential with larger practices. Most importantly, small practices lack the leverage retained by larger practices, putting them at a significant disadvantage when negotiating payment schedules. The single most influential factor in ensuring a sustainable level of payment for small practices is leverage. Strong network adequacy requirements that expect all health plans to contract with sufficient numbers and types of physicians bestow bargaining power by making it difficult for insurers to dismiss negotiation on an in-network payment schedule. Alternatively, when small practices are able to drop onerous insurance contracts and achieve out-of-network status, their leverage is amplified, most markedly when underwritten by fair out-of-network rules that require out-of-network physicians be eligible to be paid at rates higher than in-network physicians would otherwise receive for those services. There are resources available to help small practices succeed, most notably in underserved markets where average private professional service payments tend to be higher than those in more competitive physician markets.[33]

Resolution 108-A-23 presumes that small practices experience private insurance payment rates well below Medicare payment rates. However, research shows that private insurance payment rates are, on average, higher than Medicare payment rates for the same health care services.[34] While there are limitations in the available data due to inclusion of larger practices and hospital-employed physicians, variability in private insurance payment schedules means that most small practices accept multiple different payment schedules from different payers, making it difficult for them to respond to questions about payment rates with accuracy. Accordingly, the Council believes a physician survey is not likely to illuminate payment variations in small practices between private insurance and Medicare payment rates. Small practices have a higher percentage of private health insurance patients than larger practices, which should benefit them. However, not all private insurance payments are reflective of the full cost of practice, the value of the care provided, or include inflation-based updates.

Research also indicates that Medicaid payment rates are substantially below Medicare payment rates. As the largest public health insurance provider in the United States, Medicaid policy has significant health equity implications. Low payment rates may limit access to quality care and contribute to poor health outcomes for Medicaid beneficiaries. While Medicaid state flexibility is intended to preserve state operational autonomy and programming, it has fostered wide variability and geographic inequities, particularly between Medicaid expansion states and non-expansion states, further enabling health disparities. Substantial dependence on state revenues has led to low payment rates that effectively limit access, as it disincentivizes providing care to the often minoritized populations the program serves. As small practices must absorb costs required to provide care to the Medicaid population, such as compliance with regulations and addressing Social Determinants of Health toward equitable care, lower payment makes it almost impossible to recover those costs.

Although AMA policy does not endorse a specific payment mechanism such as the Medicare RBRVS and opposes any type of mandatory payment schedule, it does support payment at no less than 100 percent of RBRVS Medicare allowable as one option that could provide the basis for both public and private physician payment systems. However, consideration must be given to the challenges presented by tying payment to a Medicare benchmark, which can be manipulated by payers to provide them with a financial advantage. Some payers may adopt only a portion of the Medicare RBRVS or use an outdated RBRVS where the RVUs are no longer reflective of current resource costs. Other payers may implement time-limited or temporary arrangements or apply the RBRVS to only certain specialties, leading to disruption in care or difficulties with patient referrals. Most importantly, continuing to tether payment to a Medicare payment rate that has been reduced by almost 10 percent in four years presents an untenable situation for small practices. As such, uncoupling payment schedules from a Medicare benchmark may allow for a level of payment that reflects the full cost of practice, the value of the care provided, and includes inflation-based updates, thereby sustaining small practices.

It is unfeasible to establish an equitable minimum government payment rate defensible across the six major government health care programs. Furthermore, it would be impracticable to establish a minimum payment rate in the private physician market, which is currently riding a consolidation wave, transforming health insurers into much larger and more powerful conglomerates. The Council believes that an ideal payment benchmark will reflect the cost of providing care both in the short term and long term while acknowledging risk, variable expenses, an appropriate allocation of fixed costs, and physician work. It is essential that the benchmark reflect the full cost of practice and the value of the care provided, as well as include inflation-based updates. The benchmark should disclose payment amounts and the methodology used to calculate them, as these are fundamental to establishing trust between physicians and insurers and promoting sound decision making by all participants in the health care system.

For small community practices, sustainable payment reflects the full cost of practice and the value of the care provided. Additionally, it includes annual inflation-based payment updates, which are essential to measure practice cost inflation and account for changes in physicians' operating costs. Annual updates enable small practices to better absorb other payment redistributions triggered by budget neutrality rules and performance adjustments, as well as periods of high inflation and rising staffing costs; they also help physicians invest in their practices and implement new strategies to provide high-value care.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 108-A-23, and the remainder of the report be filed:

1. That our American Medical Association (AMA) support making bonuses for population-based programs accessible to small community practices, taking into consideration the size of the populations they manage and with a specific focus on improving care and payment for children, pregnant people, and people with mental health conditions, as these groups are often disproportionately covered by Medicaid. (New HOD Policy)

2. That our AMA amend Policy D-400.990 by addition and deletion, and modify the title by addition and deletion, as follows:

   Uncoupling Commercial Fee Schedules from the Medicare Physician Payment Schedule ~~Conversion Factors~~ D-400.990
   Our AMA: (1) shall use every means available to convince health insurance companies and managed care organizations to immediately uncouple fee schedules from the Medicare Physician Payment Schedule ~~conversion factors~~ and to maintain a ~~fair and appropriate~~ level of payment ~~reimbursement~~ that is sustainable, reflects the full cost of practice, the value of the care provided, and includes an inflation-based update; and (2) will seek legislation and/or regulation to prevent managed care companies from utilizing a physician payment schedule below the updated Medicare Physician Payment ~~professional fee s~~Schedule. (Modify Current HOD Policy)

3. That our AMA amend Policy H-290.976 by addition and deletion, and modify the title by addition and deletion, as follows:

   Enhanced ~~S~~CHIP Enrollment, Outreach, and Payment ~~Reimbursement~~ H-290.976
   1. It is the policy of our AMA that prior to or concomitant with states' expansion of ~~State~~ Children's Health Insurance Programs (~~S~~CHIP) to adult coverage, our AMA urge all states to maximize their efforts at outreach and enrollment of ~~S~~CHIP eligible children, using all available state and federal funds.
   2. Our AMA affirms its commitment to advocating for ~~reasonable~~ ~~S~~CHIP and Medicaid payment that is sustainable, reflects the full cost of practice, the value of the care provided, and includes inflation-based updates, ~~reimbursement for its medical providers, defined as at minimum~~ and is no less than 100 percent of RBRVS Medicare allowable. (Modify Current HOD Policy)

4. That our AMA amend Policy H-385.921 by addition and deletion as follows:

   Health Care Access for Medicaid Patients H-385.921
   It is AMA policy that to increase and maintain access to health care for all, payment for physician providers for Medicaid, TRICARE, and any other publicly funded insurance plan must be sustainable, reflect the full cost of practice, the value of the care provided, and include inflation-based updates, and is no less than ~~at minimum~~ 100 percent of ~~the~~ RBRVS Medicare allowable. (Modify Current HOD Policy)

5. That our AMA reaffirm Policy D-405.988, which calls for advocacy in Congress to ensure adequate payment for services rendered by private practicing physicians, creating and maintaining a reference document establishing principles for entering into and sustaining a

private practice, and issuing a report in collaboration with the Private Practice Physicians Section at least every two years to communicate efforts to support independent medical practices. (Reaffirm HOD Policy)

6. That our AMA reaffirm Policy H-200.949, which supports development of administrative mechanisms to assist primary care physicians in the logistics of their practices to help ensure professional satisfaction and practice sustainability, support increased financial incentives for physicians practicing primary care, especially those in rural and urban underserved areas, and advocate for public and private payers to develop physician payment systems to promote primary care and specialty practices in progressive, community-based models of integrated care focused on quality and outcomes. (Reaffirm HOD Policy)

7. That our AMA reaffirm Policy H-285.904, which supports fair out-of-network payment rules coupled with strong network adequacy requirements for all physicians. (Reaffirm HOD Policy)

8. That our AMA reaffirm Policy H-385.986, which opposes any type of national mandatory fee schedule. (Reaffirm HOD Policy)

Fiscal Note: Less than $500.

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Council on Medical Service Report 8-A-24
Sustainable Payment for Community Practices
Policy Appendix

Uncoupling Commercial Fee Schedules from Medicare Conversion Factors D-400.990
Our AMA: (1) shall use every means available to convince health insurance companies and managed care organizations to immediately uncouple fee schedules from Medicare conversion factors and to maintain a fair and appropriate level of reimbursement; and (2) will seek legislation and/or regulation to prevent managed care companies from utilizing a physician payment schedule below the updated Medicare professional fee schedule.
Res. 137, A-02 Reaffirmed: CCB/CLRPD Rep. 4, A-12 Appended: Res. 103, A-13 Reaffirmation: A-19

The Preservation of the Private Practice of Medicine D-405.988
Our AMA: (1) supports preserving the value of the private practice of medicine and its benefit to patients; (2) will utilize its resources to protect and support the continued existence of solo and small group medical practice, and to protect and support the ability of these practices to provide quality care; (3) will advocate in Congress to ensure adequate payment for services rendered by private practicing physicians; (4) will work through the appropriate channels to preserve choices and opportunities, including the private practice of medicine, for new physicians whose choices and opportunities may be limited due to their significant medical education debt; (5) will work through the appropriate channels to ensure that medical students and residents during their training are educated in all of medicine's career choices, including the private practice of medicine; (6) will create, maintain, and make accessible to medical students, residents and fellows, and physicians, resources to enhance satisfaction and practice sustainability for physicians in private practice; (7) will create and maintain a reference document establishing principles for entering into and sustaining a private practice, and encourage medical schools and residency programs to present physicians in training with information regarding private practice as a viable option; and (8) will issue a report in collaboration with the Private Practice Physicians Section at least every two years communicating their efforts to support independent medical practices.
Res. 224, I-10 Appended: Res. 604, A-12 Reaffirmation I-13 Appended: Res. 735, A-14 Reaffirmed in lieu of Res. 223, I-14 Modified: Speakers Rep. 01, A-17 Reaffirmed: Res. 724, A-22 Reaffirmation: A-22 Appended: Res. 602, A-22

Principles of and Actions to Address Primary Care Workforce H-200.949
1. Our patients require a sufficient, well-trained supply of primary care physicians--family physicians, general internists, general pediatricians, and obstetricians/gynecologists--to meet the nation’s current and projected demand for health care services.
2. To help accomplish this critical goal, our American Medical Association (AMA) will work with a variety of key stakeholders, to include federal and state legislators and regulatory bodies; national and state specialty societies and medical associations, including those representing primary care fields; and accreditation, certification, licensing, and regulatory bodies from across the continuum of medical education (undergraduate, graduate, and continuing medical education).
3. Through its work with these stakeholders, our AMA will encourage development and dissemination of innovative models to recruit medical students interested in primary care, train primary care physicians, and enhance both the perception and the reality of primary care practice, to encompass the following components: a) Changes to medical school admissions and recruitment of medical students to primary care specialties, including counseling of medical students as they develop their career plans; b) Curriculum changes throughout the medical education continuum; c) Expanded financial aid and debt relief options; d) Financial and logistical support for primary care practice, including adequate reimbursement, and enhancements to the practice environment to

ensure professional satisfaction and practice sustainability; and e) Support for research and advocacy related to primary care.
4. Admissions and recruitment: The medical school admissions process should reflect the specific institution's mission. Those schools with missions that include primary care should consider those predictor variables among applicants that are associated with choice of these specialties.
5. Medical schools, through continued and expanded recruitment and outreach activities into secondary schools, colleges, and universities, should develop and increase the pool of applicants likely to practice primary care by seeking out those students whose profiles indicate a likelihood of practicing in primary care and underserved areas, while establishing strict guidelines to preclude discrimination.
6. Career counseling and exposure to primary care: Medical schools should provide to students career counseling related to the choice of a primary care specialty, and ensure that primary care physicians are well-represented as teachers, mentors, and role models to future physicians.
7. Financial assistance programs should be created to provide students with primary care experiences in ambulatory settings, especially in underserved areas. These could include funded preceptorships or summer work/study opportunities.
8. Curriculum: Voluntary efforts to develop and expand both undergraduate and graduate medical education programs to educate primary care physicians in increasing numbers should be continued. The establishment of appropriate administrative units for all primary care specialties should be encouraged.
9. Medical schools with an explicit commitment to primary care should structure the curriculum to support this objective. At the same time, all medical schools should be encouraged to continue to change their curriculum to put more emphasis on primary care.
10. All four years of the curriculum in every medical school should provide primary care experiences for all students, to feature increasing levels of student responsibility and use of ambulatory and community-based settings.
11. Federal funding, without coercive terms, should be available to institutions needing financial support to expand resources for both undergraduate and graduate medical education programs designed to increase the number of primary care physicians. Our AMA will advocate for public (federal and state) and private payers to a) develop enhanced funding and related incentives from all sources to provide education for medical students and resident/fellow physicians, respectively, in progressive, community-based models of integrated care focused on quality and outcomes (such as the patient-centered medical home and the chronic care model) to enhance primary care as a career choice; b) fund and foster innovative pilot programs that change the current approaches to primary care in undergraduate and graduate medical education, especially in urban and rural underserved areas; and c) evaluate these efforts for their effectiveness in increasing the number of students choosing primary care careers and helping facilitate the elimination of geographic, racial, and other health care disparities.
12. Medical schools and teaching hospitals in underserved areas should promote medical student and resident/fellow physician rotations through local family health clinics for the underserved, with financial assistance to the clinics to compensate their teaching efforts.
13. The curriculum in primary care residency programs and training sites should be consistent with the objective of training generalist physicians. Our AMA will encourage the Accreditation Council for Graduate Medical Education to (a) support primary care residency programs, including community hospital-based programs, and (b) develop an accreditation environment and novel pathways that promote innovations in graduate medical education, using progressive, community-based models of integrated care focused on quality and outcomes (such as the patient-centered medical home and the chronic care model).
14. The visibility of primary care faculty members should be enhanced within the medical school, and positive attitudes toward primary care among all faculty members should be encouraged.

15. Support for practicing primary care physicians: Administrative support mechanisms should be developed to assist primary care physicians in the logistics of their practices, along with enhanced efforts to reduce administrative activities unrelated to patient care, to help ensure professional satisfaction and practice sustainability.
16. There should be increased financial incentives for physicians practicing primary care, especially those in rural and urban underserved areas, to include scholarship or loan repayment programs, relief of professional liability burdens, and Medicaid case management programs, among others. Our AMA will advocate to state and federal legislative and regulatory bodies, among others, for development of public and/or private incentive programs, and expansion and increased funding for existing programs, to further encourage practice in underserved areas and decrease the debt load of primary care physicians. The imposition of specific outcome targets should be resisted, especially in the absence of additional support to the schools.
17. Our AMA will continue to advocate, in collaboration with relevant specialty societies, for the recommendations from the AMA/Specialty Society RVS Update Committee (RUC) related to reimbursement for E&M services and coverage of services related to care coordination, including patient education, counseling, team meetings and other functions; and work to ensure that private payers fully recognize the value of E&M services, incorporating the RUC-recommended increases adopted for the most current Medicare RBRVS.
18. Our AMA will advocate for public (federal and state) and private payers to develop physician reimbursement systems to promote primary care and specialty practices in progressive, community-based models of integrated care focused on quality and outcomes such as the patient-centered medical home and the chronic care model consistent with current AMA Policies H-160.918 and H-160.919.
19. There should be educational support systems for primary care physicians, especially those practicing in underserved areas.
20. Our AMA will urge urban hospitals, medical centers, state medical associations, and specialty societies to consider the expanded use of mobile health care capabilities.
21. Our AMA will encourage the Centers for Medicare & Medicaid Services to explore the use of telemedicine to improve access to and support for urban primary care practices in underserved settings.
22. Accredited continuing medical education providers should promote and establish continuing medical education courses in performing, prescribing, interpreting and reinforcing primary care services.
23. Practicing physicians in other specialties--particularly those practicing in underserved urban or rural areas--should be provided the opportunity to gain specific primary care competencies through short-term preceptorships or postgraduate fellowships offered by departments of family medicine, internal medicine, pediatrics, etc., at medical schools or teaching hospitals. In addition, part-time training should be encouraged, to allow physicians in these programs to practice concurrently, and further research into these concepts should be encouraged.
24. Our AMA supports continued funding of Public Health Service Act, Title VII, Section 747, and encourages advocacy in this regard by AMA members and the public.
25. Research: Analysis of state and federal financial assistance programs should be undertaken, to determine if these programs are having the desired workforce effects, particularly for students from disadvantaged groups and those that are underrepresented in medicine, and to gauge the impact of these programs on elimination of geographic, racial, and other health care disparities. Additional research should identify the factors that deter students and physicians from choosing and remaining in primary care disciplines. Further, our AMA should continue to monitor trends in the choice of a primary care specialty and the availability of primary care graduate medical education positions. The results of these and related research endeavors should support and further refine AMA policy to enhance primary care as a career choice.
CME Rep. 04, I-18

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

Enhanced SCHIP Enrollment, Outreach, and Reimbursement H-290.976

1. It is the policy of our AMA that prior to or concomitant with states' expansion of State Children's Health Insurance Programs (SCHIP) to adult coverage, our AMA urge all states to maximize their efforts at outreach and enrollment of SCHIP eligible children, using all available state and federal funds.

2. Our AMA affirms its commitment to advocating for reasonable SCHIP and Medicaid reimbursement for its medical providers, defined as at minimum 100 percent of RBRVS Medicare allowable.

Res. 103, I-01 Reaffirmation A-07 Reaffirmation A-11 Reaffirmed: CMS Rep. 7, I-14 Reaffirmation
A-15 Reaffirmed: CMS Rep. 3, A-15 Reaffirmation: A-17 Reaffirmed: CMS Rep. 02, A-19 Reaffirmed: CMS Rep. 5, I-20 Reaffirmed: CMS Rep. 9, A-21 Reaffirmed: CMS Rep. 3, I-21 Reaffirmed: CMS Rep. 1, I-22

Health Care Access for Medicaid Patients H-385.921
It is AMA policy that to increase and maintain access to health care for all, payment for physician providers for Medicaid, TRICARE, and any other publicly funded insurance plan must be at minimum 100 percent of the RBRVS Medicare allowable.
Res. 103, A-07 Reaffirmed: CMS Rep. 2, I-08 Reaffirmation A-12 Reaffirmed: Res 132, A-14 Reaffirmed in lieu of Res. 808, I-14 Reaffirmation A-15 Reaffirmed in lieu of: Res. 807, I-18

National Mandatory Fee Schedule H-385.986
The AMA opposes any type of national mandatory fee schedule.
Res. 27, A-85 Reaffirmed: BOT Rep. UU, A-93 Reaffirmed CLRPD Rep. 2, I-95 Reaffirmed: CMS Rep. 7, A-05 Reaffirmed in lieu of Res. 127, A-10 Reaffirmation A-15

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 101
(A-24)

Introduced by: Medical Student Section

Subject: Infertility Coverage

Referred to: Reference Committee A

Whereas, fertility assistance and preservation are commonly used by patients diagnosed with or at risk for infertility (including iatrogenic infertility due to medical interventions, such as cancer treatment or hormone replacement therapy), LGBTQ+ patients, military and veteran patients, and patients who desire future pregnancy at advanced reproductive age[1-2]; and

Whereas, cost for services such as in vitro fertilization or oocyte cryopreservation ranges from $10,000 to $13,000, not including medications, further tests, multiple cycles, and cryostorage fees[3-5]; and

Whereas, the average cost for semen analysis by emission is around $750, with additional costs for cryostorage[6]; and

Whereas, cost due to lack of insurance coverage and need for supplemental insurance is the most common barrier for patients with infertility, often leading them to end treatment[7-8]; and

Whereas, in states where employer plans cover assisted reproductive technology, the cost of in vitro fertilization (IVF) is 13% of average annual disposable income compared to 52% in other states, indicating that coverage regulations drastically affect affordability[9]; and

Whereas, Medicaid covers fertility drugs in only one state, covers infertility diagnostics in only a few states, and does not cover other fertility assistance or preservation services[10]; and

Whereas, TRICARE only covers infertility care that enables “natural conception,” and the VA only covers care for infertility due to service-related injuries and only if donor eggs and sperm are from a couple, excluding LGBTQ+ and unmarried individuals[10]; and

Whereas, 25 states and DC have various regulations at least partially restricting coverage of some fertility diagnostics or services in at least a portion of employer plans offered, although sex and gender-based restrictions, cost-sharing, age cutoffs, marital requirements, exemptions for small and large employers, and other stipulations vary widely[10-14]; and

Whereas, states with private coverage for fertility services do not experience significant premium increases, with estimates ranging from 0.5-1% ($1-5), while demonstrating 150-300% greater use of fertility services compared to states without[10,15-17]; and

Whereas, Black women may have higher infertility rates but are less likely to use fertility services, and Black, Hispanic, and Asian women all experience poorly understood lower success rates for fertility services, alongside many financial and logistic barriers[18-20]; and

Whereas, women of color also report hearing comments disregarding their fertility concerns or perpetuating stereotypes (that they can become pregnant easily or that they should not become pregnant at all)[20]; and

Whereas, LGBTQ+ individuals and unmarried individuals are often excluded from conditions and requirements for fertility services[10,11,21,22]; and

Whereas, unlike the IHS, other federal health programs such as the Veterans Health Administration and Federal Employees Health Benefit Program, provide a spectrum of coverage for infertility diagnostics and treatment[23]; and

Whereas, the prevalence of infertility and impaired fecundity (reproductive fitness) among American Indian and Alaska Native (AI/AN) persons is 7.0% and 13.2%, respectively, which is greater than that of the U.S. population (6.4% and 11.0%)[24]; and

Whereas, positive pregnancy (PP) and ongoing pregnancy/delivery (OP/D) rates are estimated to be 15% and 10% per IUI cycle in the general population, respectively, but AI/AN patients have marked PP/OP/D disparities (5.10% PP and 3.3% OP/D)[25]; and

Whereas, the IHS defines Level 5 (Excluded Services) as services and procedures considered purely cosmetic in nature, experimental or investigational, or with no proven medical benefit and includes IVF and related services in this category, preventing IHS, Tribal, and Urban Indian Health Programs from paying for this care[26-28]; therefore be it

RESOLVED, that our American Medical Association amend Policy H-185.990, "Infertility and Fertility Preservation Insurance Coverage" by addition and deletion to read as follows;

1. Our AMA ~~encourages third-party payer health insurance carriers to make available insurance benefits~~ supports federal protections that ensure insurance coverage by all payers 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.
3. Our AMA will work with interested organizations to encourage the Indian Health Service to cover infertility diagnostics and treatment for patients seen by or referred through an Indian Health Service, Tribal, or Urban Indian Health Program. (Modify Current HOD Policy); and be it further

RESOLVED, that our AMA study the feasibility of insurance coverage for fertility preservation for reasons other than iatrogenic infertility (Directive to Take Action); and be it further

RESOLVED, that our AMA support the review of services defined to be experimental or excluded for payment by the Indian Health Service and for the appropriate bodies to make evidence-based recommendations for updated health services coverage. (New HOD Policy)

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

Received: 4/5/2024

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RELEVANT AMA POLICY

H-185.990 Infertility and Fertility Preservation Insurance Coverage
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. [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]

H-65.956 Right for Gamete Preservation Therapies
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. [Res. 005, A-19]

H-185.922 Right for Gamete Preservation Therapies
3. 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. [Res. 005, A-19]

H-510.984 Infertility Benefits for Veterans
1. Our AMA supports: (A) 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; and (B) 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; and (C) 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.
2. Our AMA encourages: (A) 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, and (B) 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. [CMS Rep. 01, I-16; Appended: Res. 513, A-19]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 102
(A-24)

Introduced by: Medical Student Section

Subject: Medicaid & CHIP Benefit Improvements

Referred to: Reference Committee A

Whereas, the Centers for Medicare and Services list hearing, vision, and dental care as optional benefits in Medicaid, and states vary drastically in Medicaid coverage of these services; and

Whereas, Medicaid is not subject to Medicare's budgetary constraints, and much of the cost of improved benefits is borne by existing federal agreements for Medicaid expansion funding; and

Whereas, only 28 states provide varying levels of hearing coverage based on hearing loss severity, 18 states offer no coverage, and some only cover devices but not services;[2] and

Whereas, of the 28 states providing some Medicaid hearing coverage, a study rated only 6 as "fair" (on a scale of poor, fair, good, excellent);[2] and

Whereas, Medicaid patients are more likely to report hearing problems compared to privately insured patients, and lower-income patients are twice as likely to experience more difficulty using hearing aids, in part due to the cost of required support services;[3,4] and

Whereas, while FDA approval of over-the-counter hearing aids is expected to greatly increase access, a pair can still cost $1,000, a prohibitive cost for many Medicaid patients;[5-6] and

Whereas, only 33 states offer some Medicaid vision coverage, with 28 limiting access based on severity of vision impairment, pre-existing conditions, restrictions to only eyeglasses and not contacts, number of visits allowed, and approval of coverage only every 2 to 4 years;[7] and

Whereas, a *JAMA Ophthalmology* study found that Medicaid patients had significantly decreased odds of securing an appointment compared to privately insured patients (OR=0.41);[8] and

Whereas, a study in *Ophthalmology* (the journal of the American Academy of Ophthalmology) found that Medicaid patients are over twice as likely to not receive follow-up care after glaucoma diagnosis compared to privately insured patients;[9] and

Whereas, no minimum requirements for Medicaid dental coverage exist, and in 2019, only 19 states offered comprehensive coverage while 31 offered limited/emergency coverage;[10-13] and

Whereas, 18% of Medicaid patients under 65 report an unmet dental need due to cost, double the rate of privately insured patients;[4] and

Whereas, up to 25% of non-elderly adults forgo dental care due to cost, as the average yearly cost of dental care for adults under the poverty level is $523;[14-15] and

Whereas, adults in poverty are three times as likely to develop dental caries, and 29% of low-income adults report that appearance of their teeth affects their employment chances;[16-17] and

Whereas, Medicaid patients with dental coverage are more likely to seek dental care due to reduced out-of-pocket cost and receive dental caries treatment than those without;[18] and

Whereas, our 2 million dental-related emergency room visits a year cost $2 billion;[19-22] and

Whereas, California and Massachusetts cut Medicaid dental benefits in 2010 and subsequently saw 32% and 11% increases in dental-related ER visits respectively;[23-24] and

Whereas, California and Massachusetts restored dental benefits in 2014, and Massachusetts saw a 15% reduction in dental-related ER visits afterward;[23-24] and

Whereas, from 2012 to 2014, states that did not expand Medicaid or expanded Medicaid without dental coverage saw a 27% increase in dental-related ER visits, compared to a 14% reduction in states that expanded Medicaid with dental coverage;[25] and

Whereas, AMA advocacy on Medicaid dental coverage does not conflict with the position of the American Dental Association (ADA), which is active on this issue, and amendments to existing AMA policy on working with the ADA on public payer dental benefits to include Medicaid ensures that the AMA would collaborate with and not conflict with the ADA in this area;[26] and

Whereas, to increase savings on emergency and inpatient care costs and overall costs due to lost productivity, reduced employment, and disability, the benefits of Medicaid expansion can be better realized via comprehensive hearing, vision, and dental coverage; therefore be it

RESOLVED, that our American Medical Association amend H-185.929 Hearing Aid Coverage by addition as follows; and be it further

Hearing Aid Coverage H-185.929

1) Our American Medical Association 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.
8) Our AMA supports physician and patient education on the proper role of over the counter hearing aids, including the value of physician-led assessment of hearing loss, and when they are appropriate for patients and when there are possible cost-savings.
9) Our AMA encourages the United States Preventive Services Task Force to re-evaluate its determination not to recommend preventive hearing services and screenings in asymptomatic adults over age 65 in consideration of new evidence connecting hearing loss to dementia.
10) Our AMA advocates that hearing exams, hearing aids, cochlear implants, and aural rehabilitative services be covered in all Medicaid and CHIP programs and any new public payers.

(Modify Current HOD Policy)

RESOLVED, that our AMA advocate that routine comprehensive vision exams and visual aids (including eyeglasses and contact lenses) be covered in all Medicaid and CHIP programs and by any new public payers (Directive to Take Action); and be it further

RESOLVED, that our AMA amend H-330.872, "Medicare Coverage for Dental Services" by addition and deletion as follows.

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, Medicaid, CHIP, and other public payer beneficiaries; and (2) initiatives to expand health services research on the effectiveness of expanded dental coverage in improving health and preventing disease among ~~in the~~ Medicare, Medicaid, CHIP, and other public payer beneficiaries ~~population~~, the optimal dental benefit plan designs to cost-effectively improve health and prevent disease ~~in the~~ among Medicare, Medicaid, CHIP, and other public payer beneficiaries ~~population~~, and the impact of expanded dental coverage on health care costs and utilization.

(Modify Current HOD Policy)

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

Received: 4/19/2024

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RELEVANT AMA Policy

H-185.929 Hearing Aid Coverage

1) Our American Medical Association 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.
8) Our AMA supports physician and patient education on the proper role of over the counter hearing aids, including the value of physician-led assessment of hearing loss, and when they are appropriate for patients and when there are possible cost-savings.
9) Our AMA encourages the United States Preventive Services Task Force to re-evaluate its determination not to recommend preventive hearing services and screenings in asymptomatic adults over age 65 in consideration of new evidence connecting hearing loss to dementia. [CMS Rep. 6, I-15; Appended: Res. 124, A-19; Appended: CMS Rep. 02, A-23; Reaffirmed: CMS Rep. 02, A-23]

H-25.990 Eye Exams for the Elderly

1. Our American Medical Association encourages the development of programs and/or outreach efforts to support periodic eye examinations and access to affordable prescription eyeglasses for elderly patients.
2. Our AMA 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; Modified: CMS Rep. 02, A-23]

H-330.872 Medicare Coverage for Dental Services

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; Reaffirmed: CMS Rep. 02, A-23]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 103
(A-24)

Introduced by: Oklahoma

Subject: Medicare Advantage Plans

Referred to: Reference Committee A

Whereas, 52% of Medicare beneficiaries are now enrolled in Medicare Advantage (MA) plans, with an anticipated growth to 70% within a years; and

Whereas, a former Center for Medicare and Medicaid Services (CMS) administrator stated recently in a national publication that, “I think MA growth should be slowed or stopped, at least until we end the extraordinarily high subsidies for MA plans, which are unfair to traditional Medicare and burdensome to the treasury and many beneficiaries.”[1]; and

Whereas, it is anticipated that MA plans, in 2024 will receive $88 billion more than what is spent for the same number of patient in traditional Medicare; and

Whereas, it is anticipated that MA plans, in 2024 will receive $88 billion more than what is spent for the same number of patient in traditional Medicare; and

Whereas, the amount that an MA plan gets is adjusted for the number of codes for diagnoses that a beneficiary has; and

Whereas, providers and physicians are rewarded in any MA plans for upcoming, or they receive a percentage of the insurance premium the MA collects from CMS or, they are employed by the MA; and

Whereas, this ends up being a transfer of funds out of the healthcare arena into the private sector, which goes to profit for the MA, or for stock buybacks, or for higher compensation for the MA executives, and activities that don’t benefit beneficiaries; therefore be it

RESOLVED, that our American Medical Association urge the United States Congress and Center for Medicare and Medicaid Services to take steps to end the upcoding for Medicare Advantage plans that results in high subsidies which are unfair to traditional Medicare and burdensome to the public treasury and many beneficiaries (New HOD Policy); and be it further

RESOLVED, that our AMA encourages Center for Medicare and Medicaid Services to improve the attractiveness of traditional Medicare so that the option remains robust and available giving beneficiaries greater traditional choices for this option and to seek better care for themselves. (New HOD Policy)

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

Received: 4/22/2024

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 104
(A-24)

Introduced by: Medical Student Section

Subject: Medicaid Estate Recovery Reform

Referred to: Reference Committee A

Whereas, 70% of Medicare beneficiaries will require long-term supports and services (LTSS), but since annual LTSS costs exceeds the median Medicare beneficiary's total savings, many must deplete their savings and become destitute to receive Medicaid LTSS coverage;[1-9] and

Whereas, the Social Security Act requires states to recover all Medicaid costs from patients' estates after their death, but states typically only recover 0-1%, resulting in insignificant effects on state budgets but disproportionate detriment to patients' inheritors;[4,10-12] and

Whereas, because the Social Security Act does not require recovery of nonprobate assets, patients with greater wealth or access to legal and financial estate planning services can evade estate recovery with careful planning and modern methods of wealth transfer;[10,13-15] and

Whereas, states disproportionately recover costs from low-income patients, exacerbating racial wealth gaps and preventing intergenerational wealth;[13] and

Whereas, Black Medicaid patients die with a median net worth of $800, compared to white Medicaid patients with $2100, so estate recovery more rapidly depletes Black wealth;[12] and

Whereas, 25 states use 1115 waivers to capitate Medicaid LTSS coverage and may therefore recover capitation payments from estates, even if a patient never received LTSS;[16-18] and

Whereas, alternative methods to reduce LTSS costs exist, such as clinical demonstration projects that improve patient outcomes while saving $12,000 per patient annually;[19] and

Whereas, California dramatically limited estate recovery by excluding patients survived by a spouse and homes of modest value, and the Stop Unfair Medicaid Recoveries Act in Congress would end Medicaid estate recovery altogether;[20-21] therefore be it

RESOLVED, that our American Medical Association oppose federal or state efforts to impose liens on or seek adjustment or recovery from the estate of individuals who received long-term services or supports coverage under Medicaid. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 4/24/20/2024

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RELEVANT AMA Policy

Policy Directions for the Financing of Long-Term Care H-280.991

Our American Medical Association believes that programs to finance long-term care should:

1. Assure access to needed services when personal resources are inadequate to finance care.
2. Protect personal autonomy and responsibility in the selection of LTC service providers.
3. Prevent impoverishment of the individual or family in the face of extended or catastrophic service costs.
4. Account for equity in order to assure affordability of long-term care for all Americans.
5. Cover needed services in a timely, coordinated manner in the least restrictive setting appropriate to the health care needs of the individual.

6. Coordinate benefits across different LTC financing program.
7. Provide coverage for the medical components of long-term care through Medicaid for all individuals with income below 100 percent of the poverty level.
8. Provide sliding scale subsidies for the purchase of LTC insurance coverage for individuals with income between 100-200 percent of the poverty level.
9. Encourage private sector LTC coverage through an asset protection program; equivalent to the amount of private LTC coverage purchased.
10. Create tax incentives to allow individuals to prospectively finance the cost of LTC coverage, encourage employers to offer such policies as a part of employee benefit packages and otherwise treat employer-provided coverage in the same fashion as health insurance coverage, and allow tax-free withdrawals from IRAs and Employee Trusts for payment of LTC insurance premiums and expenses.
11. Authorize a tax deduction or credit to encourage family care giving. Consumer information programs should be expanded to emphasize the need for prefunding anticipated costs for LTC and to describe the coverage limitations of Medicare, Medicaid, and traditional medigap policies. State medical associations should be encouraged to seek appropriate legislation or regulation in their jurisdictions to:

a. provide an environment within their states that permit innovative LTC financing and delivery arrangements, and
b. assure that private LTC financing and delivery systems, once developed, provide the appropriate safeguards for the delivery of high quality care.

Our AMA continues to evaluate and support additional health system reform legislative initiatives that could increase states' flexibility to design and implement long-term care delivery and financing programs. Our AMA will also encourage and support the legislative and funding changes needed to enable more accurate and disaggregated collection and reporting of data on health care spending by type of service, so as to enable more informed decisions as to those social components of long-term care that should not be covered by public or private health care financing mechanisms.

2. Our AMA will work with Centers for Medicare & Medicaid Services and other relevant stakeholders to formulate appropriate medical insurance plans to provide long-term care coverage for patients with Alzheimer’s and other forms of dementia. [BOT Rep. O, A-88; BOT Rep. X, I-88; Reaffirmed: CMS Rep. 3, A-94; BOT Rep. S, I-87; Reaffirmed: CMS Rep. 3-A-94; CMS Rep. 11, I-95; Reaffirmation A-04; Modified: CMS Rep. 6, I-05; Reaffirmed: BOT Rep. 32, A-09; Reaffirmation A-11; Reaffirmed: CMS Rep. 05, A-18; Appended: Res. 110, A-23; Modified: Res. 815, I-23]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 105
(A-24)

Introduced by: Medical Student Section

Subject: Medigap Patient Protections

Referred to: Reference Committee A

Whereas, Medicare Supplement (Medigap) plans are used by 23% of Medicare beneficiaries (14 million) to make Traditional Medicare more affordable and avoid the myriad problems with Medicare Part C, including limited networks and prior authorizations[1-13]; and

Whereas, when seniors enroll in Medicare Part B, they are offered a one-time 6-month enrollment period for Medigap, during which they are protected by guaranteed issue and community rating, preventing price discrimination based on health, age, or gender[13-14]; and

Whereas, after the initial 6-month Medigap enrollment period, protections for guaranteed issue and community rating no longer apply, even though guaranteed issue and (modified) community ratings are permanent and universal in the Affordable Care Act (ACA) marketplace[13-16]; and

Whereas, Medigap plans are required to be offered to all Medicare beneficiaries over 65, but not to other Medicare beneficiaries under 65 on dialysis or with disabilities[17-18]; and

Whereas, several states have enacted Medigap protections for guaranteed issue, community rating, and eligibility for Medicare beneficiaries under 65 and demonstrated reduced switching from Traditional Medicare to Medicare Part C[19-25]; and

Whereas, Congress is currently investigating deceptive tactics by private Medigap insurers, presenting a timely opportunity for regulation of private health insurance companies' dubious marketing tactics to steer consumers into purchasing more expensive Medigap plans, representing a timely opportunity for regulatory reform[24,26]; and

Whereas, at I-23, the AMA passed H-390.832, "Saving Traditional Medicare," "recognizing that Traditional Medicare is a critical healthcare program while educating the public on the benefits and threats of Medicare Part C expansion" and "acknowledg[ing] that the term "Medicare Advantage" can be misleading, as it implies a superiority or enhanced value over traditional Medicare, which may not accurately reflect the nature and challenges of these plans"; therefore be it

RESOLVED, that our American Medical Association support annual open enrollment periods and guaranteed lifetime enrollment eligibility for Medigap plans (New HOD Policy); and be it further

RESOLVED, that our AMA advocate for extending modified community rating regulations to Medigap supplemental insurance plans, similar to those enacted under the Affordable Care Act for commercial insurance plans (Directive to Take Action); and be it further

RESOLVED, that our AMA support efforts to expand access to Medigap policies to all individuals who qualify for Medicare benefits (New HOD Policy); and be it further

RESOLVED, that our AMA supports efforts to improve the affordability of Medigap supplemental insurance for lower income Medicare beneficiaries. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 4/24/2024

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RELEVANT AMA Policy

Health Insurance Market Regulation H-165.856
Our AMA supports the following principles for health insurance market regulation:
(1) There should be greater national uniformity of market regulation across health insurance markets, regardless of type of sub-market (e.g., large group, small group, individual), geographic location, or type of health plan.
(2) State variation in market regulation is permissible so long as states demonstrate that departures from national regulations would not drive up the number of uninsured, and so long as variations do not unduly hamper the development of multi-state group purchasing alliances, or create adverse selection.
(3) Risk-related subsidies such as subsidies for high-risk pools, reinsurance, and risk adjustment should be financed through general tax revenues rather than through strict community rating or premium surcharges.
(4) Strict community rating should be replaced with modified community rating, risk bands, or risk corridors. Although some degree of age rating is acceptable, an individual's genetic information should not be used to determine his or her premium.
(5) Insured individuals should be protected by guaranteed renewability.
(6) Guaranteed renewability regulations and multi-year contracts may include provisions allowing insurers to single out individuals for rate changes or other incentives related to changes in controllable lifestyle choices.
(7) Guaranteed issue regulations should be rescinded.
(8) Health insurance coverage of pre-existing conditions with guaranteed issue within the context of an individual mandate, in addition to guaranteed renewability.
(9) Insured individuals wishing to switch plans should be subject to a lesser degree of risk rating and pre-existing conditions limitations than individuals who are newly seeking coverage.
(10) The regulatory environment should enable rather than impede private market innovation in product development and purchasing arrangements. Specifically: (a) legislative and regulatory barriers to the formation and operation of group purchasing alliances should, in general, be removed; (b) benefit mandates should be minimized to allow markets to determine benefit packages and permit a wide choice of coverage options; and (c) any legislative and regulatory barriers to the development of multi-year insurance contracts should be identified and removed.
[CMS Rep. 7, A-03; Reaffirmed: CMS Rep. 6, A-05; Reaffirmation A-07; Reaffirmed: CMS Rep. 2, I-07; Reaffirmed: BOT Rep. 7, A-09; Appended: Res. 129, A-09; Reaffirmed: CMS Rep. 9, A-11; Reaffirmed in lieu of Res. 811, I-11; Reaffirmed in lieu of Res. 109, A-12; Reaffirmed in lieu of Res. 125, A-12; Reaffirmed: Res. 239, A-12; Reaffirmed: CMS Rep. 9, A-14; Reaffirmation: A-17; Reaffirmed: Res. 518, A-17; Reaffirmed: Res. 105, A-18; Reaffirmed: Joint CMS CSAPH Rep. 01, I-18; Reaffirmed: CMS Rep. 03, A-23]

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

Ensuring Marketplace Competition and Health Plan Choice H-165.825
Our AMA will: (1) support health plans offering coverage options for individuals and small groups competing on a level playing field, including providing coverage for pre-existing conditions and essential health benefits; (2) oppose the sale of health insurance plans in the individual and small group markets that do not guarantee: (a) pre-existing condition protections and (b) coverage of essential health benefits and their associated protections against annual and lifetime limits, and out-of-pocket expenses, except in the limited circumstance of short-term limited duration insurance offered for no more than three months; and (3) support requiring the largest two Federal Employees Health Benefits Program (FEHBP) insurers in counties that lack a marketplace plan to offer at least one silver-level marketplace plan as a condition of FEHBP participation. [CMS Rep. 03, A-18; Reaffirmed: CMS Rep. 01, I-20]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 106
(A-24)

Introduced by: American Society for Gastrointestinal Endoscopy, American College of Gastroenterology, American Gastroenterological Association

Subject: Incorporating Surveillance Colonoscopy into the Colorectal Cancer Screening Continuum

Referred to: Reference Committee A

Whereas, in 2024, an estimated 153,000 cases of colorectal cancer (CRC) will be diagnosed in the United Sates, and a total of 53,010 people will die from this cancer[1]; and

Whereas, while CRC incidence and mortality rates have been declining because, in part, of screening uptake among adults ages 50 years and older, rates have increased by 1-2 percent per year since the mid-1990s in those younger than 55 years of age[2]; and

Whereas, when detected and treated early, the five-year survival rate for CRC is 90 percent; yet, early detection occurs in less than 40 percent of CRC cases[3]; and

Whereas, the Affordable Care Act (ACA) requires that several CRC screening modalities, including colonoscopy, be covered without patient cost-sharing for eligible individuals by non-grandfathered group health plans and non-grandfathered group or individual health insurance coverage; and

Whereas, the Centers for Medicare and Medicaid Services recently reported 21.3 million consumers signed up for 2024 individual health insurance coverage through the Marketplaces,[4] with nearly 65 percent of individuals between 18-54 years of age[5] — the same demographic experiencing increased rates of CRC; and

Whereas, the U.S. Multi-Society Task Force on Colorectal Cancer recommends that asymptomatic individuals undergoing screening colonoscopy seek follow-up colonoscopy exams to evaluate for new polyps at specific intervals based on the findings of the exam, ranging between one to 10 years[6;] and

Whereas, Medicare considers these additional, follow-up, or surveillance, colonoscopies as screening exams; and

Whereas, commercial insurers regulated by the ACA routinely treat a follow-up colonoscopy exam at an interval shorter than 10 years as a “diagnostic” service rather than screening or surveillance, even if a patient is asymptomatic; and

Whereas, clinical evidence indicates screening colonoscopy exams, including surveillance colonoscopies, and post-polypectomy follow-up play a critical role in reducing colorectal cancer incidence and death; and

Whereas, the U.S. Department of Health and Human Services (HHS) has the authority to issue written guidance that clarifies surveillance colonoscopy after an original screening colonoscopy that required polyp removal is part of the screening continuum and should therefore be covered without patient cost sharing as a preventive services benefit under the ACA; and

Whereas, more than 90 national and state medical societies and patient advocacy groups have asked[7] HHS to use its existing regulatory authority make this policy clarification. And, in early 2024, 45 members of the U.S. House of Representatives sent a similar letter[8] to HHS, also urging the same change; therefore be it

RESOLVED, that our American Medical Association Policy H-185.960, "Support for the Inclusion of the Benefit for Screening for Colorectal Cancer in All Health Plans" be amended by addition to read as follows:

1. Our AMA supports health plan coverage for the full range of colorectal cancer screening tests.

2. Our AMA will seek to eliminate cost-sharing in all health plans for the full range of colorectal cancer screening and all associated costs, including colonoscopy that includes a "diagnostic" intervention (i.e. the removal of a polyp or biopsy of a mass), as defined by Medicare. To further this goal, the AMA will develop a coding guide to promote common understanding among health care providers, payers, health care information technology vendors, and patients.

3. Our AMA will seek to eliminate cost-sharing in all health plans for "follow-on" colonoscopies performed for colorectal cancer screening and all associated costs, defined as when other alternative screening tests are found to be positive.

4. Our AMA will seek to classify follow-up, follow-on, or surveillance, colonoscopy after an original screening colonoscopy that required polyp removal as a screening service under the Affordable Care Act preventive services benefit and will seek to eliminate patient cost sharing in all health plans under such circumstances.

(Modify Current HOD Policy)

Fiscal Note: TBD

Received: 4/24/2024

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RELEVANT AMA POLICY

Support for the Inclusion of the Benefit for Screening for Colorectal Cancer in All Health Plans H-185.960
1. Our AMA supports health plan coverage for the full range of colorectal cancer screening tests.
2. Our AMA will seek to eliminate cost-sharing in all health plans for the full range of colorectal cancer screening and all associated costs, including colonoscopy that includes a “diagnostic” intervention (i.e. the removal of a polyp or biopsy of a mass), as defined by Medicare. To further this goal, the AMA will develop a coding guide to promote common understanding among health care providers, payers, health care information technology vendors, and patients.
Citation: Res. 726, I-04 Reaffirmation I-07 Reaffirmed: CMS Rep. 01, A-17 Reaffirmed: Res. 123, A-17 Appended: CMS/CSAPH Joint Rep. 01, A-18

Encourage Appropriate Colorectal Cancer Screening H-55.967
Our AMA, in conjunction with interested organizations and societies, supports educational and public awareness programs to assure that physicians actively encourage their patients to be screened for colon cancer and precursor lesions, and to improve patient awareness of appropriate guidelines, particularly within minority populations and for all high-risk groups.
CSAPH Rep. 8, A-23

Encourage Appropriate Colorectal Cancer Screening H-55.967
Our AMA, in conjunction with interested organizations and societies, supports educational and public awareness programs to assure that physicians actively encourage their patients to be screened for colon cancer and precursor lesions, and to improve patient awareness of appropriate guidelines, particularly within minority populations and for all high-risk groups.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 107
(A-24)

Introduced by: Mississippi

Subject: Requiring Government Agencies to Contract Only with Not-For-Profit Insurance Companies

Referred to: Reference Committee A

Whereas, the medical system in the United States involves a market-like environment with a charity mission; and

Whereas, for profit insurance companies have taken over much of the health care system, with most of their profits directed to private entities outside of our health system; and

Whereas, many of the tactics for making a profit include strategies which complicate the provision of medical care for both the patient and the physician; and

Whereas, the Dutch health care system is recognized as a successful health care system using a market-type multi-payer system which utilizes not-for-profit cooperatives whose profits are allocated to reserves or returned in the form of lower premiums; and

Whereas, Medicare and Medicaid, which are government owned health insurance agencies, contract with insurance companies to operate aspects of the medical care delivery; therefore be it

RESOLVED, that our American Medical Association advocate that government-owned health agencies such as Medicare and Medicaid be required to contract only with not-for-profit insurance companies or cooperatives (Directive to Take Action); and be it further

RESOLVED, that our AMA support that those not-for-profit insurance companies or cooperatives receiving public revenues must allocate profits to reserves, investments in improving the quality of care in the system, or returned in the form of lower premiums for patients or the health agency. (New HOD Policy).

Fiscal Note: Minimal - less than $1,000

Received: 4/24/2024

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 108
(A-24)

Introduced by: Mississippi

Subject: Requiring Payments for Physician Signatures

Referred to: Reference Committee A

Whereas, insurance companies often require multiple physician signatures outside of a patient-physician office, nursing home or hospital visit for bureaucratic reasons or to place hurdles to obtaining testing, health services, medications, referrals, or medical equipment; and

Whereas, primary care physicians often have to sign dozens of signatures daily which are outside of the clinical visit in caring for patients; and

Whereas, this duty is often a significant burden on physician time and staff time which is not usually paid for; and

Whereas, physicians desire to care for their patients but often feel like these signatures are deliberately placed by the insurance companies to complicate the provision of services needed; and

Whereas, if insurance companies had to pay for a physician's time in signing forms, they might reduce the administrative burdens currently imposed on physicians; therefore be it

RESOLVED, that our American Medical Association advocate that insurance companies be required to pay a physician for any required physician signature and/or peer to peer review which is requested or required outside of a patient visit. (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000

Received: 4/24/2024

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 109
(A-24)

Introduced by: Association for Clinical Oncology, American Society for Radiation Oncology

Subject: Coverage for Dental Services Medically Necessary for Cancer Care

Referred to: Reference Committee A

Whereas, dental services may be required prior to or after cancer treatment and such services are an integral part of successful cancer treatment; and

Whereas, dental care is linked to improved outcomes in patients with cancer and improved quality of life; and

Whereas, the Centers for Medicare & Medicaid Services (CMS) recently expanded coverage for certain cancer treatment-related oral and dental conditions, as well as for pre-treatment exams; and

Whereas, all patients, regardless of insurance coverage, deserve equal access to these medically necessary treatments; therefore be it

RESOLVED, that our American Medical Association supports that oral examination and dental services prior to and following the administration of radiation, chemotherapy, chimeric antigen receptor (CAR) T-cell therapy and high-dose bone-modifying agents for the treatment of cancer are part of medically necessary care (New HOD Policy); and be it further

RESOLVED, that our AMA will advocate that all insurers cover medically necessary oral examination and dental services prior to the administration of and resulting as a complication of radiation, chemotherapy and/or surgery for all cancer of the head and neck region. (Directive to Take Action)

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

Received: 4/24/2024

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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.

Increasing Patient Access to Hearing, Dental and Vision Services D-185.972
Our AMA will: (1) promote awareness of hearing impairment as a potential contributor to the development of cognitive impairment or dementia in later life, to physicians as well as to the public; (2) 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 or dementia and amenable to correction; (3) 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; and (4) 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.

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.

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, including prosthodontic reconstruction (including dental implants) 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 supports that reconstructive surgery be covered by all insurers and encourages third party payers to use these definitions in determining services eligible for coverage under the plans they offer or administer.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 110
(A-24)

Introduced by: American Academy of Physical Medicine and Rehabilitation, American Association of Neuromuscular & Electrodiagnostic Medicine, American Academy of Pediatrics

Subject: Coverage for Shoes and Shoe Modifications for Pediatrics Patients Who Require Lower Extremity Orthoses

Referred to: Reference Committee A

Whereas, pediatric patients with musculoskeletal and/or neuromuscular disorders frequently require lower extremity orthoses to help with their mobility, maximize their function, and prevent contractures; and

Whereas, an orthosis or orthotic device is defined by the International Standards Organization as an externally applied device used to modify the structural and functional characteristics of the neuromuscular and skeletal system; and

Whereas, shoes that work with lower extremity orthoses are an essential component of the orthotic intervention; and

Whereas, one of the goals when choosing the orthoses is to optimize forces and moments acting on bones, ligaments, and joints during standing and walking to allow for the most natural gait; and

Whereas, the orthoses will not normalize the gait to the best potential without proper footwear; and

Whereas, there are some shoe options on the market that are deep and roomy enough to accommodate braces which eliminates the need for custom shoes for most patients; and

Whereas, the commercially available shoes may require external modifications, such as for leg length discrepancy or plantar flexion contracture, which require foot elevation or an external heel lift respectively; and

Whereas, patients with severe hypotonia, calcaneus feet, and severe crouch using solid ankle-foot orthoses (AFOs) to ambulate require shoes with a stiff sole, custom rocker, and heel lever to maintain consistent roll over to imitate the natural rocking motion of gait; and

Whereas, those shoe modifications are relatively inexpensive and in the skilled hands of an orthotist are easy to accomplish; and

Whereas, insurance coverage for shoes to use with orthoses as well as shoe modifications is limited or nonexistent; and

Whereas, this creates a burden on the patients and families and makes the providers more hesitant to recommend the shoe modifications despite being medically indicated; therefore be it

RESOLVED, that our American Medical Association support coverage by all private and government insurance companies for pediatric footwear suitable for use with lower extremity orthoses and medically necessary shoe modifications. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 4/24/2024

REFERENCES

1. Daryabor A, Aminian G, Arazpour M, Baniasad M, Yamamoto S. The effects of ankle-foot orthoses with plantar flexion stop and plantar flexion resistance using rocker-sole shoes on stroke gait: A randomized-controlled trial. Turk J Phys Med Rehabil. 2021 Dec 1;67(4):449-461. doi: 10.5606/tftrd.2021.6448. PMID: 35141485; PMCID: PMC8790265.
2. Mojaver A, Arazpour M, Aminian G, Ahmadi Bani M, Bahramizadeh M, Sharifi G, Sherafatvaziri A. The effect of footwear adapted with a multi-curved rocker sole in conjunction with knee-ankle-foot orthoses on walking in poliomyelitis subjects: a pilot study. Disabil Rehabil Assist Technol. 2017 Oct;12(7):747 751. doi: 10.1080/17483107.2016.1260654. Epub 2016 Dec 16. PMID: 27982715.
3. Mueller M, Strube M, Allen B. Effect of six types of footwear on peak plantar pressures in patients with diabetes and transmetatarsal amputation. Clin Biomech (Bristol, Avon). 1997 Apr;12(3):S3. doi: 10.1016/s0268-0033(97)88308-8. PMID: 11415697.
4. Wu WL, Rosenbaum D, Su FC. The effects of rocker sole and SACH heel on kinematics in gait. Med Eng Phys. 2004 Oct;26(8):639-46. doi: 10.1016/j.medengphy.2004.05.003. PMID: 15471691.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 111
(A-24)

Introduced by: Ohio

Subject: Protections for “Guarantee Issue” of Medigap Insurance and Traditional Medicare

Referred to: Reference Committee A

Whereas, the Federal Medicare program has 4 parts A, B, C, and D, offering hospital, medical, and pharmacy benefits; and

Whereas, Part C, known as Medicare Advantage, has become popular for its offerings of zero premiums and additional benefits which are not available through traditional Medicare; and

Whereas, Medicare Advantage plans have various other limitations such as narrow networks, limited drug coverage, and numerous preauthorization requirements; and

Whereas, traditional Medicare often requires supplementation through Medigap or Supplemental Insurance policies to cover the remaining 20% of approved expenses not covered by Medicare; and

Whereas, beneficiaries who switch from Medicare Advantage to traditional Medicare face significant barriers in obtained Medigap or Supplemental Insurance, often finding themselves effectively locked into their Medicare Advantage plan even if it no longer meets their healthcare needs; and

Whereas, only four states—Connecticut, Massachusetts, New York, and Maine—offer "guaranteed issue" protections that allow access to Medigap or Supplemental Insurance policies without restrictions after the initial enrollment period for Medicare beneficiaries; therefore be it

RESOLVED, that our American Medical Association pursue all necessary legislative and administrative measures to ensure that Medicare beneficiaries have the freedom to switch back to Traditional Medicare and obtain Medigap insurance under federal "guaranteed issue" protections. (Directive to Take Action)

Fiscal Note: Moderate - between $5,000 - $10,000

Received: 4/26/2024

REFERENCES

1. https://www.wsj.com/health/healthcare/medicare-advantage-enrollment-risks-923e7952

RELEVANT AMA POLICY

H-285.913 Medicare Advantage Policies
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. [Res. 907, I-07; Reaffirmation A-08; Reaffirmed: CMS Rep. 01, A-18; Reaffirmation: I-18]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 112
(A-24)

Introduced by: American Academy of Physical Medicine and Rehabilitation

Subject: Private and Public Insurance Coverage for Adaptive Sports Equipment including Prostheses and Orthoses

Referred to: Reference Committee A

Whereas, adults with lifelong disabilities are more likely to have chronic disease than adults with no limitations[1]; and

Whereas, increased physical activity and exercise are associated with reduced chronic disease risk and most physiologic systems in the body benefit positively from physical activity and exercise by primary and secondary disease prevention[2]; and

Whereas, the Centers for Disease Control (CDC) acknowledge the benefits of exercise to prevent chronic disease in patients with disability[3]; and

Whereas, the CDC recommends that adults need a weekly 150 minutes of moderate-intensity physical activity and 2 days of muscle strengthening activity for chronic disease prevention[4]; and

Whereas, people living with disabilities, including lower limb amputations, are 16-62% less likely to meet physical activity guidelines[4]; and

Whereas, sports are a popular means of exercise and physical activity for children, adolescents, and adults in the United States; and

Whereas, children with disabilities are 4.5 times less likely to engage in physical activity than children without disabilities; and

Whereas, individuals with disabilities need specialized prostheses and orthoses for physical activity and recreation to improve access and equity; and

Whereas, organizations like So Every BODY Can Move have helped introduce bills in 13 states for insurance coverage of activity specific adaptive sports and exercise equipment and bills have passed in 5 states; and

Whereas, Medicare part B already covers durable medical equipment including ambulatory assistive devices to promote safe ambulation and increased independence for people with disabilities; therefore be it

RESOLVED, that our American Medical Association recognizes activity-specific adaptive sports and exercise equipment as assistive devices that are integral to the health maintenance of persons with disabilities in accordance with national exercise guidelines (New HOD Policy); and be it further

RESOLVED, that our AMA recognizes activity-specific adaptive sports and exercise equipment, such as activity-specific prostheses and orthoses, as medical devices that facilitate independence and community participation (New HOD Policy); and be it further

RESOLVED, that our AMA advocate for coverage by all private and public insurance plans for activity-specific adaptive sports and exercise equipment for eligible beneficiaries with disabilities in order to promote health maintenance and chronic disease prevention. (Directive to Take Action)

Fiscal Note: Moderate - between $5,000 - $10,000

Received: 5/7/2024

REFERENCES

1. Dixon-Ibarra A, Horner-Johnson W. Disability status as an antecedent to chronic conditions: National Health Interview Survey, 2006-2012. Prev Chronic Dis. 2014 Jan 30;11:130251. doi: 10.5888/pcd11.130251. PMID: 24480632; PMCID: PMC3917726.
2. Anderson E, Durstine JL. Physical activity, exercise, and chronic diseases: A brief review. Sports Med Health Sci. 2019 Sep 10;1(1):3-10. doi: 10.1016/j.smhs.2019.08.006. PMID: 35782456; PMCID: PMC9219321.
3. Physical Activity for People with Disability, *Centers for Disease Control and Prevention (CDC)* 4 January 2022, https://www.cdc.gov/ncbddd/disabilityandhealth/features/physical-activity-for-all.html#:~:text=Physical%20activity%20can%20also%20improve,activity%20is%20better%20than%20none
4. How much physical activity do adults need?, *Centers for Disease Control and Prevention (CDC)* 2 June 2022, https://www.cdc.gov/physicalactivity/basics/adults/index.htm#:~:text=Each%20week%20adults%20need%20150,Physical%20Activity%20Guidelines%20for%20Americans.&text=We%20know%20150%20minutes%20of,do%20it%20all%20at%20once
Martin Ginis KA, van der Ploeg HP, Foster C, Lai B, McBride CB, Ng K, Pratt M, Shirazipour CH, Smith B, Vásquez PM, Heath GW. Participation of people living with disabilities in physical activity: a global perspective. Lancet. 2021 Jul 31;398(10298):443-455.

RELEVANT AMA POLICY

H-470.990 Promotion of Exercise Within Medicine and Society
Our AMA supports (1) education of the profession on exercise, including instruction on the role of exercise prescription in medical practice in its continuing education courses and conferences, whenever feasible and appropriate; (2) medical student instruction on the prescription of exercise; (3) physical education instruction in the school system; and (4) education of the public on the benefits of exercise, through its public relations program. [Res. 56, I-78; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmation I-98; Reaffirmation A-07; Reaffirmed: BOT Rep. 21, A-12; Reaffirmed: CSAPH Rep. 1, A-22]

H-470.991 Promotion of Exercise
Our AMA: (A) supports the promotion of exercise, particularly exercise of significant cardiovascular benefit; and (B) encourages physicians to prescribe exercise to their patients and to shape programs to meet each patient's capabilities and level of interest. 2. Our AMA supports National Bike to Work Day and encourages active transportation whenever possible. [Res. 83, parts 1 and 2, I-77; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CSAPH Rep. 1, A-10; Appended: Res. 604, A-11; Reaffirmed: CSAPH Rep. 1, A-21]

H-25.995 Exercise Programs for the Elderly
The AMA recommends that physicians: (1) stress the importance of exercise for older patients and explain its physiological and psychological benefits; (2) obtain a complete medical history and perform a physical examination that includes exercise testing for quantification of cardiovascular and physical fitness as appropriate, prior to the specific exercise prescription; (3) provide appropriate follow-up of patients' exercise programs; and (4) encourage all patients to establish a lifetime commitment to an exercise program. [CSA Rep. C, I-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: CSA Rep. 8, A-05; Reaffirmed: CSAPH Rep. 1, A-15]

H-470.952 Government to Support Community Exercise Venues
Our AMA encourages: (1) towns, cities and counties across the country to make recreational exercise more available by utilizing existing or building walking paths, bicycle trails, swimming pools, beaches and community recreational fitness facilities; and (2) governmental incentives such as tax breaks and grants for the development of community recreational fitness facilities. [CSAPH Rep. 1, A-22]

H-470.997 Exercise and Physical Fitness
Our AMA encourages all physicians to utilize the health potentialities of exercise for their patients as a most important part of health promotion and rehabilitation, and urges state and local medical societies to emphasize through all available channels the need for physical activity for all age groups and both sexes. The AMA encourages other organizations and agencies to join with the Association in promoting physical fitness through all appropriate means. Our AMA will study evidence of the efficacy of physical activity interventions (e.g. group fitness, personal training, or physical therapy) on behavioral activation and outcomes on depressive and anxiety symptoms. [BOT Rep. K, A-66; Reaffirmed: CLRPD Rep. C, A-88; Reaffirmed: Sunset Report, I-98; Modified and Reaffirmed: CSAPH Rep. 2, A-08; Reaffirmed: BOT Rep. 10, A-14; Modified: Res. 421, A-23]

H-90.968 Medical Care of Persons with Disabilities
1. Our AMA encourages: (a) clinicians to learn and appreciate variable presentations of complex functioning profiles in all persons with disabilities including but not limited to physical, sensory, developmental, intellectual, learning, and psychiatric disabilities and chronic illnesses; (b) medical schools and graduate medical education programs to acknowledge the benefits of education on how aspects in the social model of disability (e.g. ableism) can impact the physical and mental health of persons with disabilities; (c) medical schools and graduate medical education programs to acknowledge the benefits of teaching about the nuances of uneven skill sets, often found in the functioning profiles of persons with developmental disabilities, to improve quality in clinical care; (d) education of physicians on how to provide and/or advocate for developmentally appropriate and accessible medical, social and living support for patients with disabilities so as to improve health outcomes; (e) medical schools and residency programs to encourage faculty and trainees to appreciate the opportunities for exploring diagnostic and therapeutic challenges while also accruing significant personal rewards when delivering care with professionalism to persons with profound disabilities and multiple co-morbid medical conditions in any setting; (f) medical schools and graduate medical education programs to establish and encourage enrollment in elective rotations for medical students and residents at health care facilities specializing in care for the disabled; and (g) cooperation among physicians, health & human services professionals, and a wide variety of adults with disabilities to implement priorities and quality improvements for the care of persons with disabilities.
2. Our AMA seeks: (a) legislation to increase the funds available for training physicians in the care of individuals with disabilities, and to increase the reimbursement for the health care of these individuals; and (b) insurance industry and government reimbursement that reflects the true cost of health care of individuals with disabilities.
3. Our AMA entreats health care professionals, parents, and others participating in decision-making to be guided by the following principles: (a) All people with disabilities, regardless of the degree of their disability, should have access to appropriate and affordable medical and dental care throughout their lives; and (b) An individual's medical condition and welfare must be the basis of any medical decision. Our AMA advocates for the highest quality medical care for persons with profound disabilities; encourages support for health care facilities whose primary mission is to meet the health care needs of persons with profound disabilities; and informs physicians that when they are presented with an opportunity to care for patients with profound disabilities, that there are resources available to them.
4. Our AMA will collaborate with appropriate stakeholders to create a model general curriculum/objective that (a) incorporates critical disability studies; and (b) includes people with disabilities as patient instructors in formal training sessions and preclinical and clinical instruction.
5. Our AMA recognizes the importance of managing the health of children and adults with developmental and intellectual disabilities as a part of overall patient care for the entire community.
6. Our AMA supports efforts to educate physicians on health management of children and adults with intellectual and developmental disabilities, as well as the consequences of poor health management on mental and physical health for people with intellectual and developmental disabilities.
7. Our AMA encourages the Liaison Committee on Medical Education, Commission of Osteopathic College Accreditation, and allopathic and osteopathic medical schools to develop and implement a

curriculum on the care and treatment of people with a range of disabilities.
8. Our AMA encourages the Accreditation Council for Graduate Medical Education and graduate medical education programs to develop and implement curriculum on providing appropriate and comprehensive health care to people with a range of disabilities.
9. Our AMA encourages the Accreditation Council for Continuing Medical Education, specialty boards, and other continuing medical education providers to develop and implement continuing programs that focus on the care and treatment of people with a range of disabilities.
10. Our AMA will advocate that the Health Resources and Services Administration include persons with disabilities as a medically underserved population.
11. Specific to people with developmental and intellectual disabilities, a uniquely underserved population, our AMA encourages: (a) medical schools and graduate medical education programs to acknowledge the benefits of teaching about the nuances of uneven skill sets, often found in the functioning profiles of persons with developmental and intellectual disabilities, to improve quality in clinical education; (b) medical schools and graduate medical education programs to establish and encourage enrollment in elective rotations for medical students and residents at health care facilities specializing in care for individuals with developmental and intellectual disabilities; and (c) cooperation among physicians, health and human services professionals, and a wide variety of adults with intellectual and developmental disabilities to implement priorities and quality improvements for the care of persons with intellectual and developmental disabilities. [CCB/CLRPD Rep. 3, A-14; Appended: Res. 306, A-14; Appended: Res. 315, A-17; Appended: Res. 304, A-18; Reaffirmed in lieu of the 1st Resolved: Res. 304, A-18; Modified: Res. 428, A-22]

D-330.961 Social Security Disability Medical Benefits
Our American Medical Association will continue to monitor future research and related developments on Medicare benefits for Social Security disability recipients, and will report and recommend further action to the House of Delegates as appropriate. [Sub. Res. 101, A-03; Reaffirmed: CMS Rep. 4, A-13; Reaffirmed: CMS Rep. 01, A-23]

H-425.970 Promoting Health Awareness and Preventive Screenings in Individuals with Disabilities
Our American Medical Association will work closely with relevant stakeholders to advocate for equitable access to health promotion and preventive screenings for individuals with disabilities. [Res. 911, I-13; Reaffirmed: BOT Rep. 09, A-23]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 113
(A-24)

Introduced by: New England

Subject: Support Prescription Medication Price Negotiation

Referred to: Reference Committee A

Whereas, the passage of the "Inflation reduction act" is now allowing for negotiation of 10 high priced medications, and allowed for reasonable reduction of the price of insulin[1]; and

Whereas, there are many more overpriced medications that our patients struggle to afford[2]; and

Whereas, high prices of medications lead to non-compliance, and worse clinical outcomes[3, 4]; and

Whereas, medication prices in the US are far above any other country in the world, adversely affecting our patient's health[5]; and

Whereas, excessive pharmaceutical prices put a massive strain on our health care system, and directly contribute to high insurance and Medicare premiums[6]; therefore be it

RESOLVED, that our American Medical Association support pharmaceutical price negotiation for all prescription medications, both Medicare and private insurance (New HOD Policy); and be it further

RESOLVED, that our AMA advocate for any medication price that is raised by a pharmaceutical company more than the rate of inflation be immediately subject to price negotiation in the following year's negotiation schedule (Directive to Take Action); and be it further

RESOLVED, that our AMA support extending the cap on annual out of pocket prescription drug spending in Medicare Part D plans to all insurance plans. (New HOD Policy)

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

Received: 5/7/2024

REFERENCES

1. https://www.cms.gov/files/document/medicare-drug-price-negotiation-program-initial-guidance.pdf
2. Why do your prescription drugs cost so much? https://www.health.harvard.edu/blog/why-do-your-prescription-drugs-cost-so-much-202401183007
3. Prescription Noncompliance due to Cost Among Adults With Disabilities in the United States, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1447201/
4. Cost-Related Medication Nonadherence and its Risk Factors among Medicare Beneficiaries Med Care. 2021 Jan; 59(1): 13-21.
5. https://aspe.hhs.gov/sites/default/files/documents/d5541b529a379d1f908ed2f9c00a9255/aspe-cover-idr-pricing-availability.pdf
6. Are Specialty Drug Prices Destroying Insurers and Hurting Consumers? Are Specialty Drug Prices Destroying Insurers and Hurting Consumers? - PMC (nih.gov)

RELEVANT AMA POLICY

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.
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 Reaffirmed: CMS Rep. 4, A-22 Reaffirmed in lieu of: Res. 810, I-22

American Medical Association House of Delegates

Resolution: 114
(A-24)

Introduced by: New York

Subject: Breast Cancer Screening/Clinical Breast Exam Coverage

Referred to: Reference Committee A

Whereas, Centers for Medicare and Medicaid Services, CMS, reimburses Internists and Family Physicians for a single physical at the time of Medicare enrollment at the age of 65 with the Initial Preventive Physical Exam, IPPE; and

Whereas, CMS does not reimburse for any further annual physical exams for medicare patients; and

Whereas, female patients no longer require annual cervical pap smears after the age of 65 if prior pap smears have been negative and they are not at higher risk for cervical cancer, as is applicable for the majority of medicare female patients; and

Whereas, female patients therefore opt to no longer see their gynecologists after the age of 65 as they no longer require a pap smear or have any active gynecological issues; and

Whereas, these female patients need an annual or biennial clinical breast exam and this should therefore be performed by their internist or family practitioner at their Annual Wellness Visits (AWV) or Subsequent Annual Wellness Visits (SAWV) after their initial IPPE; and

Whereas, an internist or family practitioner cannot bill for this clinical breast exam as part of this AWV or SAWV visit, even though this exam is critical and a part of the standard of care for breast cancer screening which includes both imaging and a clinical breast exam; and

Whereas, this policy by CMS is inconsistent and gender biased since a digital rectal exam for prostate cancer screening in men over 65 for Medicare patients is a covered procedure at the time of their AWV or SAWV appointment with their internist or family practitioner; therefore be it

RESOLVED, that our American Medical Association advocate for Medicare coverage of clinical breast exams for all female and at-risk male patients during the Medicare Annual Wellness Visit (AWV) and Subsequent Annual Wellness Visit (SAWV) appointments. (Directive to Take Action)

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

Received: 5/8/2024

American Medical Association House of Delegates

Resolution: 115
(A-24)

Introduced by: New York

Subject: Payments by Medicare Secondary or Supplemental Plans

Referred to: Reference Committee A

Whereas, there are more than 50,000 health plans in the United States; and

Whereas, patients have paid for health insurance either as a supplemental Medicare plan or through their job or union as an earned benefit prior to meeting eligibility for Medicare; and

Whereas, Medicare allowed amounts are not market based and fixed as an act of government edict; secondary payer does not vary whether a Medicare participating physician is in-network with the secondary payer; and

Whereas, secondary health plans and Medicare supplemental health plans engage in abusive, predatory, and anticompetitive practices by tying payment as a Medicare secondary plan to whether the Medicare-participating physician that provides care to Medicare patients is in-network with the secondary health plan; and

Whereas, patients on Medicare are subjected to financial burdens when health plans fail to pay the balance (Medicare deductible and 20% coinsurance) that rightfully belongs to a secondary payer with adverse effects on their health and health equity; therefore be it

RESOLVED, that our American Medical Association advocate for legislation that would mandate that all health plans cover Medicare secondary claims regardless of the provider participating in the secondary health plan (Directive to Take Action); and be it further

RESOLVED, that our AMA will report on the status of this resolution and policies H-390.839 and D-390.984 at the 2025 Annual Meeting. (Directive to Take Action)

Fiscal Note: Moderate - between $5,000 - $10,000

Received: 5/7/2024

RELEVANT AMA POLICY

Requiring Secondary and Supplemental Insurers to Medicare to Follow Medicare Payments H-390.839
Our AMA will support payment by secondary insurers of the balance of the approved Medicare payment in an amount bringing Medicare and secondary payments up to the full allowance of the secondary insurer for services covered by the secondary insurer. Res. 120, A-16

Managed Care Secondary Payers H-385.950
Our AMA:
(1) will seek regulatory changes that require all payers of secondary Medicare insurance to reimburse the co-insurance and applicable deductible obligations of Medicare beneficiaries;
(2) will require that these co-insurance and deductible obligations cannot be waived contractually;
(3) will consider the development of draft federal legislation to require Medicare to recognize the total coinsurance and deductible amounts facing Medicare beneficiaries in instances where Medicare provides secondary insurance coverage;
(4) advocates that all patients covered by Medicare as their primary carrier and another health insurance plan (not a Medigap policy) as their secondary carrier should be entitled to receive payment in full from their secondary carriers for all Medicare patient deductible and copayments without regard to the amount of the Medicare payment for the service;
(5) advocates that all patients covered by Medicare as their primary carrier and another health insurance plan as secondary should be entitled to receive payment in full from their secondary plans for all Medicare patient deductibles and copayments without regard to any requirement that there be prior authorization by the secondary plan for medical care and treatment that is medically necessary under Medicare, by imposing limits on the amount, type or frequency of services covered, and by thereby seeking to "manage" the Medicare benefit, as if the secondary carrier were the primary carrier; and
(6) in its advocacy efforts, will address and seek to solve (by negotiation, regulation, or legislation) the problem wherein a secondary insurance company does not reimburse the patient for, nor pay the physician for, the remainder/balance of the allowable amount on the original claim filed with the patient's primary insurance carrier, regardless of the maximum allowed by the secondary insurance payer.|
BOT Rep. 33, A-96 Appended: Res. 122, A-98 Reaffirmed: Res. 105, A-00 Sub. Res. 104, A-01 Reaffirmation I-01 Appended: Res. 105 and 106, A-03 Appended: Res. 821, I-11 Modified: BOT Rep. 7, A-21

Payment by Health Insurance Plans of Medicare Deductibles and Copayments D-390.984
Our AMA will: (1) seek legislation to compel all insurers paying secondary to Medicare to be required to pay the deductibles and coinsurance owed after the Medicare payment is made; and (2) seek federal legislation to require that a secondary plan not manage the primary Medicare benefit by imposing limits as if it were primary.
Res. 105 and 106, A-03 Reaffirmed: BOT Rep. 28, A-13 Modified: CCB/CLRPD Rep. 2, A-14