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REPORT 2 OF THE COUNCIL ON MEDICAL SERVICE (A-25)
Reconsidering the Affordable Care Act (ACA) Eligibility Firewall
(Resolution 103-A-23)
(Reference Committee A)

EXECUTIVE SUMMARY

As highlighted in this report, employer-sponsored health insurance (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. A provision in the Affordable Care Act (ACA), colloquially referred to as "the firewall," prohibits workers with "affordable" and "adequate" ESI offers from receiving premium tax credits to purchase marketplace plans.

The main concerns from Council on Medical Service about eliminating the firewall abruptly and fully include the potential impacts on physician payment and practice sustainability, employer behavior and ESI stability, and federal expenditures, since allowing millions of people to opt out of ESI coverage and into the ACA marketplace could prove to be prohibitively expensive, while also disrupting both ESI and ACA markets. Instead, the Council recommends an incremental approach to reducing the affordability threshold that prioritizes workers most in need. As such, we believe it makes the most sense to support a firewall policy change that targets individuals and families with the lowest incomes who could benefit the most from ACA premium tax credits and cost-sharing subsidies that are not available under ESI. Accordingly, the Council recommends that it be the policy of our AMA that the ACA eligibility firewall not apply to individuals offered employer-sponsored coverage whose household incomes are at or below 200 percent of the federal poverty level. We believe this recommendation is an appropriate first step in addressing ESI affordability challenges while at the same time preserving physician practice sustainability, stability in the ESI market, and limits on federal spending increases.

Because ESI enrollees with lower incomes are more likely to report difficulties covering the costs of medical care and may not know if they are subject to the firewall, 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.

To address physician payment concerns, the Council also recommends advocating that physician payments by insurers participating in the ACA marketplace be sustainable, reflect the full cost of practice and the value of the care provided, include inflation-based updates, and pay no less than prevailing Medicare rates.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 2-A-25

Subject: Reconsidering the Affordable Care Act (ACA) Eligibility Firewall (Resolution 103-A-23)

Presented by: Stephen Epstein, MD, MPP, 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.

Council on Medical Service Report 2-A-24 was referred back to the Council to ensure that the recommendations maximize patient access to care while protecting physician practice revenue and sustainability. This report discusses employer-sponsored insurance (ESI) affordability, explains the ACA affordability threshold (known as the "firewall"), summarizes relevant AMA policy, and makes policy recommendations.

BACKGROUND

Almost a decade and a half after enactment of the ACA, employer-sponsored insurance ESI continues to be the dominant source of health coverage for Americans under 65 years of age. In 2023, 164.7 million people under age 65, or 60 percent of the non-elderly population, had health insurance coverage through an employer.[1] Although ESI is the most common type of health insurance, coverage varies significantly by income as well as race and ethnicity. While 84 percent of individuals with incomes at or above 400 percent of the federal poverty level (FPL) had ESI, it covered fewer than one-quarter of individuals with incomes below 200 percent FPL. 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.[2,3]

Overall, most Americans appear satisfied with employment-based coverage. 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 ACA 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.[4] 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.[5] 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.[6]

Although ESI is popular, it has become increasingly costly for employers and employees, especially small firms and lower-income workers. According to 2024 data from the KFF Employer Health Benefits Survey:

- Fifty-four percent of all firms offered health benefits, including almost all (98 percent) large employers (those with 200 or more workers) and just over half (53 percent) of smaller firms (those with three to 199 workers). Eight percent of firms with at least 50 employees that offer health benefits offer a plan that has a narrow provider network.[7]
- 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). Across both firms that offer health benefits and those that do not, more than half (54 percent) of workers have employer coverage.[8]
- Annual health insurance premiums averaged $8,951 for individual coverage and $25,572 for family coverage, six and seven percent more than last year, respectively. In comparison, the

Bureau of Labor Statistics found that wages increased 4.5 percent while inflation grew by 3.2 percent. Notably, premiums for family coverage have increased 24 percent over the last five years while, during the same time period, inflation has risen 23 percent and wages have increased 28 percent. Workers pay, on average, $1,368 annually for individual coverage and $6,296 toward the cost of family premiums.

- Seventy-six percent of firms offering coverage offered only one type of plan. Large firms were significantly more likely to offer more than one plan type than small firms.
- Almost half (48 percent) of covered employees are enrolled in preferred provider organizations (PPOs), the most common plan type offered. Twenty-seven percent of covered workers are enrolled in a high-deductible health plan (HDHP) with savings option.[9]

ESI Affordability

To manage costs, many employer-based plans include substantial deductibles and other out-of-pocket cost-sharing that, together with premium contributions, increase employee health costs and impact affordability.[10] The comparability of ESI and ACA marketplace plan affordability is complicated by differences among enrollees across plans; differences in plan design and regulatory requirements; and enrollee tax savings. In a 2024 report, the U.S. Government Accountability Office (GAO) found that average premiums for employer plans in 2022 were lower than average premiums for marketplace plans. However, after accounting for employer contributions to workers' premiums and federal premium tax credits for marketplace plans, average worker premium contributions to ESI plans were higher than average enrollee premium contributions to marketplace plans.[11] A report from The Commonwealth Fund and Urban Institute found that, prior to the American Rescue Plan Act of 2021 (ARPA) enhancements to marketplace premium tax credits, adults with nongroup coverage reported higher average premiums and health care costs than ESI enrollees and were more likely to report foregoing health care and having problems affording care.[12]

According to KFF's 2024 Employer Health Benefits Survey, the average annual deductible for employees with single coverage was $1,787, a figure that has held relatively steady over the last five years but is 47 percent higher than the average deductible amount 10 years ago.[13] Overall, nearly a third of employees (32 percent) had plan deductibles of $2,000 or more, including half of workers at small firms, whose average annual deductible was $2,575 compared to $1,538 for employees of larger firms.[14]

High-Deductible Health Plans: Not only are deductible amounts rising, but more workers are now covered by high-deductible health plans (HDHPs), which typically have higher deductibles and lower premiums when compared to traditional plans. Such plans generally require patients to pay the full cost of health services and medications until deductibles are met. Although an HDHP's lower premium may be attractive to some people, the responsibility for out-of-pocket expenses becomes problematic when deductibles are too high for enrollees to afford and patients are unable to cover their costs. Not surprisingly, studies have found that reductions in health spending achieved through HDHPs are primarily due to patients simply receiving less medical care as they become more cost-conscious when seeking services.[15] As previously highlighted by the Council on Medical Service (Council on Medical Service Report 2-Nov-20, Mitigating the Negative Effects of High-Deductible Health Plans), the imposition of greater consumer cost-sharing is frequently used to ensure that those receiving health care services "have skin in the game," and as a lever to minimize premium growth.

Over the years, HDHPs have become a more common ESI offering. Among workers with HDHPs, 52 percent had plans with Health Savings Accounts (HSAs) while eight percent participated in

plans with Health Reimbursement Arrangements (HRAs), figures that varied considerably between high and low wage employees. Among workers in the lowest 25 percent wage category, 32 percent had plans with HSAs and 12 percent had HRAs. Among workers in the highest 25 percent wage category, 66 percent had plans with HSAs and seven percent had HRAs.[16] Theoretically, lower premiums may result in higher wages that may help offset the risk associated with HDHPs.

Small Employer Coverage: Health coverage is especially challenging for small business, whose employees frequently pay more for health coverage. According to the Commonwealth Fund, these workers generally contribute a greater share of premium costs and have larger deductible amounts than large-firm employees.[17] 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.[18]

Lower-Income Employees and Affordability: 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.[19, 20, 21] 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.[22] Additional 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).[23] 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.[24] COBRA coverage is often too costly an option for 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.[25] 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.[26] 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.[27]

ACA Provisions on Affordability and Employer Shared Responsibility

Though not nearly as dominant as ESI, ACA marketplace plans have become a growing source of health coverage; in January 2025, more than 23 million people had enrolled in marketplace plans, up from 11 million in 2020.[28] 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 2025, an employer plan was considered unaffordable if an employee's premium contribution exceeded 9.02 percent of that person's household income.[29] To be considered adequate, a plan must cover at least 60 percent of average costs (actuarial value); anything less is deemed inadequate.[30] The ACA provision making workers with affordable and adequate ESI offers ineligible to receive 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 as the principal source of health coverage in this country. Notably, the affordability threshold changes from year to year based on a methodology that considers rates of premium growth and income growth.

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).[31] Under this provision, employers face two potential penalties:

- 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 was $2,970 per employee.[32]
- 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.[33]

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 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 and Cost-Sharing

In 2023, the federal government subsidized coverage obtained through the ACA marketplaces and the Basic Health Program (BHP) at a cost of $92 billion.[34] 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), which decreased the maximum required contribution for previously eligible enrollees and extended eligibility to people with incomes exceeding 400 percent FPL, effectively reducing premium costs by 44 percent, on average. [35] 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.[36] 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 2025[37]

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%

The more generous federal subsidies have made marketplace plan premiums much more affordable while targeting the largest premium tax credits to people most in need. Notably, more than 90 percent of the 21 million people enrolled in marketplace coverage in 2024 received subsidies that lowered their premium amounts. If the subsidies are not extended beyond 2025, many people will face substantial premium increases, making marketplace coverage less affordable and less attractive as an insurance option. According to the Congressional Budget Office (CBO), without a permanent extension of the premium tax credits, healthier people will leave the ACA marketplace and premiums will rise for remaining enrollees by an estimated 4.3 percent in 2026, 7.7 percent in 2027, and 7.9 percent, on average, over the 2026-2034 period. The CBO also estimates that the number of uninsured people will increase by 2.2 million in 2026, 3.7 million in 2027, and 3.8 million on average between 2026 and 2034.[38] The Urban Institute projects that expiration of the enhanced subsidies will cause four million people to lose health insurance, especially in states that have not adopted Medicaid expansion.[39] According to the Commonwealth Fund, the loss of enhanced subsidies after 2025 would also cause significant economic harm to states, including job losses to health providers and other economic sectors.[40]

Premium tax credits for ACA marketplace coverage are calculated by subtracting the required contribution from the actual cost of the "benchmark" (second-lowest-cost silver) plan, though the credit can be applied toward any marketplace plan except catastrophic coverage.[41] 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.[42] 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,[43] although the range of subsidy amounts is considerable.

Federal Subsidies for ESI

For many decades, the U.S. tax code has provided a sizeable tax benefit to both employers and employees by excluding premium contributions towards ESI from federal income and payroll taxes. As ESI premiums have risen over the years, so has the tax benefit. 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.[44] According to the CBO, the average federal subsidy per ESI enrollee in 2023 was $2,170.[45]

In part due to the enhanced subsidies for marketplace enrollees established by ARPA and extended by the IRA, several analysts have observed a 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.[46] 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 could be financially advantageous for these workers to move to the marketplace.[47] However, lower-income workers, including those with incomes at or below 200 percent of FPL ($30,120 for an individual; $62,400 for a family of four), cannot enroll in marketplace coverage if they have an offer of ESI. Without the firewall, and if current subsidy enhancements are extended, workers earning less than 150

percent of FPL would be eligible for zero premium silver plans in the ACA marketplace as well as generous cost-sharing reductions. Employees making 200 percent of FPL would also be eligible for cost-sharing reductions and their premium contributions would be capped at two percent of household income.[48] Thus, lower-income workers at or below 200 percent of FPL may find more affordable coverage on the marketplace, depending on how much they must pay for premiums, deductibles and copayments under their ESI plan.

Importantly, some lower-income 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 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.[49] 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 less expensive 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 be structured to provide greater support to lower-income employees but less support to those with higher incomes.[50]

Bipartisan Policy Center (BPC): A 2022 BPC report recognized 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 recommended that Congress adjust the affordability threshold to align with the percentage cap on premium contributions for marketplace plans.[51] As discussion of broad tax cut extensions (and the need to pay for them) intensified late last year, BPC suggested

that the ESI tax exclusion be capped at the 80th percentile of premiums, or around $10,000 for single plans and $30,000 for family plans.[52]

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.[53]

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.[54] 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.[55]

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.[56]

Urban Institute: Urban Institute data presented to the Council and published by The Commonwealth Fund estimated that eliminating the firewall would decrease ESI coverage by two percent or less, meaning approximately 1.8 million people would transition out of ESI, with most of these workers shifting to marketplace coverage. Urban Institute's modeling assumes that most workers would stay enrolled in ESI coverage because ESI tax benefits are substantial. In this scenario, federal spending on marketplace premium tax credits would increase by $17.8 billion, or 18 percent; state spending would increase by $460 million; employer spending on premium contributions would decrease $8.1 billion; and households would save $4.4 billion per year in health spending. This study also projected that 1.4 million fewer people would be uninsured if the firewall was eliminated, including 0.4 million people between 138 percent and 200 percent of the poverty line, 0.8 million people between 200 percent and 400 percent of the poverty line, and 0.1 million people above 400 percent of the poverty line. It is estimated that this would save an estimated $1.5 billion in uncompensated care costs. The study also noted additional benefits may occur from elimination of the ESI firewall due to elimination of red tape that will make it easier for individuals who already qualify for PTCs to actually receive those benefits.[57]

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-185.918 further encourages employers to: (a) provide robust education to help patients make good use of their benefits to obtain the care they need, (b) collaborate with employees to understand their health insurance preferences and needs, (c) tailor benefit designs to the health insurance preferences and needs of their employees, and (d) pursue strategies to help enrollees spread the costs associated with high out-of-pocket costs across the plan year. 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. Under Policy D-165.971, the AMA will work to ensure that any Association Health Plan Programs safeguard state and federal patient protection laws.

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. This policy further supports education regarding deductibles, cost-sharing, and Health Savings Accounts (HSAs).

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. ESI continues to be the dominant source of health coverage for people under 65 years of age, and most people enrolled in employer 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 employed by smaller firms.

As explained in this report, people with higher earnings receive larger federal ESI subsidies than their lower-income peers, and lower-income people pay a greater share of earnings towards ESI. The Council recognizes that federal tax benefits available to ESI subscribers facing the greatest affordability challenges are not nearly as generous as the enhanced subsidies currently available to lower-income individuals enrolled in ACA marketplace plans. However, the affordability "firewall" makes employees with "affordable" ESI offers ineligible for federal subsidies to purchase ACA plans. To illustrate, an employee of a big box retailer earning 200 percent of FPL or less could pay up to 9.02 percent of his income towards "affordable" ESI. However, if he was eligible to move to the ACA marketplace, his premium contributions would be capped at two percent of income and he would also be eligible for cost-sharing subsidies. Under Policy H-165.828[1]), the AMA supports lowering the affordability threshold (firewall) 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 presenting an array of views regarding the potential impacts of fully eliminating the firewall, which is the policy change requested by referred Resolution 103-A-23. The Council found that estimates varied regarding how many workers would transition from ESI to exchange plans if the firewall was repealed. Therefore, we cannot predict with certainty how coverage patterns and payments to physicians would be affected. The Council's revised recommendations reflect, in part, our concerns regarding the harms that significant coverage transitions out of ESI and into ACA plans could have on physician payment and the sustainability of physician practices. Although payment rates in the nongroup market tend to vary, they are generally lower than rates paid by ESI plans. In fact, a study published in 2024 found that, in 2021, marketplace nongroup insurers paid health providers substantially less than employer small-group plans. Even though the study found that marketplace rates were generally higher than Medicare payments,[58] the Council is aware that in some states marketplace plan payments barely exceed, or are even lower than, Medicare rates. In the current environment of Medicare and Medicaid physician payment inadequacies, the Council recognizes that significant shifts from ESI to the ACA marketplace could have deleterious effects on physician practices, adding to their considerable burdens and threatening their viability.

The Council is also concerned about potential employer responses to a repeal of the firewall, 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 lower-income workers who may be contributing more for an employer plan than they would pay for marketplace coverage and for people working for small employers whose ESI costs have become increasingly expensive. Given the enhanced subsidies for premium tax credits and cost-sharing reductions available under current law, it is likely that at least some employees with incomes at or below 200 percent of FPL—whose premium contributions for exchange plans would be capped at two percent of income—would find marketplace coverage significantly more affordable than their ESI plan. However, if the more generous premium tax credits are allowed to expire at the end of this year, the cost of marketplace coverage will rise, potentially making ACA plans less attractive. 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.

If the firewall was eliminated, the Council is also concerned about the potential 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.[59] Allowing potentially millions of ESI enrollees to access ACA marketplace subsidies could 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 expect it could total tens of billions of dollars or more per year. 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 (and employees) who value and want to preserve the ESI tax exclusion.

For all of these reasons, the Council decided to recommend an incremental approach to reducing the affordability threshold so that it first benefits workers most in need, after which the effects of this change on coverage patterns, federal and consumer health spending, and employer behavior could be monitored. At this time, we support a firewall policy change that targets employees with the lowest incomes who could benefit the most from ACA premium tax credit and cost-sharing subsidies not available under ESI. Accordingly, the Council recommends that the ACA eligibility firewall not apply to individuals offered employer-sponsored coverage whose household incomes are at or below 200 percent of the FPL, so they can receive federal premium tax credits and cost-sharing assistance if they opt to enroll in a marketplace health plan. We believe this recommendation is an appropriate first step to addressing ESI affordability challenges among the lowest-wage workers while at the same time preserving physician practice sustainability, stability in the ESI market, and limits on federal spending increases. We recommend 200 percent of the FPL since it represents workers most in need and, as the studies cited in this report note, more data are available for individuals with incomes at this threshold. Furthermore, we believe that defining the affordability threshold by a percentage of FPL should make it easier for employees to determine whether they are eligible for ACA subsidies. To protect employees and their ability to choose a health plan that best meets their needs, the Council maintains that some level of employer shared responsibility requirements will need to continue so that employers do not push workers to the marketplace involuntarily or stop offering ESI to certain income groups.

Because ESI enrollees with lower incomes 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.

To address physician payment concerns, the Council also recommends advocating that physician payments by insurers participating in the ACA marketplace be sustainable, reflect the full cost of practice and the value of the care provided, include inflation-based updates, and pay no less than prevailing Medicare rates. This policy mirrors other AMA physician payment policies and is critical to ensuring physician practice sustainability.

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 it be the policy of our American Medical Association (AMA) that the Affordable Care Act (ACA) eligibility firewall not apply to individuals offered employer-sponsored coverage whose household incomes are at or below 200 percent of the federal poverty level, so they can receive federal premium tax credits and cost-sharing assistance if they opt to enroll in a marketplace health plan as an affordable alternative to their employer-based plan. (New 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 advocate that physician payments by health insurers participating in the ACA marketplace be sustainable, reflect the full cost of practice and the value of the care provided, include inflation-based updates, and pay no less than prevailing Medicare rates. (New HOD Policy)

Fiscal Note: Less than $500.

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REPORT 5 OF THE COUNCIL ON MEDICAL SERVICE (A-25)
Medicaid Estate Recovery Reform
(Resolution 104-A-24)
(Reference Committee A)

EXECUTIVE SUMMARY

At the 2024 Annual Meeting, the House of Delegates referred Resolution 104, which was sponsored by the Medical Student Section and asked the American Medical Association (AMA) to 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. During the development of this report, the Council reviewed the literature on Medicaid estate recovery, met with an expert, and discussed potential reforms. Of note, the Council's deliberations took place at a time of heightened concern regarding potential reductions in Medicaid funding, which would have deleterious effects on state budgets and Medicaid programs.

Because Medicaid estate recovery is not directly addressed in AMA policy, the Council found that new policy is needed and that, given widespread concerns regarding potential federal Medicaid funding cuts, new policy must allow for state flexibility. The Council's recommendations are thus intended to support and encourage meaningful estate recovery reforms without requiring states to abandon the practice. In some states, the return on investment may not be worth the costs of administering Medicaid estate recovery programs; however, states that recoup the most funds may not want to forego that revenue, especially if federal Medicaid funds are reduced. For these reasons, the Council decided not to oppose estate recovery efforts outright. Instead, this report recommends support for specific reforms intended to help maintain Medicaid as a safety net and ensure that long-term services and supports (LTSS) are provided to people most in need.

To acknowledge the variance in estate recovery efforts and allow states more flexibility than they currently have, the Council recommends that the AMA support making Medicaid estate recovery optional, instead of mandatory. This recommendation allows states to decide whether (or not) to continue their estate recovery programs, which is consistent with longstanding AMA policy allowing states some flexibility in implementing their Medicaid programs. When Medicaid estate recovery is pursued, the Council recommends: 1) limiting recoupment to the costs of LTSS and not for other Medicaid services that were provided; 2) standards for hardship waivers that prohibit claims against a sole income-producing asset of heirs, homes of modest value, and any estate less than a specified threshold value; 3) exempting estates from recovery efforts when the value of the recovery is projected to be less than the cost of recoupment efforts; 4) basing estate recovery on the costs of LTSS care when managed care organizations are utilized, instead of the capitation amount, when the cost of LTSS is lower than the capitation amount; 5) providing education regarding state Medicaid estate recovery requirements; 6) screening patients for hardship waivers and assisting them with filing, if eligible; and 7) collecting and making publicly available important data regarding estates that have been pursued and amounts that have been recovered.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 5-A-25

Subject: Medicaid Estate Recovery Reform (Resolution 104-A-24)

Presented by: Stephen Epstein, MD, MPP, Chair

Referred to: Reference Committee A

At the 2024 Annual Meeting, the House of Delegates (HOD) referred Resolution 104, which was sponsored by the Medical Student Section and asked the American Medical Association (AMA) to 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. The Board of Trustees assigned this item to the Council on Medical Service for a report back to the House of Delegates. This report describes federal Medicaid estate recovery requirements, discusses the pros and cons of estate recovery, and makes policy recommendations for future reforms.

BACKGROUND

Since the Medicaid program's inception in 1965, states have been permitted to try to collect repayments for certain Medicaid services after older enrollees had died. In 1982, the Tax Equity and Fiscal Responsibility Act gave states the option to utilize property liens to prevent Medicaid enrollees from evading estate recovery efforts by transferring their homes to someone else shortly before their death. The Omnibus Budget Reconciliation Act of 1993 (OBRA 93) mandated estate recovery efforts targeting certain deceased enrollees who had used Medicaid long-term services and supports (LTSS), including nursing facility services and home and community-based services (HCBS), while allowing states some discretion in how estate recovery programs are implemented. Under OBRA 93, states must attempt to recover payments from the estates of individuals who received Medicaid LTSS when they were aged 55 or older; enrollees of any age expected to reside permanently in long-term care facilities; and, under certain circumstances, individuals with long-term care insurance.[1]

For the age 55 and older group, federal law stipulates that states must pursue estate payments for amounts that are at least equal to the costs of a patient's nursing facility care, HCBS, and hospital services and prescriptions provided while an enrollee was receiving LTSS. States have the option to also pursue estate recovery for the costs of other Medicaid-covered services, except for Medicare cost-sharing assistance that is provided to individuals who are dually eligible for Medicaid and Medicare. According to KFF, 37 states go beyond minimum federal estate recovery requirements and apply recoupment efforts to optional Medicaid services, including 32 states that try to recover the costs of all Medicaid services (as long as LTSS services were provided); 28 states that target some people under age 55; and five states that focus on certain optional benefits.[2]

Generally speaking, and depending on a specific state's policies, elements of an individual's estate that can be subject to recovery efforts include cash, checking and savings accounts, stocks and bonds, remaining funds in certain types of trusts (e.g., Qualified Income Trust and/or Irrevocable

Funeral Trust) and any other items of value, including an individual's home. Life insurance policies are generally protected unless the beneficiary is the Medicaid enrollee's estate.[3]

Federal law also places some parameters around estate recovery efforts. For example, states are not permitted to seek recovery from the estate of a deceased Medicaid enrollee who is survived by a spouse until the spouse has died, and once the spouse has died, states can waive recovery if they determine efforts will not be cost effective. Similarly, states must exempt or defer recovery from the estates of enrollees who are survived by a child under 21 or a child of any age who is blind or has a disability.[4] As such, states may not try to take the homes of deceased enrollees that are occupied by a surviving spouse, child under 21, child of any age who is blind or has a disability, or a sibling who has an equity stake in that home. However, states are allowed to impose liens on the property of enrollees who are receiving institutionalized care and are not expected to return home, unless the home is occupied by the individual's spouse, child under age 21, child of any age who is blind or has a disability, or sibling who has an equity interest in the home.[5] Once survivors have died or a surviving child has turned 21, states can—and often do—proceed with attempting to recoup payments from estates. Pursuant to court judgments, states are also permitted to impose liens to pay for Medicaid benefits that were incorrectly provided.

OBRA 93 required states to establish procedures for waiving estate recovery due to undue hardships, which the Centers for Medicare & Medicaid Services (CMS) has stated could include: 1) an estate that is the sole income-producing asset for survivors (e.g., family farm); 2) a home of modest value, defined as roughly half the average home value in the county; and 3) other compelling circumstances. Although states are not required to implement these particular hardship examples, most (49) have reported adopting at least one of the three, including 35 states that said they use the "sole income-producing asset" criteria.[6] Notably, only 15 states report waiving estate recovery for homes of modest value.[7]

For Medicaid managed care organization (MCO) enrollees who would be subject to estate recovery under fee for service (FFS), states can seek recoupment of MCO capitation payments rather than the costs of Medicaid services that were provided. In states that pursue estate recovery for all Medicaid services, the total capitation payment for the period the individual was enrolled in the MCO must be sought. If the state applies estate recovery to some, but not all services, the state must pursue recoupment of the part of the capitation payment attributed to those services.[8] According to KFF, 30 states report trying to recoup payments for MCO capitation payments which, notably, can exceed the amount that Medicaid had actually spent on the enrollee.

Medicaid Long-Term Services and Supports (LTSS)

LTSS refers to the broad range of clinical health and related services provided to help people who have functional or cognitive limitations with activities of daily living (ADL) when these individuals need extra care either at home or in a facility. ADLs include eating, bathing, dressing, and instrumental tasks like medication management, house cleaning, and meal preparation. LTSS are intended to help individuals with self-care needs over an extended time period, which differentiates them from post-acute services, such as home health or skilled nursing facility (SNF) care, that are designed to help individuals recover after a hospitalization.[9]

Older adults and people living with chronic illnesses and disabilities are among the estimated nine million users of Medicaid LTSS, a figure that includes the 7.8 million enrollees who received HCBS in 2022 and 1.5 million individuals who received LTSS that year in an institutional setting.[10] The significantly larger share of people receiving HCBS reflects a shift over the years in the provision of LTSS from nursing homes and other facilities to home and community settings. Over half (57

percent) of enrollees receiving Medicaid LTSS are under 65, although—not surprisingly—more than two-thirds of individuals receiving institutional care are 65 and older.[11] Importantly, these statistics exclude individuals receiving unpaid LTSS that is generally provided by family members and friends outside of Medicaid, as well as individuals paying for LTSS (including assisted living or nursing home care) out of pocket. Although more people have private long-term care insurance than was the case years ago, in 2021 only about 80,000 people filed claims for such benefits.[12] Of note, insurance coverage for LTSS is profoundly different than coverage for other health care services in that it is quite limited outside of Medicaid and, within Medicaid, LTSS is only available to people meeting strict eligibility requirements who must spend down their income and assets to qualify.

Although nursing facility services are a mandatory benefit under Medicaid, coverage for most HCBS—other than home health—is optional and, therefore, varies by state. Complex eligibility rules regarding income, assets, and functional limitations also vary significantly by state, as do LTSS eligibility pathways. In general, applicants for Medicaid LTSS must "spend down" their income and assets in order to qualify for LTSS, and "look-back" rules are in place to try to keep people from transferring assets to others to become Medicaid-eligible. Although data are somewhat lacking on this topic, analyses have found that advantaged groups are more likely to engage in estate planning to circumvent "look-back" and estate recovery requirements.[13]

As the largest payer, Medicaid covers the costs of roughly 60 percent of total LTSS expenditures in the United States. Additional payments are made out of pocket by individuals and by private long-term care insurers, the Department of Defense, the Department of Veterans Affairs, and state and local governments.[14] In 2022, Medicaid LTSS spending totaled just over $200 billion, which included $129.4 billion for HCBS and $71 billion for institutional care. The average expenditure per user on institutional care was over $48,000, significantly higher than average per-person spending on HCBS ($16,491).[15] Demonstrating the need for LTSS, approximately 700,000 people are on waiting lists for HCBS.[16] In 2020, CBO estimated that, in 2030, $160 billion will be spent on HCBS and $80 billion on institutional care.[17] Recognizing that people are aging and living longer, which will impact the use of and spending for LTSS, the Council on Medical Service has addressed long-term care in this country and presented reports on LTSS financing reforms (Council Report 5-A-18) and financing structures for HCBS (Council Report 4-N-21).

PROS AND CONS OF MEDICAID ESTATE RECOVERY

The Federal Estate Recovery Mandate was established as a program integrity tool intended to help ensure that Medicaid LTSS recipients use their own resources to cover the costs of their care. Proponents of estate recovery underscore that such efforts are needed to ensure that families are not transferring or otherwise protecting their financial resources in order to qualify for Medicaid LTSS and that Medicaid funds are used to care for the neediest enrollees. Additionally, the recovery of assets may help supplement Medicaid funding in some states and even federally, since a portion of the money recovered must be paid to the federal government for the share of the services that were federally funded. Within federal parameters, states have discretion in how aggressively they choose to pursue estate recovery and, therefore, there is wide variability in how states administer their recovery programs.

Criticisms over the years have highlighted that Medicaid estate recovery primarily targets individuals and families who are poor, that families of color are disproportionately affected, and that the process contributes to wealth inequality and intergenerational poverty. To qualify for Medicaid LTSS in the first place, individuals must have limited incomes and have spent down most of their financial resources, though the value of a person's home and certain other assets are not counted in eligibility assessments. Due to the high cost of long-term care in this country, many middle-income

people also qualify for Medicaid once their savings have been spent down. However, critics also note that middle- and higher-income people frequently use estate planning vehicles (e.g., trusts) to protect their assets and evade recovery efforts, while people who cannot afford estate planning services tend to give up more to the state, thus widening estate recovery disparities. The lack of available data prevents a thorough understanding of how many people shelter assets from state Medicaid programs, but it is not an unusual practice. Notably, the Medicaid and CHIP Payment Access Commission (MACPAC) has concluded from its surveys and interviews that estate recovery is not very effective in recouping money from people who may have the means to cover LTSS themselves.[18]

Advocates concerned about estate recovery efforts have noted that estate recovery programs can dissuade people in need of LTSS from applying for Medicaid services. Critics also argue that very little payment is collected by most states and that recovered dollars represent a small slice of what Medicaid spends on LTSS. In 2019, when an estimated $733 million was recovered overall from estates, only eight states recouped more than one percent of the cost of FFS LTSS and 28 states recovered less than 0.5 percent.[19] Based in part on each state's priorities and program administration, amounts recovered vary significantly by state. For example, in 2019, Iowa recovered over 14 percent of FFS LTSS spending in the state while Hawaii, Louisiana, and West Virginia recovered only 0.02 percent. Moreover, five states with the largest recoveries (Massachusetts, New York, Pennsylvania, Ohio, and Wisconsin) recouped nearly half of all collections in the U.S.[20] As noted by the authors of Resolution 104-A-24, the administrative costs of implementing estate recovery programs can be substantial, thus diminishing the utility of such efforts. Although little data are available on state administrative costs, there seems to be a wide range of spending on estate recovery across states. According to MACPAC's data from five states, the administrative costs of recovery ranged from 3.7 percent to 32.1 percent of the amount collected. MACPAC's research also suggests that states could collect more from estates if their program efforts mirrored those in states that recoup the most money.[21]

REFORM PROPOSALS

At the national level, MACPAC published a thorough analysis of the state-of-play in a 2021 report to Congress on estate recovery reforms. This report recommended that Congress amend the Social Security Act to:

1. Make Medicaid estate recovery optional for the populations and services for which it is required under current law;
2. Allow states providing LTSS under managed care arrangements to pursue estate recovery based on the cost of care when the cost of services used by an enrollee was less than the capitation payment made to an MCO; and
3. Direct the Department of Health and Human Services Secretary to set minimum standards for hardship waivers so that states are not allowed to pursue recovery for: a) any asset that is the sole income-producing asset of survivors; b) homes of modest value; and c) any estate valued under a certain threshold.[22]

Federal legislation from the last Congress includes H.R. 7573, which was sponsored solely by Democrats and prohibits all estate recovery efforts, and H.R. 8094, which was introduced by a Republican House member and would prohibit states from pursuing estate recovery when the individual's home is transferred to someone who is eligible for medical assistance or has an income below 138 percent of the Federal Poverty Level (FPL).[23]

Although states must meet minimum federal requirements for estate recovery, within those parameters, they can implement their own reforms. Examples of recent state activity include legislation in Maine and Massachusetts that scaled back recovery efforts to federal minimum requirements. Additionally, Georgia, Illinois, Massachusetts, and South Carolina have established cost effectiveness thresholds that essentially waive recovery of estates worth less than $25,000. [24] Illinois has also begun requiring the state Medicaid agency to publicly report data on estate recovery. Some states, like Massachusetts, also provide enrollees with more thorough explanations of estate recovery requirements when they are applying for Medicaid LTSS.

RELEVANT AMA POLICY

AMA policy does not specifically address Medicaid estate recovery efforts, although numerous policies focus on long-term care and LTSS. Under Policy H-280.991, the AMA maintains that programs to finance long-term care should:

- Assure access to needed services when personal resources are inadequate to finance care;
- Prevent impoverishment of the individual or family in the face of extended or catastrophic service costs.
- Cover needed services in a timely, coordinated manner in the least restrictive setting;
- Provide coverage for the medical components of long-term care through Medicaid for all individuals with income below 100 percent of the FPL; and
- Provide sliding scale subsidies for the purchase of LTC insurance coverage for individuals with income between 100-200 percent of the FPL.

Although not specific to Medicaid estate recovery, Policy H-290.982 supports increasing investments in HCBS; allowing states to use long-term care eligibility criteria which distinguish between people who can be served in a home or community-based setting and those who can only be serviced in a nursing facility; buy-ins for home and community-based care for people with incomes and assets above Medicaid eligibility limits; and grants to states to develop new long-term care infrastructures and encourage expansion of long-term care financing to middle-income families who need assistance. Policy H-280.945 also supports incentivizing states to expand access to HCBS. Policy D-280.982 directs the AMA to:

- Advocate for business models in long-term care for the elderly which incentivize and promote the ethical and equitable use of resources to maximize care quality, staff and resident safety, and resident quality of life, and which hold patients' interests as paramount over maximizing profit; and
- Advocate for further research into alternatives to current options for long-term care to promote the highest quality and value LTSS models as well as functions and structures which best support these models for care.

DISCUSSION

The Council reviewed the literature on Medicaid estate recovery, met with an expert, and deliberated at length about potential reforms. At the request of the Medical Student Section, which sponsored referred Resolution 104-A-24, the Council limited its study to estate recovery and, therefore, does not make recommendations regarding Medicaid LTSS eligibility requirements (e.g., spend-down rules), which are equally complex and should be addressed separately.

Of note, the Council's deliberations took place at a time of heightened unease among state medical associations, national medical specialty societies, the AMA, and many states and advocacy groups

regarding potential reductions in Medicaid funding, which would have deleterious effects on state budgets and Medicaid programs. At the time this report was written, Congress had not enacted any Medicaid cuts; however, many states were considering how to prepare for federal Medicaid changes. For context, it is also important to point out that the AMA has not received any inquiries or requests for assistance with estate recovery reforms. Still, because estate recovery is not directly addressed in AMA policy, the Council agrees that new policy is needed and that, given the uncertainties around federal Medicaid funding, this policy should retain state flexibility. Accordingly, the Council crafted recommendations that support and encourage meaningful estate recovery reforms without requiring states to abandon the practice or take other immediate actions.

Medicaid LTSS provides a critical safety net for lower-income people who have few resources and need assistance with ADLs, including older adults with chronic illnesses or dementia and younger people living with disabilities. The Council recognizes that demand for critical LTSS services is likely to grow as the U.S. population ages and people live longer, and that Medicaid services should be available to those most in need of LTSS. We do not believe that Medicaid should pay for the long-term care costs of people who have financial means to do so themselves; however, because LTSS is exorbitantly expensive and not covered by most insurers, we understand the challenges of preventing people from sheltering their assets and misusing the system.

As discussed in this report, federal law requires states to perform estate recovery as a condition of their participation in Medicaid. Based on surveys and interviews with key stakeholders, MACPAC reported that states primarily recoup funds from modest-sized estates and that individuals with more financial means often evade recovery efforts, raising equity concerns. We acknowledge these concerns and believe that additional guardrails may be needed. We also recognize that states and other stakeholders, including physicians, hold differing views on the benefits and harms of estate recovery programs. For example, in some states, the return on investment may not be worth the costs of administering estate recovery programs; however, states that recoup the most funds may not want to forego that revenue, especially in a challenging fiscal environment. For these reasons, the Council decided not to oppose estate recovery efforts outright. Instead, we recommend support for specific reforms intended to help maintain Medicaid as a safety net and ensure that, as intended, LTSS are provided to people most in need. To acknowledge the variance in estate recovery across states and allow states more flexibility than they currently have, the Council recommends that the AMA support making Medicaid estate recovery optional, instead of mandatory. This recommendation allows states to decide whether (or not) to continue their estate recovery programs, which is consistent with longstanding AMA policy allowing states some flexibility in implementing their Medicaid programs.

When Medicaid estate recovery is pursued, the Council recommends supporting the following additional reforms:

- First, the Council learned that more than half of states apply recoupment efforts beyond LTSS and attempt to recover the costs of some or all other Medicaid-covered services provided to an enrollee. We do not believe it is appropriate to pursue recovery beyond the costs of LTSS care, and, therefore, recommend that estate recovery be limited to the costs of LTSS and not other Medicaid services that may have been utilized.
- The Council also recommends support for developing standards for hardship waivers that prohibit claims against a sole income-producing asset of heirs; homes of modest value; and any estate less than a specified threshold value. This language mirrors one of MACPAC's recommendations and was also used by CMS to describe sample hardship waiver criteria. The Council discussed recommending a specified threshold value but believe that other stakeholders are better equipped to determine an appropriate threshold amount.

- Relatedly, the Council recommends support for exempting estates when the value of the recovery is projected to be less than the cost of recoupment efforts. We do not believe it makes sense to pursue estate recovery when the return would be so low.
- When MCOs are utilized, the Council recommends basing estate recovery on the costs of LTSS care, instead of the capitation amount, when the cost of LTSS is lower. Similar to the first reform (see above), we do not believe that estates should be pursued for amounts exceeding the cost of care that was provided. Our recommended approach would also be easier for families to understand since they may not know the amount of capitation that was paid for them.
- Similarly, the Council feels strongly that LTSS enrollees and their families must be better educated about estate recovery requirements so they are not surprised by a state's recoupment efforts after the enrollee has died. Although states are required to provide basic information to enrollees, it is not always adequate or easy to find. Accordingly, the Council recommends supporting education at the time of enrollment in LTSS, and during any renewal process, that is appropriate to enrollees' language and health literacy abilities.
- To ensure that available hardship waivers are offered to eligible enrollees, the Council recommends screening patients for hardship waivers and assisting them with filing such waivers, if eligible.
- Finally, the Council also recommends supporting data collection and public reporting on estate recovery programs. We found data to be lacking and believe more information is needed to accurately evaluate the impacts and effectiveness (or not) of estate pursuits.

RECOMMENDATIONS

The Council on Medical Service recommends that the following recommendations be adopted in lieu of Resolution 104-A-24, and that the remainder of the report be filed:

1. That our American Medical Association (AMA) support making Medicaid estate recovery optional, instead of mandatory, for states. (New HOD Policy)

2. That our AMA support the following when Medicaid estate recovery is pursued:

    a. Limiting recoupment to the costs of long-term services and supports (LTSS) and not for other Medicaid services that were provided;
    b. Establishing standards for hardship waivers that prohibit claims against a sole income-producing asset of heirs; homes of modest value; and any estate less than a specified threshold value;
    c. Exempting estates from recovery efforts when the value of the recovery is projected to be less than the cost of recoupment efforts;
    d. Basing estate recovery on the costs of LTSS care when managed care organizations are utilized, instead of the capitation amount, when the cost of LTSS is lower than the capitation amount;
    e. Providing education regarding state Medicaid estate recovery requirements at the time of enrollment in LTSS, and during any renewal process, that is appropriate to enrollees' language and health literacy abilities;
    f. Screening patients for hardship waivers and assisting them with filing, if eligible; and
    g. Collecting and making publicly available important data regarding estates that have been pursued and amounts that have been recovered. (New HOD Policy)

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

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REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 6-A-25

Subject: Prescription Medication Price Negotiation (Resolution 113-A-24)

Presented by: Stephen Epstein, MD, MPP, Chair

Referred to: Reference Committee A

At the 2024 Annual Meeting, the House of Delegates referred Resolution 113, which was sponsored by the New England Delegation, and asked our American Medical Association (AMA) to support drug price negotiation for all payers, advocate that any medication in which the price rises faster than inflation be automatically added to the negotiation schedule, and support extending the annual Medicare cap on out-of-pocket prescription drug spending to all payers. The following report discusses the history and current state of medication price negotiation, out-of-pocket caps, AMA efforts on the topic, and offers recommendations in line with the spirit of the resolution.

BACKGROUND

Enactment of the Inflation Reduction Act of 2022 (IRA) has had far-reaching impacts in the health care sector, particularly regarding Medicare drug pricing.[1] Most notably, the IRA allows the Centers for Medicare & Medicaid Services (CMS) to directly negotiate the prices of certain high-cost drugs.[2,3] CMS initially selected 10 medications that are considered "high expenditure," are single source, and do not have a biosimilar/generic alternative. Additionally, manufacturers are required to pay rebates to the federal government if the price of medications for Medicare Part B or Part D beneficiaries are raised faster than the rate of overall inflation as measured by the Consumer Price Index for All Urban Consumers (CPI-U).[1,2]

At the time this report was written, there had not been significant movement in either direction regarding implementation of the drug pricing regulations by the Trump administration. However, it seems likely that they will choose to maintain current drug pricing practices put in place by the Biden administration, implement modifications to these practices, or repeal them altogether.[4] A focus on reducing drug prices through Medicare negotiations remains a cause with bipartisan support. Over half of all Americans report believing that Medicare drug pricing should be a "top priority" of the current administration.[5] CMS released a statement declaring that the current administration intends to focus on the issue by negotiating drug prices,[6] although recent actions may indicate a change in focus from the Biden administration. For example, shortly after taking office, President Trump signed executive orders rescinding regulations designed to lower Medicare beneficiaries' drug spending. Specifically, the two-dollar generic out-of-pocket (OOP) cap was removed and the reduction of Medicare payment for accelerated Food and Drug Administration (FDA) medications was reduced.[7] Additionally, three ongoing projects through the CMS Innovation Center designed to explore strategies to lower drug prices were halted .[7] It is also possible that the administration will not directly support nor reject the Medicare negotiations, thereby indirectly supporting drug industry opposition. For example, the administration may choose not to defend the existing laws and regulations against legal challenge or may propose rules designed to exempt more drugs from negotiations.[4]

Pharmaceutical prices are typically categorized in three ways: public list price, net price, and OOP expense for the patient.[8] The public list price of a drug is set by the manufacturer and is typically the starting point for negotiations. The net price of a drug is the amount that is actually paid by the plan sponsor or, in the case of public plans, the government. This price is determined through either negotiation, mostly done by pharmacy benefit managers (PBMs), or in some rare cases by the payer itself. This is also the price that is typically dictated by legislation or regulations when applicable. Finally, patient OOP cost is the amount that the patient pays to receive the medication.[8,9] There are many elements that are incorporated in price determination, such as the number of medications available to treat the same condition, the route of administration of the medication, and the payer. These elements are used to set the prices that are paid by patients and plans.[8,9] Without PBMs, this process is relatively straightforward. Manufacturers sell prescription drugs to pharmacies who, in turn, sell the drug to the patient at a price determined by their insurance coverage and plan. However, the addition of PBMs to this process increases complexity and reduces transparency. These benefit managers become the "middlemen" between manufacturers, pharmacies, insurance companies, and consumers, which allows them to determine the actual OOP cost to the patient.[8,10]

PRICE NEGOTIATION

Private payers engage in drug price negotiation, primarily relying on PBMs to handle the negotiations. PBMs work directly with drug manufacturers to negotiate drug prices and associated rebates to find the lowest cost for the payer. While, in theory, this should lead to beneficiaries having access to lower cost medications, in reality PBMs often favor the higher priced drugs. This is due to the rebates, calculated as a percentage of the list price, that are kept by the PBM and payer, and rarely directly benefit beneficiaries.[11] These rebates are not typically passed on to the patient and, as a result, patients may end up paying a higher price and/or not benefiting from the PBM negotiations.[11,12] Additionally, a significant portion of PBMs are vertically integrated with payers, stifling competition. This lack of competition, which is not just a result of vertical integration but also the process of rebate negotiation, often results in higher insurance premiums for beneficiaries and lower pharmaceutical reimbursement rates.[12] While the negotiation practices of private payers, often via PBMs, may not be as advantageous for patients as it should be, the bottom line is that these payers do currently negotiate drug prices to lower overall insurer costs.

Historically, public payers have not negotiated drug prices in the manner that was implemented by the aforementioned IRA. Since its inception in 2022, the IRA has allowed CMS to negotiate the price of Medicare Part B and D prescription drugs. This negotiation process began in 2024 for Part D and included 10 drugs in the initial negotiation cycle.[1] The Maximum Fair Prices (MFPs) for these 10 drugs will go into effect in January 2026. These drugs include blood thinners and medications to treat diabetes, heart failure, psoriasis, rheumatoid arthritis, blood cancers, and Crohn's disease. Medicare negotiated prices ranged from a price drop as small as $6 and as large as $22,027. Not surprisingly, the drug with the highest list price, Stelara,® showed the most significant price decrease while the drug with the lowest list price, NovoLog®/Fiasp,® yielded the smallest price reduction. A full and regularly updated table of the Medicare negotiated drug prices can be accessed via the Peterson-KFF Health System Tracker. In early 2025, CMS announced 15 additional drugs that will be included in the Medicare drug pricing negotiation schedule. Assuming the cycle of negotiation continues as intended, the MFPs for these drugs will go into effect January 2027.[2,3] CMS projects that the negotiated MFPs will save approximately $1.5 billion in its first year.[2] In order for prescription drugs to be eligible for negotiation, they must meet certain criteria. Specifically, they must be covered by Medicare and be a single brand-name drug or biologic that does not have a therapeutically equivalent generic or biosimilar that is being marketed. Additionally, eligible biologics must be 11 years past the earliest FDA approval or licensure and

name-brand small-molecule drugs must be at least seven years past approval/licensure. Until 2028, negotiation is limited to Part D plans adding 15 drugs each year through 2028. In 2029 Part B plans will be included and the number of negotiated drugs will increase to 20.[1,3,13]

Importantly, there is no "trigger" that automatically includes a medication in future negotiations. However, under the IRA if the cost of a drug rises faster than inflation, manufacturers are required to provide Medicare with rebates.[3] This provision is designed to discourage manufacturers from unnecessarily raising drug prices without valid reasoning, as in 2015 when the manufacturer for Daraprim® increased the price by over 5,000 percent overnight.[3,13] Though a medication's price increasing faster than inflation *might* be a reason for inclusion, it is not *necessarily* a reason. There are valid reasons that a drug price may increase, such as when a medication's treatment value increases or an increase in the cost of raw materials.[14,15] While it is important to discourage unnecessary hikes in drug prices, it is also important to ensure that medications are accessible to patients when needed. Therefore, drugs should not be automatically included in negotiations without complete assessment from appropriate regulators, legislators, and/or experts. A discussion surrounding the criteria states have utilized to select regulated or negotiated medications can be found in CMS Report 8-A-25.

Pharmaceutical manufacturers have pursued litigation to stop these government negotiation practices, citing that the negotiated prices may harm competition and, as a result, innovation. At the time this report was written, there were nine open legal cases against the federal government and/or CMS.[16] These lawsuits generally center around the claim that the program will violate the Fifth Amendment by forcing manufacturers to provide selected medications to the government without fair compensation, that the program limits corporate free speech, and that associated penalties are "excessive fines" which is in violation of the Eighth Amendment. Some cases also claim that the negotiation program violates portions of the Due Process Clause by not allowing for adequate separation of powers.[14,15] To date, none of these legal challenges have been successful in blocking or minimizing the drug negotiation. However, most of these cases are still ongoing and one has recently found minor traction via an appeals court.[17] Most experts following these cases agree that it is likely one will end up being heard by the United States Supreme Court. Although the voracity with which the current administration will defend the program is uncertain, potentially mitigating the need for a Supreme Court ruling.[15,16]

IMPACT OF PRICE NEGOTIATION

While experts do agree that reducing the amount patients pay for drugs will improve medication adherence, and as a result health outcomes, there is some debate regarding whether price negotiation, and particularly the establishment of MFPs, are the best method to reduce drug prices. Some experts suggest that increasing drug price negotiation is a tactic that could be used in tandem with other tactics to lower drug prices in the U.S.[18] Specifically, the Congressional Budget Office (CBO) analyzed a bill asserting more aggressive negotiation and found that it could yield over $450 billion in savings for Medicare over a 10-year period. It is estimated that if the negotiated prices were expanded to commercial insurance plans, anticipated savings to the system could reach the trillion-dollar mark over 10 years.[17] These experts stress that drug price negotiation alone is not likely to solve the problem of U.S. drug prices. However, in tandem with other efforts such as rebate reform, administrative simplification, and increased transparency, costs could be reduced.[17]

Other experts have voiced concerns surrounding the increased use of price negotiation. Many drug manufacturers claim that the implementation of negotiation and MFPs will stifle innovation and potentially prevent, or slow, the development of new pharmaceuticals.[18] Importantly, much of the

resistance to price negotiation has come from entities that benefit from the current system, such as manufacturers, potentially calling the motives of these challenges into question.[14,15,18]

In addition to the lowered costs that may result from negotiation, the price transparency required in the IRA may improve pricing.[17,19] The public access to a drug's Medicare Negotiated Price, the MFP, is a relatively novel level of transparency that may encourage private payers to follow the lead on CMS negotiated prices. While the current legislation does not require private payers to follow the set MFPs, it is common for private insurance companies to eventually follow the lead of CMS.[18] Research has demonstrated that increases in transparency throughout the drug pricing system could be a significant help in lower drug prices overall.[17]

Federal efforts, like the Prescription Pricing for the People Act of 2025, have been introduced to regulated PBM business practices and drug pricing. Additionally, the Transparency in Coverage rule, released in 2020, outlines the requirements for payers/plans to disclose negotiated rates and historical net price for prescription drugs. In addition to federal efforts, a number of states have enacted laws related to portions of the drug pricing process. These laws center around affordability reviews, consumer cost sharing, PBMs, increased transparency, and purchasing processes. However, since none of these state laws have been enacted at a federal level, no impact has been seen nationally.[20] Due to the lack of transparency in the drug pricing process, the result of each specific element, be it negotiation, PBMs, or another aspect, is difficult to assess.

OUT-OF-POCKET CAPS

In addition to introducing CMS drug price negotiations, the IRA also lowered the prescription drug OOP cap for Medicare Part D beneficiaries. Historically, this cap has been between $3,300 and $3,800. Starting in 2025, this has been lowered to $2,000 due to elimination of the coinsurance cost in the catastrophic coverage phase. Experts estimate that if this cap had been implemented in 2021, 1.5 million beneficiaries would have saved in OOP costs.[21]

While the IRA did not expand the prescription drug OOP cap to non-Medicare payers, most, if not all, plans have caps on annual OOP spending. Research has demonstrated that median annual OOP spending on medical expenses ranged between $360 and $1,500 with the top 10 percent spending at least $7,000.[22] Importantly, this is for all medical spending, not just prescription drugs. Because many private payers do not separate prescription drug OOP costs from overall OOP medical costs, it is challenging to make a direct comparison to Medicare levels.[21] Researchers and other experts agree that high OOP costs can be detrimental to patients, some suggesting spending caps as a potential solution to this issue.[23,24] The financial burden of high OOP costs can often lead to patients accruing significant medical debt and potentially forgoing future, necessary treatment. If a patient cannot afford their OOP cost, they may delay or skip treatment altogether, leading to lower medication adherence and poorer health outcomes. OOP caps could have potential to increase prescription drug affordability for patients in turn potentially leading to better health outcomes.[23,24]

While experts agree that high OOP costs can be detrimental to patients, some voice concerns around the unintended consequences of OOP caps such as disproportionate financial burdens to lower income patients.[24,25] If all beneficiaries are given a uniform cap, this may be affordable for some but not for others. Even more importantly, these caps are often not paid for by insurers but rather shifted to patients through premium increases. These premium raises could, and often do, make insurance unaffordable for many beneficiaries. Some experts argue that this could be mitigated by adding income-based eligibility requirements for OOP costs or income-proportional caps.[23,24,25] Nonetheless, it is essential to ensure that the potential economic impacts of universal

OOP caps be weighed against the potential benefits to ensure that patients still have access to reasonably priced insurance coverage.

AMA POLICY AND ADVOCACY

The AMA has undertaken robust advocacy efforts to lower drug costs for patients, especially around regulation and increasing the transparency of PBMs. Specifically, over the past two years the AMA has written a number of letters to payers, regulators, and legislators and testified before both the House and Senate regarding regulation of PBMs. The AMA also has an ongoing grassroots campaign, TruthinRx, designed to support patients and physicians in understanding and fighting the lack of transparency through education and advocacy. Additionally, the AMA has expressed support to federal legislators to implement drug price negotiation, regulators in reducing patient OOP costs, and for reasonable OOP caps on drug spending. The AMA is continuing to work with legislators, regulators, drug manufacturers, and payers to ensure that patients not only have access to affordable medications but also affordable health coverage.

In addition to the advocacy on drug pricing transparency and affordability, the AMA has extensive policies that address the issue. Policies H-110.980 and H-110.987 outline the AMA's efforts to ensure that patients have access to affordable medications. These policies discuss AMA standards for drug affordability, process transparency, and patient access. Policy H-110.980 highlights different strategies and approaches, such as supporting increased transparency and promoting value-based pricing, that the AMA utilizes to ensure that medications are accessible and affordable. Policies H-110.986 and H-110.979 expand on this support for value-based strategies to manage drug coverage. Specifically, H-110.986 discusses AMA support for adding value metrics into drug prices and H-110.979 outlines AMA advocacy for formulary development to incorporate value-based processes. In conjunction with the aforementioned policies that address all payer types, Policy D-330.954 focuses on managing prescription drug prices in Medicare and outlines support for price negotiation. Finally, Policies D-110.987, D-120.988, and D-120.934 target PBMs and the need for increased regulation and transparency. Policy D-120.934 outlines AMA steps to ensure that PBMs do not prevent physicians from appropriately treating patients, Policy D-120.988 details prevention of appropriate treatment by PBMs, and Policy D-110.987 discusses the impacts of these, and other, negative PBM practices.

The AMA also has policy and ongoing advocacy to address concerns from experts surrounding unintended consequences of introducing OOP caps or extending drug price negotiations. Policies H-320.939 and D-320.982, along with the AMA's Fix Prior Auth grassroots campaign, work to mitigate concerns regarding increases in utilization management/prior authorization. Policy H-320.939 outlines the efforts that the AMA has made to reduce the amount of utilization management and fix the system as a whole. Policy D-320.982 outlines strategies, including emerging technology, that could be used to assist in minimizing the impact of utilization management on patients and physicians. Finally, Policies H-165.828, H-290.954, and H-165.824 outline AMA efforts to support the affordability of health insurance for all. Policy H-165.828 centers around the AMA efforts to ensure that health coverage is affordable for all patients, while Policies H-165.824 and H-290.954 center on ACA and public plan affordability.

DISCUSSION

Despite the current uncertainty of Medicare drug price negotiations, the practice of negotiation has been a part of drug pricing in the private sector for decades. The current drug pricing system, hallmarked by close relationships between private insurers and their PBM negotiators, is complicated and opaque. As a result, the system often still yields drug prices that remain

unaffordable for many patients. While this system is not simple to fix, it is possible that the current CMS negotiation efforts may be a step in the right direction. While some experts voice concern that negotiation may stifle innovation, many anticipate that it has the potential to save both consumers and public payers significant amounts of money, helping prescriptions become more affordable. Regardless of the impact of price negotiation, it is clear that payers of all types participate in the negotiation process. For private payers this is often done by PBMs and for public payers via CMS. The Council believes that when used responsibly, prescription drug price negotiation has real potential to make significant changes, and that the AMA should support utilization of all ongoing efforts, to make drug prices affordable. The AMA has a strong body of policy and ongoing advocacy to address drug affordability. Therefore, the Council recommends the reaffirmation of Policy H-110.987, which details the AMA's efforts to encourage regulators, legislators, physicians, and patients to work together towards transparency and affordability in drug pricing. To ensure that this support is explicit for all medications, including those used to manage health and prevent future complications, the Council recommends the adoption of new HOD policy as outlined in Recommendation 1. Additionally, as outlined in the report, PBMs are exceptionally influential in setting drug prices, as they are currently faced with little regulation. Therefore, the Council recommends that Policy D-110.987 be reaffirmed, as it outlines how the AMA continues to hold legislators and regulators accountable to ensure that PBMs are monitored and transparency is increased. The Council believes that this new HOD policy, along with the suggested reaffirmations, will ensure that efforts to increase medication affordability continue.

As previously discussed, OOP costs are another aspect of drug pricing that elicit affordability concerns for patients. Researchers agree that high OOP medical costs can cause significant financial burden to patients and adverse health outcomes. Specifically, when OOP costs are higher, patients are less likely to adhere to treatment and often experience worse health outcomes. However, blanket OOP caps may not be a simple solution to the problem. Experts have called the actual impact of these caps into question and expressed concern that payers might shift costs to patients via premium increases. It is clear that OOP caps need to be handled in a manner that balances the potential positives and negatives. Therefore, the Council recommends the adoption of new HOD policy that supports the establishment of a reasonable OOP prescription drug cap while maintaining patient premiums. The Council believes that this new policy captures the intent of the third resolve of Resolution 113-A-24 while balancing potential unintended consequences.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 113-A-24, and the remainder of the report be filed:

1. That our American Medical Association (AMA) support efforts to ensure that patients have affordable access to medications. (New HOD Policy)

2. That our AMA encourage all payers, both public and private, in efforts to establish a reasonable and affordable cap on patient out-of-pocket prescription drug spending in a manner that does not increase patient premiums. (New HOD policy)

3. That our AMA reaffirm Policy H-110.987, which supports efforts to ensure drug prices are affordable to patients. (Reaffirm HOD Policy)

4. That our AMA reaffirm Policy D-110.987, which supports efforts to increase PBM transparency and regulation. (Reaffirm HOD Policy)

Fiscal Note: Less than $500

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Council on Medical Service Report 6-A-25
Prescription Medication Price Negotiation
Policy Appendix

Additional Mechanisms to Address High and Escalating Pharmaceutical Prices, H-110.980
1. Our American Medical Association (AMA) will advocate that the use of arbitration in determining the price of prescription drugs meet the following standards to lower the cost of prescription drugs without stifling innovation:
a. The arbitration process should be overseen by objective, independent entities.
b. The objective, independent entity overseeing arbitration should have the authority to select neutral arbitrators or an arbitration panel.
c. All conflicts of interest of arbitrators must be disclosed and safeguards developed to minimize actual and potential conflicts of interest to ensure that they do not undermine the integrity and legitimacy of the arbitration process.
d. The arbitration process should be informed by comparative effectiveness research and cost-effectiveness analysis addressing the drug in question.
e. The arbitration process should include the submission of a value-based price for the drug in question to inform the arbitrator's decision.
f. The arbitrator should be required to choose either the bid of the pharmaceutical manufacturer or the bid of the payer.
g. The arbitration process should be used for pharmaceuticals that have insufficient competition; have high list prices; or have experienced unjustifiable price increases.
h. The arbitration process should include a mechanism for either party to appeal the arbitrator's decision.
i. The arbitration process should include a mechanism to revisit the arbitrator's decision due to new evidence or data.
2. Our AMA will advocate that any use of international price indices and averages in determining the price of and payment for drugs should abide by the following principles:
a. Any international drug price index or average should not be used to determine or set a drug's price, or determine whether a drug's price is excessive, in isolation.
b. The use of any international drug price index or average should preserve patient access to necessary medications.
c. The use of any international drug price index or average should limit burdens on physician practices.
d. Any data used to determine an international price index or average to guide prescription drug pricing should be transparent and updated regularly.
3. Our AMA supports the use of contingent exclusivity periods for pharmaceuticals, which would tie the length of the exclusivity period of the drug product to its cost-effectiveness at its list price at the time of market introduction. (CMS Rep. 4, I-19; Reaffirmed: CMS Rep. 3, I-20; Modified: CMS Rep. 4, A-22)

Pharmaceutical Costs, H-110.987
1. Our American Medical Association (AMA) encourages Federal Trade Commission (FTC) actions to limit anticompetitive behavior by pharmaceutical companies attempting to reduce competition from generic manufacturers through manipulation of patent protections and abuse of regulatory exclusivity incentives.
2. Our AMA encourages Congress, the FTC and the Department of Health and Human Services to monitor and evaluate the utilization and impact of controlled distribution channels for prescription pharmaceuticals on patient access and market competition.
3. Our AMA will monitor the impact of mergers and acquisitions in the pharmaceutical industry.

4. Our AMA will continue to monitor and support an appropriate balance between incentives based on appropriate safeguards for innovation on the one hand and efforts to reduce regulatory and statutory barriers to competition as part of the patent system.
5. Our AMA encourages prescription drug price and cost transparency among pharmaceutical companies, pharmacy benefit managers and health insurance companies.
6. Our AMA supports legislation to require generic drug manufacturers to pay an additional rebate to state Medicaid programs if the price of a generic drug rises faster than inflation.
7. Our AMA supports legislation to shorten the exclusivity period for biologics.
8. Our AMA will convene a task force of appropriate AMA Councils, state medical societies and national medical specialty societies to develop principles to guide advocacy and grassroots efforts aimed at addressing pharmaceutical costs and improving patient access and adherence to medically necessary prescription drug regimens.
9. Our AMA will generate an advocacy campaign to engage physicians and patients in local and national advocacy initiatives that bring attention to the rising price of prescription drugs and help to put forward solutions to make prescription drugs more affordable for all patients.
10. Our AMA supports:
a. drug price transparency legislation that requires pharmaceutical manufacturers to provide public notice before increasing the price of any drug (generic, brand, or specialty) by 10 percent or more each year or per course of treatment and provide justification for the price increase;
b. legislation that authorizes the Attorney General and/or the Federal Trade Commission to take legal action to address price gouging by pharmaceutical manufacturers and increase access to affordable drugs for patients; and
c. the expedited review of generic drug applications and prioritizing review of such applications when there is a drug shortage, no available comparable generic drug, or a price increase of 10 percent or more each year or per course of treatment.
11. Our AMA advocates for policies that prohibit price gouging on prescription medications when there are no justifiable factors or data to support the price increase.
12. Our AMA will provide assistance upon request to state medical associations in support of state legislative and regulatory efforts addressing drug price and cost transparency.
13. Our AMA supports legislation to shorten the exclusivity period for FDA pharmaceutical products where manufacturers engage in anti-competitive behaviors or unwarranted price escalations.
14. Our AMA supports legislation that limits Medicare annual drug price increases to the rate of inflation. (CMS Rep. 2, I-15; Reaffirmed in lieu of: Res. 817, I-16; Appended: Res. 201, A-17; Reaffirmed in lieu of: Res. 207, A-17; Modified: Speakers Rep. 01, A-17; Appended: Alt. Res. 806, I-17; Reaffirmed: BOT Rep. 14, A-18; Appended: CMS Rep. 07, A-18; Appended: BOT Rep. 14, A-19; Reaffirmed: Res. 105, A-19; Appended: Res. 113, I-21; Reaffirmed in lieu of: Res. 810, I-22; Reaffirmed: Res. 801, I-23; Reaffirmed: Res. 801, I-23)

Value-Based Management of Drug Formularies, H-110.979
Our American Medical Association: (1) will advocate that pharmacy benefit managers (PBMs) and health plans use a transparent process in formulary development and administration, and include practicing network physicians from the appropriate medical specialty when making determinations regarding formulary inclusion or placement for a particular drug class; (2) will advocate that any refunds or rebates received by a health plan or PBM from a pharmaceutical manufacturer under an outcomes-based contract be shared with impacted patients; and (3) opposes indication-based formularies in order to protect the ability of patients to access and afford the prescription drugs they need, and physicians to make the best prescribing decisions for their patients. (CMS Rep. 6, I-20)

Incorporating Value into Pharmaceutical Pricing, H-110.986
1. Our American Medical Association (AMA) supports value-based pricing programs, initiatives and mechanisms for pharmaceuticals that are guided by the following principles:
a. value-based prices of pharmaceuticals should be determined by objective, independent entities;
b. value-based prices of pharmaceuticals should be evidence-based and be the result of valid and reliable inputs and data that incorporate rigorous scientific methods, including clinical trials, clinical data registries, comparative effectiveness research, and robust outcome measures that capture short- and long-term clinical outcomes;
c. processes to determine value-based prices of pharmaceuticals must be transparent, easily accessible to physicians and patients, and provide practicing physicians and researchers a central and significant role;
d. processes to determine value-based prices of pharmaceuticals should limit administrative burdens on physicians and patients;
e. processes to determine value-based prices of pharmaceuticals should incorporate affordability criteria to help assure patient affordability as well as limit system-wide budgetary impact; and
f. value-based pricing of pharmaceuticals should allow for patient variation and physician discretion.
2. Our AMA supports the inclusion of the cost of alternatives and cost-effectiveness analysis in comparative effectiveness research.
3. Our AMA supports direct purchasing of pharmaceuticals used to treat or cure diseases that pose unique public health threats, including hepatitis C, in which lower drug prices are assured in exchange for a guaranteed market size. (CMS Rep. 05, I-16; Reaffirmed in lieu of: Res. 207, A-17; Reaffirmed: CMS-CSAPH Rep. 01, A-17; Reaffirmed: CMS Rep. 07, A-18; Reaffirmed: CSAPH Rep. 2, I-19; Reaffirmed: CMS Rep. 4, I-19; Reaffirmed: CMS Rep. 6, I-20; Reaffirmed: Res. 113, A-23)

Prescription Drug Prices and Medicare, D-330.954
1. Our American Medical Association (AMA) will support federal legislation which gives the Secretary of the Department of Health and Human Services the authority to negotiate contracts with manufacturers of covered Part D drugs.
2. Our AMA will work toward eliminating Medicare prohibition on drug price negotiation.
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-11Appended: 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)

The Impact of Pharmacy Benefit Managers on Patients and Physicians, D-110.987
1. Our American Medical Association (AMA) supports the active regulation of pharmacy benefit managers (PBMs) under state departments of insurance.
2. Our AMA will develop model state legislation addressing the state regulation of PBMs, which shall include provisions to maximize the number of PBMs under state regulatory oversight.
3. Our AMA supports requiring the application of manufacturer rebates and pharmacy price concessions, including direct and indirect remuneration (DIR) fees, to drug prices at the point-of-sale.
4. Our AMA supports efforts to ensure that PBMs are subject to state and federal laws that prevent discrimination against patients, including those related to discriminatory benefit design and mental health and substance use disorder parity.
5. Our AMA supports improved transparency of PBM operations, including disclosing:

- Utilization information;
- Rebate and discount information;
- Financial incentive information;
- Pharmacy and therapeutics (P&T) committee information, including records describing why a medication is chosen for or removed in the P&T committee's formulary, whether P&T committee members have a financial or other conflict of interest, and decisions related to tiering, prior authorization and step therapy;
- Formulary information, specifically information as to whether certain drugs are preferred over others and patient cost-sharing responsibilities, made available to patients and to prescribers at the point-of-care in electronic health records;
- Methodology and sources utilized to determine drug classification and multiple source generic pricing; and
- Percentage of sole source contracts awarded annually.

6. Our AMA encourages increased transparency in how DIR fees are determined and calculated. (CMS Rep. 05, A-19; Reaffirmed: CMS Rep. 6, I-20)

Inappropriate Actions by Pharmacies and Pharmacy Benefit Mangers, D-120.988
Our American Medical Association, in cooperation with pharmacy benefit managers, pharmacy companies, and other drug retailing organizations, shall develop model procedures that physicians may use when prescribing off-formulary pharmaceuticals that are medically indicated and that these procedures be in compliance with the Health Insurance and Portability and Accountability Act of 1996. (Res. 528, A-02; Reaffirmation I-04; Reaffirmation A-06; Reaffirmed: CSAPH Rep. 01, A-16)

Evaluating Actions by Pharmacy Benefit Manager and Payer Policies on Patient Care, D-120.934
1. Our American Medical Association (AMA) will take steps to implement AMA Policies H-120.947 and D-35.981 that prescriptions must be filled as ordered by physicians or other duly authorized/licensed persons, including the quantity ordered.
2. Our AMA will work with pharmacy benefit managers, payers, relevant pharmacy associations, and stakeholders to: (a) identify the impact on patients of policies that restrict prescriptions to ensure access to care and urge that these policies receive the same notice and public comment as any other significant policy affecting the practice of pharmacy and medicine; and (b) prohibit pharmacy actions that are unilateral medical decisions.
3. Our AMA will report back at the 2018 Annual Meeting on actions taken to preserve the purview of physicians in prescription origination. (Res. 233, I-17; Reaffirmed: CMS Rep. 05, A-23)

Prior Authorization and Utilization Management Reform, H-320.939
1. Our American Medical Association (AMA) will continue its widespread prior authorization (PA) advocacy and outreach, including promotion and/or adoption of the Prior Authorization and Utilization Management Reform Principles, AMA model legislation, Prior Authorization Physician Survey and other PA research, and the AMA Prior Authorization Toolkit, which is aimed at reducing PA administrative burdens and improving patient access to care.
2. Our AMA will oppose health plan determinations on physician appeals based solely on medical coding and advocate for such decisions to be based on the direct review of a physician of the same medical specialty/subspecialty as the prescribing/ordering physician.
3. Our AMA supports efforts to track and quantify the impact of health plans' prior authorization and utilization management processes on patient access to necessary care and patient clinical outcomes, including the extent to which these processes contribute to patient harm.

4. Our AMA will advocate for health plans to minimize the burden on patients, physicians, and medical centers when updates must be made to previously approved and/or pending prior authorization requests. (CMS Rep. 08, A-17; Reaffirmation: I-17; Reaffirmed: Res. 711, A-18; Appended: Res. 812, I-18; Reaffirmed in lieu of: Res. 713, A-19; Reaffirmed: CMS Rep. 05, A-19; Reaffirmed: Res. 811, I-19; Reaffirmed: CMS Rep. 4, A-21; Appended: CMS Rep. 5, A-21; Reaffirmation: A-22)

Prior Authorization Reform, D-320.982
Our American Medical Association will explore emerging technologies to automate the prior authorization process for medical services and evaluate their efficiency and scalability, while advocating for reduction in the overall volume of prior authorization requirements to ensure timely access to medically necessary care for patients and reduce practice administrative burdens. (Res. 704, A-19; Reaffirmation: A-22)

Health Insurance Affordability, H-165.828
1. Our American Medical Association (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)

Improving Medicaid and CHIP Access and Affordability, H-290.954
1. Our American Medical Association (AMA) opposes premiums, copayments, and other cost-sharing methods for Medicaid and the Children's Health Insurance Program, including Section 1115 waiver applications that would allow states to charge premiums or copayments to Medicaid beneficiaries.
2. Our AMA encourages the Centers for Medicare & Medicaid Services to amend existing Section 1115 waivers to disallow states the ability to charge premiums or copayments to Medicaid beneficiaries. (Res. 803, I-23)

Improving Affordability in the Health Insurance Exchanges, H-165.824

1. Our American Medical Association (AMA) will:

a. support adequate funding for and expansion of outreach efforts to increase public awareness of advance premium tax credits.

b. support expanding eligibility for premium tax credits up to 500 percent of the federal poverty level.

c. support providing young adults with enhanced premium tax credits while maintaining the current premium tax credit structure which is inversely related to income.

d. encourage state innovation, including considering state-level individual mandates, auto-enrollment and/or reinsurance, to maximize the number of individuals covered and stabilize health insurance premiums without undercutting any existing patient protections.

2. Our AMA supports:

a. eliminating the subsidy "cliff," thereby expanding eligibility for premium tax credits beyond 400 percent of the federal poverty level (FPL).

b. increasing the generosity of premium tax credits.

c. expanding eligibility for cost-sharing reductions.

increasing the size of cost-sharing reductions. (CMS Rep. 02, A-18; Appended: CMS Rep. 02, A-19; Reaffirmed: CMS Rep. 3, I-21)

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 9-A-25

Subject: Minimum Requirements for Medication Formularies (Resolution 809-I-24)

Presented by: Stephen Epstein, MD, MPP, Chair

Referred to: Reference Committee A

At the 2024 Interim Meeting, the House of Delegates referred Resolution 809, which was introduced by the Mississippi Delegation, and asked that our American Medical Association (AMA) advocate for all payers to create, maintain, and enforce a minimum formulary for all beneficiaries that includes all "commonly prescribed, inexpensive, and generic" medications unless there are reasonable safety or economic concerns. The following report discusses the background and current state of formularies, impacts of their expansion, and AMA efforts on the topic. Additionally, the report recommends the adoption and reaffirmation of policies designed to balance formulary inclusion and economic concerns.

BACKGROUND

Formularies were initially simple lists of medications implemented by the military in the late 1700s during the American War of Independence.[1] In the mid-1900s, the concept of formularies became more widespread and took root in hospital pharmacies needing authorization to dispense interchangeable medications.[2] In 1965, with the inception of Medicare, formularies became well established as part of reimbursement eligibility requirements.[3] By the 1980s, formularies began to take a more contemporary shape, primarily due to the development of multi-brand categories of drugs with similar, but not identical, uses and prices. To encourage the use of their drugs, manufacturers began to offer rebates to purchasers. As a result, payers placed the more advantageous drugs, often due to higher rebates, in more favorable formulary positions.[4] Today's formularies continue to tout the goal of managing costs, ensuring patient access to therapies, and improving health outcomes.[4,5] While the actual outcomes delivered by formularies are diverse and occasionally questionable, they are highly influential in dictating what medications are accessible to patients.[4]

Contemporary formularies tend to follow similar rebate incentive structures as were developed in the 1980s, but with time have become increasingly complicated and, in many cases, opaque.[4,6] Formularies today are usually one of four types; open, closed, value-based, and tiered. Open structured formularies are those in which coverage for all prescription medications is granted.[6] While this may seem to be the most advantageous to patients, these types of formularies often see significantly higher cost to the patient and can actually block access due to high out-of-pocket (OOP) costs and/or high premiums.[4,6] Closed formularies are those that offer a narrower range of covered medications, but often at a lower cost to patients.[6] Within these formularies payers often select the medications that have higher rebates and, therefore, are financially advantageous to the payer.[4,6] Tiered formularies are more common and more complex in their execution. Within the tiers, payers incentivize the use of medications by placing them on lower tiers which, in turn, come

with a lower OOP expense for the patient. While there is no limit on the number of tiers, it is most common for plans to have a three-tiered structure. Typically, tier one includes the most preferred medications, tier two includes preferred name brand drugs, and tier three includes non-preferred name brand drugs. Drugs are typically considered to be "preferred" by the payer when more attractive rebates are offered by the manufacturer or if the list price of the medication is lower.[4,6] Finally, value-based formularies are based on an assessment of the impact of a treatment on overall health care spending and long-term health compared to other structures which are based solely on the upfront cost of the drug. While value-based formularies vary in the specific criteria used to determine high versus low value drugs, most take clinical parameters, quality of life, and utilization of health care resources into account. Similar to tiered formularies, the use of preferred drugs, in this case defined as the higher value drugs, is encouraged by lower OOP costs.[4,6]

While it may seem that generic medications would often be placed on lower formulary tiers, that is not always the case. In practice, many payers place name-brand drugs on lower tiers due to greater price concessions offered by manufacturers. Therefore, drugs with higher list prices can often yield payers higher rebates, although these cost savings are often not passed on to the patient.[6] In some cases, patient OOP costs are determined by the list price, and as a result patients end up paying more than a generic option.[7] While the data for private plans are limited, anecdotal evidence and research based on Medicare Part D plans seem to confirm the underuse of generic drugs to reduce cost. For example, one study found that 72 percent of Medicare Part D formularies had at least one branded product place on a lower tier than the comparable generic medication and 30 percent of branded multisource drugs had fewer utilization management requirements than the generic product.[8] Additionally, trends of generic drug usage in Medicare Part D seem to be declining as there was a 22 percent drop in generic medications placed on tiers between 2016 and 2025.[7,8]

Regardless of the formulary structure or drug type, the placement of medications is determined by a pharmacy and therapeutics (P&T) committee.[5] These committees are typically made up of physicians, other practitioners, legal experts, and administrators. P&T Committees will generally assess the safety, clinical efficacy, patient adherence, patient satisfaction, and economic factors of a drug in order to determine if it is placed on a formulary and/or the appropriate tier.[4,6] While payers are able to develop their own formularies, most choose to rely on pharmacy benefit managers (PBMs) to create and maintain formularies due to the high associated costs.[6] Typically, PBMs will create a number of formulary choices for payers to select from and, if desired, customize. While there are no federal legislative or regulatory guidelines for non-Medicare plans, Part D plans must follow guidelines and participate in annual reviews coordinated by the Centers for Medicare & Medicaid Services (CMS). These requirements were put in place by CMS in 2006 and are designed to regulate how private Part D plans create and manage formularies.[4,5,6,9]

FORMULARY REQUIREMENTS

Since its founding, Medicare has required payers to provide formularies in order to be approved for reimbursement. In 2003, the Medicare Prescription Drug Improvement and Modernization Act (MMA) was signed into law and included specific details as to minimum formulary requirements. MMA's goal was to not only update Medicare's prescription benefits, but to ensure that all associated carriers and their plans provide beneficiaries with high-quality and cost-effective drug benefits.[9,10] Since 2006, Medicare has required that at least two medications from each class are included in the plan formulary. However, there is some flexibility in this requirement should a medication class not include two or more medications. Additionally, in cases when there are therapeutic advantages of a specific medication for patients with certain diseases, more than two medications may be required to be included in the formulary.[9,11]

The Patient Protection and Affordable Care Act (ACA), signed into law in 2010, also includes minimum formulary requirements for associated plans.[12] Due to the structure of the ACA, specific formulary requirements vary significantly across states. However, prescription medication is considered one of the Essential Health Benefits (EHBs) that plans are required to cover. Specifically, states must ensure that plans either cover one drug in each of the United States Pharmacopeia (USP) class or at least the same number of drugs in each category and class of the EHB Benchmark plan for the respective state.[13] The 2025 USP list includes 50 medication categories, 175 medication classes, 207 Pharmacotherapeutic informational groups, and over 2,055 example drugs and how each example fits into each category, class, and group.[14] States have the ability to, within reason, establish their own EHB Benchmark plan, or the floor plan, for their state. As a result, some states, like Washington, require that plans cover at least one drug in every USP class, while other states, like Illinois and South Dakota, have more nuanced basic requirements. Each state is required to submit a plan to the Center for Consumer Information and Insurance Oversight (CCIIO) for approval.[13] Part of the role of CCIIO is to ensure that EHB Benchmark plans allow consumers access to high quality insurance plans while minimizing payer ability to discriminate between types of beneficiaries and to encourage marketplace competition.[13]

Although private health insurance plans operating outside of Medicare do not have blanket minimum drug formulary requirements, some states require plans to meet the ACA minimum. Additionally, many organizations, including the AMA, have offered guidance around formulary best practices. Specifically, the AMA, along with other relevant organizations, endorsed the Principles of a Sound Drug Formulary System.[15] While these principles do not specifically outline a minimum formulary requirement, they do delineate the need to ensure that formularies provide patients with medications necessary to address their diagnosis in a manner that is clinically appropriate and economically responsible.[15] Other organizations, including the American Academy of Family Physicians and American Society of Health-System Pharmacists, have outlined the need for formularies to be balanced based on efficacy, safety, cost, and patient outcomes.[16,17]

FORMULARY EXCEPTION PROCESS

An important aspect of formularies is the exception process. Since the vast majority of plans do not cover every medication on the market, patients and physicians may need to engage with exceptions to seek coverage of a medication. These exceptions occur when the covered medication is not an option for a patient. Commonly, this is due to allergies, a history of unsuccessful use of covered medications, covered medications not meeting therapeutic need, and/or concern that a covered medication would exacerbate an existing condition(s).[18] There may also be the need to submit an exception if a patient needs a quantity, dosage, or delivery method that is not typically covered. Importantly, exceptions are not limited to medications that are not covered at all by a payer. In some cases, if a medication is placed on a formulary tier that makes it unaffordable to the patient, an exception can be requested. This type of exception is called a tiering exception while the traditional exception process is called a formulary exception.[18,19]

While there is not one standardized process for exceptions, typically the process includes a request from the patient/patient representative paired with a physician statement. In some cases, the physician may directly request the exception and provide the statement for the patient.[19] When requesting a formulary exception, the physician statement typically includes information regarding the medical necessity of the alternative medication and potential consequences should the covered drug be used. When requesting a tiering exception, the physician statement will discuss the medical necessity of the medication and why it is unaffordable. In some cases, payers may require a statement of patient financial hardship.[18] Payers will typically respond to exception requests within

72 hours from the submission of the physician statement, although in urgent or emergency situations the payer should respond within 24 hours.[18,19]

As previously mentioned, there is not a requirement for payers to utilize a standard exception process, and as a result there is variance in the criteria utilized to review exception requests. Most plans will compare applicable scientific evidence on the efficacy and safety of the covered and requested drugs. Should an exception request be denied by the payer, the patient and/or physician may file an appeal to reverse the decision.[19] Similar to the original exception request, there is not a standardized process for appeals, however plans should have a defined method in place. For example, Medicare Part D plans provide a multistep appeals process starting with redetermination by the drug plan and escalating to an appeal in a federal court.[10,19]

IMPACTS OF FORMULARY EXPANSION

While it may seem beneficial for all medications to be included in drug formularies, research has shown that this may have unintended consequences. Specifically, economists have shown that, at least among ACA plans, those that cover more EHB drugs have significantly more utilization management requirements in place.[20] This seems to hold true when new drugs are added to formularies, as plans are increasingly likely to add utilization management requirements, often in the form of prior authorization. As discussed in a number of previous Council reports (CMS 6-A-24; CMS 8-A-17; CMS 7-A-16) prior authorization and other forms of utilization management are extremely burdensome for physicians/physician offices and potentially dangerous to patients. However, utilization management is not the only way that physicians are impacted by formulary placement and expansion. Many physicians report challenges with securing payment for high cost, but necessary physician-administered medications placed on higher tiers. Others have reported difficulties in receiving the full payment rate for administering vaccines, especially in private practice settings, from public payers.[21] A fuller discussion of the challenges faced by physicians in adequate vaccine payment can be found in CMS Report 3-I-20.

In addition to the potential challenges faced by physicians if formularies are expanded, patients may face adverse consequences. A main concern is that if payers incur additional costs, in this case due to formulary expansion, those costs may be passed on to the beneficiary through premium increases or higher OOP costs. Specifically, payers could simply require higher levels of patient cost sharing if they are required to include more medications on a formulary. Additionally, payers may react to forced formulary expansion by placing more medications on less desirable formulary tiers, leading to higher patient OOP costs and/or more utilization management requirements.[22] In conjunction with the potential negative impacts on patients with expanded formularies, research has demonstrated that overall, stricter formularies may not negatively impact patients. In some cases, research has shown that stricter formularies are actually associated with reported positive impacts, such as better medication adherence and clinical outcomes.[22] At the same time, other research seems to show that these policies also reduce costs in the majority of cases.[23] Together these concerns and conclusions may suggest that more stringent formularies are not harmful to patients and may actually lower drug-related costs.

However, research has also demonstrated that when formularies are too restrictive, there can be negative outcomes like lower medication adherence and, in some cases, higher OOP costs for patients.[22,24] These two metrics go hand in hand as patients who face higher OOP costs are less likely to adhere to treatment plans, potentially incurring additional costs to treat the consequences from non-adherence down the line.[22,24] Additionally, the aforementioned utilization management does not just impact physicians but patients, as well. Patients who experience prior authorization have significantly increased wait times to access their medications and those who experience other

forms of utilization management, like step therapy, can face long, uphill battles to obtain the necessary medication(s).[22,25] Therefore, it is important that formularies are balanced enough to allow patients to access necessary medications while also ensuring that utilization management and patient cost-sharing are not egregious.

AMA POLICY AND ADVOCACY

The AMA has established a number of policies that address the development and maintenance of drug formularies. Policy H-125.979 outlines the need for formulary information to be available to physicians and prescribers in real-time at the point of prescribing. This policy outlines efforts to ensure that formulary lists are also accessible to patients and that medications are not removed during the policy term. Policy H-110.979 outlines the AMA's advocacy efforts to ensure that both PBMs and payers are not just transparent in the creation of formularies, but also that rebates and refunds received will be shared with patients. Policy H-125.991 details the AMA standards for the makeup of P&T committees, the approval of their decisions by medical staff within hospital or institutional settings, and suggested guidelines for the creation and maintenance of a formulary system. Finally, Policy H-125.985 encourages all entities who design formularies or benefit packages, including managed care organizations and PBMs, to follow the principles outlined in the aforementioned Principles of a Sound Drug Formulary System.

The AMA also has several policies outlining the ideal formulary exception process for payers. Policy H-285.965 outlines the steps that physicians should take to ensure that patients have awareness of the most advantageous course of treatment, even when engaging with a formulary exception process is necessary. Policy H-320.949 outlines efforts to ensure that payers are required to provide exception processes that have clear response times and appeal processes. This policy also dictates support for legislative and regulatory efforts to ensure that these standards are implemented. Policy H-185.942 details the basic criteria that should be followed by payers and physicians in relation to utilization management criteria and when it can be appropriately utilized. In addition to these policies, the second principle of the AMA Prior Authorization and Utilization Management Reform Principles outlines the flexibility that should be provided by payers to ensure that patients have the ability receive effective and individualized care. In addition to policies related to the formulary exception process, Policies H-320.939 and D-320.982 detail the AMA's fight to make sure physicians are not experiencing undue burdens related to prior authorization and to mitigate the number of prior authorizations required. Additionally, the AMA has a longstanding grassroots campaign (Fix Prior Auth) working to educate about how prior authorization impacts patients and physicians as well as working to fix the system.

Finally, the AMA has many policies outlining the need for prescription medications to be affordable and accessible to patients. Specifically, Policy H-110.997 outlines support for programs that work to lower the cost of prescription drugs while also maintain quality of care and physician autonomy. Policy H-100.964 builds on the previously mentioned policy and expands the support for efforts to ensure that medications are covered in a manner that allows patients to access medications affordably. Policy H-125.984 reiterates support for generic medications when deemed appropriate and cost effective for the patient. This policy also supports programs that are designed to bolster generic development and federal approvals. Among other strategies to improve the affordability of prescription medications, Policy H-110.987 outlines AMA support for legislation and regulation that works to reduce drug prices, anticompetitive behaviors, and price gouging in an effort to increase drug affordability. In addition to the AMA body of policy on drug pricing, there have been extensive advocacy efforts over the last few years to bring awareness and offer solutions to high drug prices through letters to regulators (CMS 2023, CMS 2024), legislators (Senate 2024), and payers (NAIC 2023), along with testimony provided to the House of

Representatives (House 2023, House 2023(a)). Additionally, the AMA grassroots campaign, TruthinRx, works to gather and disseminate physician and patient stories as well as to advocate for lower drug prices and increased process transparency.

DISCUSSION

While formularies have been around, in some form, for centuries, the current iteration is exceptionally complicated and, in many cases, opaque. As a result, the effectiveness of formularies increasingly has been called into question. Formularies are developed by P&T committees and, at least among private payers, are typically maintained by PBMs. Medication placement on these coverage lists is often heavily dictated by the rebates given to payers by drug manufacturers. Rebates, and other financial incentives are not required to be passed to the patient and, as a result, patients rarely see a share of the financial incentives that payers receive. Current formulary minimums vary greatly by payer type and state. While there is not a national minimum formulary requirement for private payers, public payers do have minimum standards that generally require a certain number of medications in each class to be included in each plan's formulary.

Patients must have access to medications deemed as most appropriate by their physicians and such access must be affordable in order to be effective. Formularies are one method designed to decrease medication costs. In some situations, more limited formularies have resulted in their intended outcomes: lower costs and greater patient access. Yet, when formularies are too restrictive, they may have the opposite effect: higher costs and lower access. In order to ensure that patients have access to affordable coverage and medications, the Council believes that formularies must find a middle ground between being too limited or too expansive, balancing the need for coverage with the potential for OOP or premium cost increases. It is essential to acknowledge that PBMs have significant negotiation power in formulary creation and drug placement and thus yield substantial power in the process. The complications of the negotiation process and the potential economic tradeoffs indicate the need for a nuanced approach to formulary minimum requirements. As such, support for a mandate to cover all medications could have serious adverse consequences on patients and physicians.

Therefore, the Council recommends the adoption of new AMA policy that supports a more nuanced approach, supporting all payers in setting a minimum formulary that covers all drugs in each of the protected classes and at least two medications in each of the non-protected classes. The Council believes that this minimum formulary requirement balances the intent of Resolution 809-I-24 while ensuring that patients and physicians will not face significant increases in OOP cost or utilization management requirements. Additionally, to ensure that patients have access to medications that are prescribed by their physician in an affordable manner, formularies exhibit transparency, and cost-savings are passed to the patient, the Council recommends that Policy H-110.979 be reaffirmed. While affordability and formulary composition are exceptionally important, it is also vital that patients and physicians have an avenue to request coverage when a medication is not included in a formulary. In order to protect and simplify this process the Council also recommends reaffirmation of Policy H-320.949, which details the AMA principles to ensure that utilization management, including formulary exception processes, are clear, not overly burdensome, and have a defined appeals process.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 809-I-24, and the remainder of the report be filed:

1. Our American Medical Association (AMA) support all public and private payers in maintaining a formulary that includes at least:
    a. Coverage for substantially all drugs in the six protected classes; immunosuppressants, antidepressants, antipsychotics, anticonvulsants, antiretrovirals, and antineoplastics; and
    b. Coverage for at least two medications in each non-protected therapeutic category. (New HOD Policy)

2. That our AMA reaffirm Policy H-110.979, which outlines AMA efforts to advocate for transparency in formularies and that patients can access medications (Reaffirm HOD Policy)

3. That our AMA reaffirm Policy H-320.949, which details AMA principles regarding requirements for the formulary exception process (Reaffirm HOD Policy)

Fiscal Note: Less than $500.

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Council on Medical Service Report 9-A-25
Minimum Requirements for Medication Formularies
Policy Appendix

Private Health Insurance Formulary Transparency, H-125.979

1. Our American Medical Association (AMA) will work with pharmacy benefit managers, health insurers, and pharmacists to enable physicians to receive accurate, real-time formulary data at the point of prescribing.
2. Our AMA supports legislation or regulation that ensures that private health insurance carriers declare which medications are available on their formularies by October 1 of the preceding year, that formulary information be specific as to generic versus trade name and include copay responsibilities, and that drugs may not be removed from the formulary nor moved to a higher cost tier within the policy term.
3. Our AMA will develop model legislation:
    a. requiring insurance companies to declare which drugs on their formulary will be covered under trade names versus generic.
    b. requiring insurance carriers to make this information available to consumers by October 1 of each year.
    c. forbidding insurance carriers from making formulary deletions within the policy term.
4. Our AMA will promote the following insurer-pharmacy benefits manager - pharmacy (IPBMP) to physician procedural policy: In the event that a specific drug is not or is no longer on the formulary when the prescription is presented, the IPBMP shall provide notice of covered formulary alternatives to the prescriber promptly so that appropriate medication can be provided to the patient within 72 hours.
5. Drugs requiring prior authorization, shall be adjudicated by the IPBMP within 72 hours of receipt of the prescription.
6. Our AMA
    a. promotes the value of online access to up-to-date and accurate prescription drug formulary plans from all insurance providers nationwide.
    b. supports state medical societies in advocating for state legislation to ensure online access to up-to-date and accurate prescription drug formularies for all insurance plans.
7. Our AMA will continue its efforts with the National Association of Insurance Commissioners addressing the development and management of pharmacy benefits.
8. Our AMA will develop model state legislation on the development and management of pharmacy benefits. (Sub. Res. 724, A-14; Appended: Res. 701, A-16; Appended: Alt. Res. 806, I-17; Reaffirmed: CMS Rep. 07, A-18; Reaffirmed: BOT Rep. 20, A-19; Reaffirmed: CMS Rep. 05, A-19; Reaffirmed: CMS Rep. 2, A-21; Reaffirmed: CMS Rep. 06, A-24)

Value-Based Management of Drug Formularies, H-110.979

Our American Medical Association: (1) will advocate that pharmacy benefit managers (PBMs) and health plans use a transparent process in formulary development and administration, and include practicing network physicians from the appropriate medical specialty when making determinations regarding formulary inclusion or placement for a particular drug class; (2) will advocate that any refunds or rebates received by a health plan or PBM from a pharmaceutical manufacturer under an outcomes-based contract be shared with impacted patients; and (3) opposes indication-based formularies in order to protect the ability of patients to access and afford the prescription drugs they need, and physicians to make the best prescribing decisions for their patients. (CMS Rep. 6, I-20)

Drug Formularies and Therapeutic Interchanges, H-125.991

It is the policy of the American Medical Association (AMA):

(1) That the following terms be defined as indicated:

(a) Formulary: a compilation of drugs or drug products in a drug inventory list; open (unrestricted) formularies place no limits on which drugs are included whereas closed (restrictive) formularies allow only certain drugs on the list;

(b) Formulary system: a method whereby the medical staff of an institution, working through the pharmacy and therapeutics committee, evaluates, appraises, and selects from among the numerous available drug entities and drug products those that are considered most useful in patient care;

(c) Pharmacy & Therapeutics (P&T) Committee: an advisory committee of the medical staff that represents the official, organizational line of communication and liaison between the medical staff and the pharmacy department; its recommendations are subject to medical staff approval;

(d) Therapeutic alternates: drug products with different chemical structures but which are of the same pharmacological and/or therapeutic class, and usually can be expected to have similar therapeutic effects and adverse reaction profiles when administered to patients in therapeutically equivalent doses;

(e) Therapeutic interchange: authorized exchange of therapeutic alternates in accordance with previously established and approved written guidelines or protocols within a formulary system; and

(f) Therapeutic substitution: the act of dispensing a therapeutic alternate for the drug product prescribed without prior authorization of the prescriber.

(2) That our AMA reaffirms its opposition to therapeutic substitution (dispensing a therapeutic alternate without prior authorization) in any patient care setting.

(3) That drug formulary systems, including the practice of therapeutic interchange, are acceptable in inpatient hospital and other institutional settings that have an organized medical staff and a functioning Pharmacy and Therapeutics (P&T) Committee, provided they satisfy the following standards:

(a) The formulary system must:

(i) have the concurrence of the organized medical staff;

(ii) openly provide detailed methods and criteria for the selection and objective evaluation of all available pharmaceuticals;

(iii) have policies for the development, maintenance, approval and dissemination of the drug formulary and for continuous and comprehensive review of formulary drugs;

(iv) provide protocols for the procurement, storage, distribution, and safe use of formulary and non-formulary drug products;

(v) provide active surveillance mechanisms to regularly monitor both compliance with these standards and clinical outcomes where substitution has occurred, and to intercede where indicated;

(vi) have enough qualified medical staff, pharmacists, and other professionals to carry out these activities;

(vii)provide a mechanism to inform the prescriber in a timely manner of any substitutions, and that allows the prescriber to override the system when necessary for an individual patient without inappropriate administrative burden;

(viii) provide a mechanism to assure that patients/guardians are informed of any change from an existing outpatient prescription to a formulary substitute while hospitalized, and whether the prior medication or the substitute should be continued upon discharge from the hospital;

(ix) include policies that state that practitioners will not be penalized for prescribing non-formulary drug products that are medically necessary; and

(x) be in compliance with applicable state and federal statutes and/or state medical board requirements.

(b) The P&T Committee must:

(i) objectively evaluate the medical usefulness and cost of all available pharmaceuticals (reliance on practice guidelines developed by physician organizations is encouraged);

(ii) recommend for the formulary those drug products which are the most useful and cost-effective in patient care;
(iii) conduct drug utilization review (DUR) activities;
(iv) provide pharmaceutical information and education to the organization's (e.g., hospital) staff;
(v) analyze adverse results of drug therapy;
(vi) make recommendations to ensure safe drug use and storage; and
(vii) provide protocols for the timely procurement of non-formulary drug products when prescribed by a physician for the individualized care of a specific patient, when that decision is based on sound scientific evidence or expert medical judgment.
(c) The P&T Committee's recommendations must be approved by the medical staff;
(d) Within the drug formulary system, the P & T Committee shall recommend, and the medical staff must approve, all drugs that are subject to therapeutic interchange, as well as all processes or protocols for informing individual prescribing physicians; and
(e) The act of providing a therapeutic alternate that has not been recommended by the P&T Committee and approved by the medical staff is considered unauthorized therapeutic substitution and requires immediate prior consent by the prescriber; i.e., authorization for a new prescription.
(4) That drug formulary systems in any outpatient setting shall operate under a P&T Committee whose recommendations must have the approval of the medical staff or equivalent body, and must meet standards comparable to those listed above. In addition:
(a) That our AMA continues to insist that managed care and other health plans identify participating physicians as their "medical staff" and that they use such staff to oversee and approve plan formularies, as well as to oversee and participate on properly elected P&T Committees that develop and maintain plan formularies;
(b) That our AMA continues to insist that managed care and other health plans have well-defined processes for physicians to prescribe non-formulary drugs when medically indicated, that this process impose minimal administrative burdens, and that it include access to a formal appeals process for physicians and their patients; and
(c) That our AMA strongly recommends that the switching of therapeutic alternates in patients with chronic diseases who are stabilized on a drug therapy regimen be discouraged.
(5) That our AMA encourages mechanisms, such as incentive-based formularies with tiered co-pays, to allow greater choice and economic responsibility in drug selection, but urges managed care plans and other third party payers to not excessively shift costs to patients so they cannot afford necessary drug therapies. (BOT Rep. 45, I-93; Reaffirmed by Sub. Res. 501, A-95; Appended: BOT Rep. 7, I-99; Modified: Sub. Res. 524 and Reaffirmed: Res. 123, A-00; Reaffirmed: Res. 515, I-00; Reaffirmed: CMS Rep. 8, A-02; Reaffirmed: Res. 533, A-03; Modified: CMS Rep. 6, A-03; Modified: CSA Rep. 2, A-04; Reaffirmation I-04; Reaffirmed in lieu of Res. 535, A-05; Reaffirmed: BOT Action in response to referred for decision Res. 503, A-05; Reaffirmed: CMS Rep. 2, I-05; Reaffirmation A-06; Reaffirmation A-08; Reaffirmed: CMS Rep. 2, A-10; Reaffirmed: CMS Rep. 01, A-20)

Expanded Use of the AMA's Principles of a Sound Drug Formulary, H-125.985
Our American Medical Association (AMA) urges managed care organizations, pharmacy benefit managers, and others who design benefit packages and/or make pharmacy benefit decisions, to utilize the Principles of a Sound Drug Formulary System (as described in BOT Rep. 28, I-00) as they develop their pharmaceutical benefit plan(s) and that the Principles of a Sound Drug Formulary System be readily available on the AMA web site.(Res. 520, A-01; Amended: Res. 514, A-02; Reaffirmed: CSA Rep. 2, A-04; Reaffirmation I-04; Reaffirmed: Sub. Res. 529, A-05; Reaffirmed in lieu of Res. 535, A-05; Reaffirmed: BOT Action in response to referred for decision Res. 503, A-05; Reaffirmation A-06; Reaffirmed: CSAPH Rep. 01, A-16)

Prior Authorization and Utilization Management Reform, H-320.939

1. Our American Medical Association (AMA) will continue its widespread prior authorization (PA) advocacy and outreach, including promotion and/or adoption of the Prior Authorization and Utilization Management Reform Principles, AMA model legislation, Prior Authorization Physician Survey and other PA research, and the AMA Prior Authorization Toolkit, which is aimed at reducing PA administrative burdens and improving patient access to care.
2. Our AMA will oppose health plan determinations on physician appeals based solely on medical coding and advocate for such decisions to be based on the direct review of a physician of the same medical specialty/subspecialty as the prescribing/ordering physician.
3. Our AMA supports efforts to track and quantify the impact of health plans' prior authorization and utilization management processes on patient access to necessary care and patient clinical outcomes, including the extent to which these processes contribute to patient harm.
4. Our AMA will advocate for health plans to minimize the burden on patients, physicians, and medical centers when updates must be made to previously approved and/or pending prior authorization requests. (CMS Rep. 08, A-17; Reaffirmation: I-17; Reaffirmed: Res. 711, A-18; Appended: Res. 812, I-18; Reaffirmed in lieu of: Res. 713, A-19; Reaffirmed: CMS Rep. 05, A-19; Reaffirmed: Res. 811, I-19; Reaffirmed: CMS Rep. 4, A-21; Appended: CMS Rep. 5, A-21; Reaffirmation: A-22)

Prior Authorization Reform, D-320.982

Our American Medical Association will explore emerging technologies to automate the prior authorization process for medical services and evaluate their efficiency and scalability, while advocating for reduction in the overall volume of prior authorization requirements to ensure timely access to medically necessary care for patients and reduce practice administrative burdens. (Res. 704, A-19; Reaffirmation: A-22)

Cost of Prescription Drugs, H-110.997

Our American Medical Association (AMA):

(1) supports programs whose purpose is to contain the rising costs of prescription drugs, provided that the following criteria are satisfied: (a) physicians must have significant input into the development and maintenance of such programs; (b) such programs must encourage optimum prescribing practices and quality of care; (c) all patients must have access to all prescription drugs necessary to treat their illnesses; (d) physicians must have the freedom to prescribe the most appropriate drug(s) and method of delivery for the individual patient; and (e) such programs should promote an environment that will give pharmaceutical manufacturers the incentive for research and development of new and innovative prescription drugs;

(2) reaffirms the freedom of physicians to use either generic or brand name pharmaceuticals in prescribing drugs for their patients and encourages physicians to supplement medical judgments with cost considerations in making these choices;

(3) encourages physicians to stay informed about the availability and therapeutic efficacy of generic drugs and will assist physicians in this regard by regularly publishing a summary list of the patient expiration dates of widely used brand name (innovator) drugs and a list of the availability of generic drug products;

(4) encourages expanded third party coverage of prescription pharmaceuticals as cost effective and necessary medical therapies;

(5) will monitor the ongoing study by Tufts University of the cost of drug development and its relationship to drug pricing as well as other major research efforts in this area and keep the AMA House of Delegates informed about the findings of these studies;

(6) encourages physicians to consider prescribing the least expensive drug product (brand name or FDA A-rated generic); and
(7) encourages all physicians to become familiar with the price in their community of the medications they prescribe and to consider this along with the therapeutic benefits of the medications they select for their patients. (BOT Rep. O, A-90; Sub. Res. 126 and Sub. Res. 503, A-95; Reaffirmed: Res. 502, A-98; Reaffirmed: Res. 520, A-99; Reaffirmed: CMS Rep. 9, I-99; Reaffirmed: CMS Rep.3, I-00; Reaffirmed: Res. 707, I-02; Reaffirmation A-04; Reaffirmed: CMS Rep. 3, I-04; Reaffirmation A-06; Reaffirmed in lieu of Res. 814, I-09; Reaffirmed in lieu of Res. 201, I-11; Reaffirmed in lieu of: Res. 207, A-17; Reaffirmed: BOT Rep. 14, A-18)

Pharmaceutical Costs, H-110.987

1. Our American Medical Association (AMA) encourages Federal Trade Commission (FTC) actions to limit anticompetitive behavior by pharmaceutical companies attempting to reduce competition from generic manufacturers through manipulation of patent protections and abuse of regulatory exclusivity incentives.
2. Our AMA encourages Congress, the FTC and the Department of Health and Human Services to monitor and evaluate the utilization and impact of controlled distribution channels for prescription pharmaceuticals on patient access and market competition.
3. Our AMA will monitor the impact of mergers and acquisitions in the pharmaceutical industry.
4. Our AMA will continue to monitor and support an appropriate balance between incentives based on appropriate safeguards for innovation on the one hand and efforts to reduce regulatory and statutory barriers to competition as part of the patent system.
5. Our AMA encourages prescription drug price and cost transparency among pharmaceutical companies, pharmacy benefit managers and health insurance companies.
6. Our AMA supports legislation to require generic drug manufacturers to pay an additional rebate to state Medicaid programs if the price of a generic drug rises faster than inflation.
7. Our AMA supports legislation to shorten the exclusivity period for biologics.
8. Our AMA will convene a task force of appropriate AMA Councils, state medical societies and national medical specialty societies to develop principles to guide advocacy and grassroots efforts aimed at addressing pharmaceutical costs and improving patient access and adherence to medically necessary prescription drug regimens.
9. Our AMA will generate an advocacy campaign to engage physicians and patients in local and national advocacy initiatives that bring attention to the rising price of prescription drugs and help to put forward solutions to make prescription drugs more affordable for all patients.
10. Our AMA supports:
    a. drug price transparency legislation that requires pharmaceutical manufacturers to provide public notice before increasing the price of any drug (generic, brand, or specialty) by 10 percent or more each year or per course of treatment and provide justification for the price increase;
    b. legislation that authorizes the Attorney General and/or the Federal Trade Commission to take legal action to address price gouging by pharmaceutical manufacturers and increase access to affordable drugs for patients; and
    c. the expedited review of generic drug applications and prioritizing review of such applications when there is a drug shortage, no available comparable generic drug, or a price increase of 10 percent or more each year or per course of treatment.
11. Our AMA advocates for policies that prohibit price gouging on prescription medications when there are no justifiable factors or data to support the price increase.
12. Our AMA will provide assistance upon request to state medical associations in support of state legislative and regulatory efforts addressing drug price and cost transparency.

13. Our AMA supports legislation to shorten the exclusivity period for FDA pharmaceutical products where manufacturers engage in anti-competitive behaviors or unwarranted price escalations.
14. Our AMA supports legislation that limits Medicare annual drug price increases to the rate of inflation. (CMS Rep. 2, I-15; Reaffirmed in lieu of: Res. 817, I-16; Appended: Res. 201, A-17; Reaffirmed in lieu of: Res. 207, A-17; Modified: Speakers Rep. 01, A-17; Appended: Alt. Res. 806, I-17; Reaffirmed: BOT Rep. 14, A-18; Appended: CMS Rep. 07, A-18; Appended: BOT Rep. 14, A-19; Reaffirmed: Res. 105, A-19; Appended: Res. 113, I-21; Reaffirmed in lieu of: Res. 810, I-22; Reaffirmed: Res. 801, I-23; Reaffirmed: Res. 801, I-23)

Generic Drugs, H-125.984
Our American Medical Association (AMA) believes that: (1) Physicians should be free to use either the generic or brand name in prescribing drugs for their patients, and physicians should supplement medical judgments with cost considerations in making this choice.
(2) It should be recognized that generic drugs frequently can be less costly alternatives to brand-name products.
(3) Substitution with Food and Drug Administration (FDA) "B"-rated generic drug products (i.e., products with potential or known bioequivalence problems) should be prohibited by law, except when there is prior authorization from the prescribing physician.
(4) Physicians should report serious adverse events that may be related to generic substitution, including the name, dosage form, and the manufacturer, to the FDA's MedWatch program.
(5) The FDA, in conjunction with our AMA and the United States Pharmacopoeia, should explore ways to more effectively inform physicians about the bioequivalence of generic drugs, including decisional criteria used to determine the bioequivalence of individual products.
(6) The FDA should fund or conduct additional research in order to identify the optimum methodology to determine bioequivalence, including the concept of individual bioequivalence, between pharmaceutically equivalent drug products (i.e., products that contain the same active ingredient(s), are of the same dosage form, route of administration, and are identical in strength).
(7) The Congress should provide adequate resources to the FDA to continue to support an effective generic drug approval process. (CSA Rep. 6, A-02; Reaffirmed: CSAPH Rep. 2, A-07; Reaffirmation A-08; Reaffirmation A-09; Reaffirmed in lieu of Res. 525, A-10; Reaffirmed in lieu of Res. 224, I-14; Reaffirmed in lieu of: Res. 922, I-18)

Managed Care Cost Containment Involving Prescription Drugs H-285.965
(1) Physicians who participate in managed care plans should maintain awareness of plan decisions about drug selection by staying informed about pharmacy and therapeutics (P&T) committee actions and by ongoing personal review of formulary composition. P&T committee members should include independent physician representatives. Mechanisms should be established for ongoing peer review of formulary policy. Physicians who perceive inappropriate influence on formulary development from pharmaceutical industry consolidation should notify the proper regulatory authorities.
(2) Physicians should be particularly vigilant to ensure that formulary decisions adequately reflect the needs of individual patients and that individual needs are not unfairly sacrificed by decisions based on the needs of the average patient. Physicians are ethically required to advocate for additions to the formulary when they think patients would benefit materially and for exceptions to the formulary on a case-by-case basis when justified by the health care needs of particular patients. Mechanisms to appeal formulary exclusions should be established. Other cost-containment mechanisms, including prescription caps and prior authorization, should not unduly burden physicians or patients in accessing optimal drug therapy.

(3) Limits should be placed on the extent to which managed care plans use incentives or pressures to lower prescription drug costs. Financial incentives are permissible when they promote cost-effectiveness, not when they require withholding medically necessary care. Physicians must not be made to feel that they jeopardize their compensation or participation in a managed care plan if they prescribe drugs that are necessary for their patients but that may also be costly. There should be limits on the magnitude of financial incentives, incentives should be calculated according to the practices of a sizable group of physicians rather than on an individual basis, and incentives based on quality of care rather than cost of care should be used. Physician penalties for non-compliance with a managed care formulary in the form of deductions from withholds or direct charges are inappropriate and unduly coercive. Prescriptions should not be changed without physicians having a change to discuss the change with the patient.
(4) Managed care plans should develop and implement educational programs on cost-effective prescribing practices. Such initiatives are preferable to financial incentives or pressures by HMOs or hospitals, which can be ethically problematic.
(5) Patients must fully understand the methods used by their managed care plans to limit prescription drug costs. During enrollment, the plan must disclose the existence of formularies, the provisions for cases in which the physician prescribes a drug that is not included in the formulary and the incentives or other mechanisms used to encourage physicians to consider costs when prescribing drugs. In addition, plans should disclose any relationships with pharmaceutical benefit management companies or pharmaceutical companies that could influence the composition of the formulary. If physicians exhaust all avenues to secure a formulary exception for a significantly advantageous drug, they are still obligated to disclose the option of the more beneficial, more costly drug to the patient, so that the patient can decide whether to pay out-of-pocket.
(6) Research should be conducted to assess the impact of formulary constraints and other approaches to containing prescription drug costs on patient welfare.
(7) Our AMA urges pharmacists to contact the prescribing physician if a prescription written by the physician violates the managed care drug formulary under which the patient is covered, so that the physician has an opportunity to prescribe an alternative drug, which may be on the formulary.
(8) When pharmacists, insurance companies, or pharmaceutical benefit management companies communicate directly with physicians or patients regarding prescriptions, the reason for the intervention should be clearly identified as being either educational or economic in nature.
(9) Our AMA will develop model legislation which prohibits managed care entities, and other insurers, from retaliating against a physician by disciplining, or withholding otherwise allowable payment because they have prescribed drugs to patients which are not on the insurer's formulary, or have appealed a plan's denial of coverage for the prescribed drug.
(10) Our AMA urges health plans including managed care organizations to provide physicians and patients with their medication formularies through multiple media, including Internet posting
(11) In the case where Internet posting of the formulary is not available and the formulary is changed, coverage should be maintained until a new formulary is distributed
(12) For physicians who do not have electronic access, hard copies must be available. (CEJA Rep. 2, A-95; Res. 734, A-97; Appended by Res. 524 and Sub. Res.714, A-98; Reaffirmed: Res. 511, A-99; Modified: Res. 501, Reaffirmed: Res. 123 and 524, A-00; Modified: Res. 509, I-00; Reaffirmed: CMS Rep. 6, A-03; Reaffirmation I-04; Reaffirmed: Sub. Res. 529, A-05; Reaffirmation A-08; Reaffirmation A-10; Reaffirmed in lieu of Res. 822, I-11; Reaffirmation A-14; Reaffirmed: CMS Rep. 05, A-19; Reaffirmed: CMS Rep. 6, I-2)

Clinical Practice Guidelines and Clinical Quality Improvement Activities H-320.949
Our American Medical Association (AMA) adopts the following principles for the development and application of utilization management guidelines:

1. The criteria or guidelines used for utilization management shall be based upon sound clinical evidence and consider, among other factors, the safety and effectiveness of diagnosis or treatment, and must be age appropriate.
2. These utilization management guidelines and the criteria for their application shall be developed with the participation of practicing physicians.
3. Appropriate data, clinical evidence, and review criteria shall be available on request.
4. When used by health plans or health care organizations, such criteria must allow variation and take into account individual patient differences and the resources available in the particular health care system or setting to provide recommended care. The guidelines should also include a statement of their limitations and restrictions.
5. Patients and physicians shall be able to appeal decisions based on the application of utilization management guidelines.
6. The competence of non-physician reviewers and the availability of same-specialty peer review must be delineated and assured.
7. Maintaining the best interests of the patient uppermost, the final decision to discharge a patient, or any other patient management decision, remains the prerogative of the physician. (BOT Rep. 6, A-99; Reaffirmed: Res. 820, A-00; Reaffirmed: CSAPH Rep. 1, A-10; Reaffirmed: Res. 708, A-16; Reaffirmed: CMS Rep. 08, A-17; Reaffirmed: CMS Rep. 4, A-21)

Third Party Payer Quantity Limits H-185.942

1. Our American Medical Association (AMA) supports the protection of the patient-physician relationship from interference by payers and Pharmacy Benefit Managers (PBMs) via various utilization control mechanisms, including medication and testing and treatment supply quantity limits.
2. Our AMA will work with third party payers and PBMs to ensure that if they use quantity limits for prescription drugs or testing and treatment supplies, an exceptions process must be in place to ensure that patients can access higher or lower quantities of prescription drugs or testing and treatment supplies if medically necessary, and that any such process should place a minimum burden upon patients, physicians and their staff.
3. Our AMA supports interested states legislative efforts and federal action and will develop model state legislation to ensure that third party payers or PBMs that institute quantity limits for prescription drugs or testing and treatment supplies include an exceptions process so that patients can access higher or lower quantities of prescription drugs or testing and treatment supplies if medically necessary, including provisions such as the following:
    - physicians can specify limited supplies of medications during initial trials of a medication, or if a larger quantity of medication would expose an at-risk patient to potential harm (e.g., opioids, benzodiazepines, or psychostimulants)
    - physicians can appeal adverse determinations regarding quantity limitations;
    - payers must provide an easily accessible list of all medications and testing and treatment supplies with quantity limits and the requirements for the exception process on the payer's Web site;
    - payers must indicate, what, if any, clinical criteria (e.g., evidence-based guidelines, FDA label, scientific literature) support the plan's quantity limitations;
    - physicians with specialized qualifications may not be subject to quantity limits;
    - payers cannot charge patients for an additional co-pay if an exception request for a higher medication or testing and treatment supply quantity has been approved based on medical necessity;
    - payer decisions on exception, and subsequent appeal requests, of quantity limits must be made within two working days in non urgent situations and one working day in urgent cases; and

- physicians or patients can submit any denied appeals to an independent review body for a final, binding decision. (BOT Rep. 12, A-12; Reaffirmation: I-17; Modified: CMS Rep. 05, A-23)

Drug Issues in Health System Reform H-100.964

1. Our American Medical Association (AMA) consistent with AMA Policy H-165.925, supports coverage of prescription drugs, including insulin, in the AMA standard benefits package.
2. Our AMA supports consumer choice of at least two options for their pharmaceutical benefits program. This must include a fee-for-service option where restrictions on patient access and physician autonomy to prescribe any FDA-approved medication are prohibited.
3. Our AMA reaffirms AMA Policy H-110.997, supporting the freedom of physicians to use either generic or brand name pharmaceuticals in prescribing drugs for their patients and encourage physicians to supplement medical judgments with cost considerations in making these choices.
4. Our AMA supports a managed pharmaceutical benefits option with market-driven mechanisms to control costs, provided cost control strategies satisfy AMA criteria defined in AMA Policy H-110.997 and that drug formulary systems employed are consistent with standards defined in AMA Policy H-125.991.
5. Our AMA supports prospective and retrospective drug utilization review (DUR) as a quality assurance component of pharmaceutical benefits programs, provided the DUR program is consistent with Principles of Drug Use Review defined in AMA Policy H-120.978.
6. Our AMA encourages physicians to counsel their patients about their prescription medicines and when appropriate, to supplement with written information; and supports the physician's role as the "learned intermediary" about prescription drugs.
    a. Our AMA encourages physicians to incorporate medication reviews, including discussions about drug interactions and side effects, as part of routine office-based practice, which may include the use of medication cards to facilitate this process. Medication cards should be regarded as a supplement, and not a replacement, for other information provided by the physician to the patient via oral counseling and, as appropriate, other written information.
7. Our AMA reaffirms AMA Policy H-120.991, supporting the voluntary time-honored practice of physicians providing drug samples to selected patients at no charge, and to oppose legislation or regulation whose intent is to ban drug sampling.
8. Our AMA supports CEJA's opinion that physicians have an ethical obligation to report adverse drug or device events; supports the FDA's MedWatch voluntary adverse event reporting program; and supports FDA efforts to prevent public disclosure of patient and reporter identities.
9. Our AMA opposes legislation that would mandate reporting of adverse drug and device events by physicians that would result in public disclosure of patient or reporter identities.
10. Our AMA reaffirms AMA Policy H-120.988, supporting physician prescribing of FDA-approved drugs for unlabeled indications when such use is based upon sound scientific evidence and sound medical opinion, and supporting third party payer reimbursement for drugs prescribed for medically accepted unlabeled uses.
11. Our AMA reaffirms AMA Policy H-100.989, supporting the present classification of drugs as either prescription or over-the-counter items and opposing the establishment of a pharmacist-only third (transitional) class of drugs. (BOT Rep. 53, A-94; Reaffirmed by Sub. Res. 501, A-95; Reaffirmed by CSA Rep. 3, A-97; Amended: CSA Rep. 2, I-98; Renumbered: CMS Rep. 7, I-05; Reaffirmation A-10; Reaffirmed in lieu of Res. 201, I-11; Modified: CMS Rep. 1, A-21)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 101
(A-25)

Introduced by: American Academy of Child and Adolescent Psychiatry, American Society of Addiction Medicine

Subject: Uniform Adoption of Service Intensity Tools to Support Medical Decision-making and Service Gap Analysis

Referred to: Reference Committee A

Whereas, our nation is in the midst of a mental health and an opioid crisis; and

Whereas, most insurers are not in compliance with state and federal parity law[1]; and

Whereas, health plans utilize proprietary service intensity decision-making criteria for medical necessity and utilization management[2]; and

Whereas, there exist evidence-based, nationally-recognized service intensity assessment instruments and level of care placement criteria consistent with generally accepted mental health and substance use disorder that determine the level of treatment services needed for a patient based on a clinically derived and empirically tested service intensity algorithm standards of care[3]; and

Whereas, since 2020, four states have passed legislation requiring health plans to adopt and utilize evidence-based, nationally recognized service intensity assessment instruments and level of care placement criteria consistent with generally accepted mental health and substance use disorder standards of care developed by professional medical associations[4]; and

Whereas, gaps in the mental health and addiction service array exist in communities across America issues; and

Whereas, utilization of nationally recognized service intensity assessment instruments and level of care placement criteria consistent with generally accepted mental health and substance use disorder standards of care can help identify gaps in the continuum of mental health and addiction treatment services in communities and certain patient populations; therefore be it

RESOLVED, that our American Medical Association advocate that federal and state policymakers utilize evidence-based nationally recognized service intensity assessment instruments and level of care placement criteria developed by professional medical associations to require coverage of treatment and recovery services in mental health and substance use disorder treatment. (Directive to Take Action)

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

Received: 4/21/2025

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2. Rogers, Hanna-Alise (2022, December 21) *Behavioral Health Benefit Coverage and Wit v. United Behavioral Health*. (CRS Repot No. LSB10881). https://crsreports.congress.gov/product/pdf/LSB/LSB10881
3. Parks, J. et al (2022). *Toward a National Standard for Service Intensity Assessment and Planning for Mental Health Care: The Level of Care Utilization System Family of Tools.* https://www.aacap.org/App_Themes/AACAP/Docs/clinical_practice_center/23.11.13_MDI_LOCUS-White-Paper.pdf
4. Pearsall, M., Wilkniss, S. (2023). *Increasing Access to Behavioral Health Services: Opportunities at the State and Federal Level. National Academy for State Health Policy.* https://nashp.org/increasing-access-to-behavioral-health-services-opportunities-at-the-state-and-federal-level/

RELEVANT AMA POLICY

H-285.920 Criteria for Level of Care Status

1. Our American Medical Association support the development and use of level of care guidelines that meet the following criteria:
   a. Level of care guidelines should function as guidelines only, and should not be used as requirements for all instances and cases. That is, level of care guidelines must allow for appropriate physician autonomy in making responsible medical decisions.
   b. Level of care guidelines should acknowledge the complexity of care for each patient under the particular set of clinical circumstances.
   c. Level of care guidelines should apply to all facility support systems so that patients are not assigned a level of care that slows or stalls their treatment.
   d. Level of care guidelines should be developed under the direction of actively practicing physicians.
   e. Level of care guidelines should be developed based on individual patient severity of illness and intensity of service.
   f. Level of care guidelines should be validated through standard data quality control checks and professional advisory consensus.
   g. Level of care guidelines should be reviewed and updated.
   h. Level of care guidelines should allow for a timely appeal process.
2. It is the policy of the AMA that private sector accrediting organizations, where applicable, should adopt standards that are consistent with AMA criteria for the development and use of level of care status guidelines.
   [CMS Rep. 5, I-01; Reaffirmed: CMS Rep. 7, A-11; Reaffirmed: CMS Rep. 1, A-21]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution:102
(A-25)

Introduced by: American College of Chest Physicians

Subject: Access to Single Maintenance and Reliever Therapy for Asthma

Referred to: Reference Committee A

Whereas, asthma inhaler adherence is as low as 22 to 63% in patients prescribed an inhaled corticosteroid maintenance inhaler with a short-acting beta-agonist reliever inhaler: and

Whereas, 60% of asthma-related hospitalizations can be attributed to poor inhaler adherence: and

Whereas, Single Maintenance and Reliever Therapy (SMART) utilizes a combined inhaled corticosteroid/long-acting beta-agonist inhaler for both maintenance and reliever therapy: and

Whereas, SMART has been shown to improve inhaler adherence, reduce asthma exacerbations, reduce emergency room visits, and reduce hospitalizations: and

Whereas, the Global Initiative for Asthma (GINA) and the National Asthma Education and Prevention Program (NAEPP) recommend SMART for patients with moderate to severe asthma; and

Whereas, SMART may require patient to use more medication than a typical 30-day supply and may require up to three inhalers per month; and

Whereas, at least 33 states have quantity limits in their Medicaid programs more restrictive than three inhalers per month for inhaled corticosteroid/long-acting beta-agonist combination inhalers; and

Whereas, commercial insurers have quantity limits as low as 1 inhaled corticosteroid/long-acting beta-agonist combination inhalers per 30-day period; and

Whereas, SMART medications are currently covered in 45 state Medicaid plans, with 35 states requiring a copay to access SMART medications in some or all plans; and

Whereas, copays as low as $1 to $5 are associated with reduced adherence and increased use of costlier services, such as the emergency room; therefore be it

RESOLVED, that our American Medical Association work with the Centers for Medicare and Medicaid Services and major national insurance carriers to remove or increase quantity limits for inhaled corticosteroid/long-acting beta-agonist combination inhalers when prescribed in accordance with evidence-based guidelines (Directive to Take Action); and be it further

RESOLVED, that our AMA work with state medical associations to advocate for the removal of copays for asthma inhalers in all state Medicaid plans. (Directive to Take Action)

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

Received: 4/21/2025

RELEVANT AMA POLICY

Patient Access to Asthma Medications H-185.906
Our American Medical Association supports efforts to ensure access to and insurance coverage, including Medicaid coverage, and reduce cost-sharing for metered-dose **inhaler** formulations for children and others who require it for optimal medication administration.

Asthma Control H-160.932
1. Our American Medical Association encourages physicians to make appropriate use of evidence-based guidelines, including those contained in the National Asthma Education and Prevention Program Coordinating Committee Expert Panel Working Group 2020 Focused Updates to the Asthma Management Guidelines.
2. Our AMA encourages physicians to provide self-management education tailored to the literacy level of the patient by teaching and reinforcing appropriate self-monitoring, the use of a written asthma action plan, taking medication correctly, and avoiding environmental factors that worsen asthma.
3. Our AMA encourages physicians to incorporate the four components of care (assessment and monitoring; education; control of environmental factors and comorbid conditions; and appropriate medication selection and use).
4. Our AMA will, in collaboration with interested parties and organizations, develop content to help physicians talk through the different asthma control options and their known economic costs and environmental impacts.

Third Party Payer Quantity Limits H-185.942
1. Our American Medical Association supports the protection of the patient-physician relationship from interference by payers and Pharmacy Benefit Managers (PBMs) via various utilization control mechanisms, including medication and testing and treatment supply quantity limits.

2. Our AMA will work with third party payers and PBMs to ensure that if they use quantity limits for prescription drugs or testing and treatment supplies, an exceptions process must be in place to ensure that patients can access higher or lower quantities of prescription drugs or testing and treatment supplies if medically necessary, and that any such process should place a minimum burden upon patients, physicians and their staff.

3. Our AMA supports interested states legislative efforts and federal action and will develop model state legislation to ensure that third party payers or PBMs that institute quantity limits for prescription drugs or testing and treatment supplies include an exceptions process so that patients can access higher or lower quantities of prescription drugs or testing and treatment supplies if medically necessary, including provisions such as the following:

    - physicians can specify limited supplies of medications during initial trials of a medication, or if a larger quantity of medication would expose an at-risk patient to potential harm (e.g., opioids, benzodiazepines, or psychostimulants)
    - physicians can appeal adverse determinations regarding quantity limitations;
    - payers must provide an easily accessible list of all medications and testing and treatment supplies with quantity limits and the requirements for the exception process on the payer's Web site;
    - payers must indicate, what, if any, clinical criteria (e.g., evidence-based guidelines, FDA label, scientific literature) support the plan's quantity limitations;
    - physicians with specialized qualifications may not be subject to quantity limits;

- payers cannot charge patients for an additional co-pay if an exception request for a higher medication or testing and treatment supply quantity has been approved based on medical necessity;
- payer decisions on exception, and subsequent appeal requests, of quantity limits must be made within two working days in non urgent situations and one working day in urgent cases; and
- physicians or patients can submit any denied appeals to an independent review body for a final, binding decision.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 103
(A-25)

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

Subject: Inadequate Reimbursement for Biosimilars

Referred to: Reference Committee A

Whereas, biologics are vitally important therapeutic options for patients with certain chronic diseases; and

Whereas, biosimilars have the potential to promote a sustainable, robust market that encourages competition, cost savings, and better patient care; and

Whereas, insurers and their pharmacy benefit managers (PBMs) have exerted disproportionate sway on drug formularies by pressuring pharmaceutical companies to offer significant rebates in exchange for preferred formulary placement, including “fail first” status; and

Whereas, these rebates are reflected in manufacturers ’quarterly Average Sales Price (ASP) reporting to the Centers for Medicare and Medicaid Services (CMS), and thus artificially lower the ASP to the point that many providers ’acquisition costs substantially exceed Medicare and other private health plan payments; and

Whereas, the ASP for most biosimilars continues to fall short of many providers ’acquisition costs – even for the earliest biosimilars – forcing providers to either administer the drug at a financial loss, transfer care to another site of service (e.g. a hospital), or switch the patient’s therapy when they are stable on current therapy, which may be further complicated by “step therapy” requirements imposed by payers; and

Whereas, the Inflation Reduction Act’s temporary increase of the ASP “add-on” from 6% to 8% does not go nearly far enough to ensure that physicians are not infusing biosimilars at a loss; and

Whereas, biosimilars will never be fully integrated into the healthcare system and many patients will be left without access to life-saving therapies until Congress removes manufacturer rebates from the ASP; therefore be it

RESOLVED, that our American Medical Association work with stakeholders to advocate for legislation that will Amend Section 1847A(c)(3) of the Social Security Act to permanently remove manufacturer rebates from the ASP methodology for biologics. (Directive to Take Action)

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

Received: 4/22/2025

RELEVANT AMA POLICY

Biosimilar Coverage Structures H-100.940

1) Our American Medical Association supports the development and implementation of strategies to incentivize the use of lower cost biosimilars when safe, fiscally prudent for the patient and not financially disadvantageous to the clinical practice, clinically appropriate, and agreed upon as the best course of treatment by the patient and physician.
2) Our AMA advocates to eliminate acquisition cost and reimbursement disparities for in-office biosimilar treatment across diverse treatment locations.
3) Our AMA supports patient education regarding biosimilars and their safety and efficacy.

CMS Rep. 04, I-24

Reforming Medicare Part B Drug Reimbursement to Promote Patient Affordability and Physician Practice Sustainability H-330.864

1. Our American Medical Association supports the creation of a new reimbursement model for Part B drugs that;

    a. disentangles reimbursement from the drug price, or any weighted market average of the drug price, by reimbursing physicians for the actual cost of the drug; and

    b. ensures adequate compensation for the cost of acquisition, inventory, storage, and administration of clinically-administered drugs that is based on physician costs, not a percent of the drug price.

2. Our AMA maintains the principles that any revised Part B reimbursement models should promote practice viability, especially for small physician practices, practices in rural and/or underserved areas, and practices with a significant proportion of Medicare patients, to promote continued treatment access for patients. Res. 221, A-24

Cuts in Medicare Outpatient Infusion Services D-330.960

1. Our AMA will actively support efforts to seek legislation to ensure that Medicare payments for drugs fully cover the physician's acquisition, inventory and carrying cost and that Medicare payments for drug administration and related services are adequate to ensure continued patient access to outpatient infusion services.

2. Our AMA will continue strong advocacy efforts working with relevant national medical specialty societies to ensure adequate physician payment for Part B drugs and patient access to biologic and pharmacologic agents.

Res. 926, I-03Reaffirmed and Modified: CMS Rep. 3, I-08Reaffirmation A-15Reaffirmed: CMS Rep. 10, A-16Reaffirmation: I-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 104
(A-25)

Introduced by: Daniel H. Johnson, Jr, MD

Subject: Study of Whether the HSA Model Could Become an Option for Medicaid Beneficiaries

Referred to: Reference Committee A

Whereas, one in five Americans are enrolled in Medicaid; and

Whereas, states have some limited flexibility in administering the benefits of Medicaid; therefore be it

RESOLVED, that our American Medical Association conduct a thorough study to determine whether subsidies of low-income beneficiaries enrolled in Medicaid could be applied using the HSA model as one option in a more pluralistic system of Medicaid insurance plan design, with a report back at the I-25 Meeting of our House of Delegates. (Directive to Take Action)

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

Received: 4/15/25

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 105
(A-25)

Introduced by: Florida, New York, Maryland, Mississippi, Tennessee, New Jersey, West Virginia

Subject: Development of an Educational Resource on Opting Out of Medicare for Physicians

Referred to: Reference Committee A

Whereas, recent Medicare reimbursement cuts have created significant financial challenges for physicians, particularly in maintaining viable practices and delivering quality care; and

Whereas, physicians participating in Medicare face increasing administrative burdens and financial strain due to payment rates that fail to keep pace with inflation and rising practice costs; and

Whereas, many physicians are unaware of the process and implications of opting out of Medicare as a means to explore alternative practice models; and

Whereas, the American Medical Association is committed to supporting physicians' ability to make informed decisions about their participation in federal programs; therefore be it

RESOLVED, that our American Medical Association create and maintain a prominently featured page on its website dedicated to providing clear, comprehensive information on the process of opting out of Medicare, including:

1. A step-by-step guide on how to opt out of Medicare, including sample documents and timelines;
2. An overview of the legal, financial, and ethical considerations for physicians considering this option;
3. Information on alternative payment models and strategies to ensure continuity of patient care; and
4. Frequently Asked Questions (FAQs) to address common concerns and scenarios physicians may face when opting out of Medicare (Directive to Take Action); and be it further

RESOLVED, that our AMA ensure this educational resource is easily accessible via the AMA website's search function and is regularly updated to reflect changes in Medicare policies and regulations (Directive to Take Action); and be it further

RESOLVED, that our AMA conduct outreach efforts to promote awareness of this resource among its members and provide additional support for physicians exploring alternative practice models. (Directive to Take Action)

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

Received: 4/21/2025

RELEVANT AMA POLICY

D-390.961 Medicare Physician Payment Reform
1. Our American Medical Association will continue to advocate for adequate investment in comparative effectiveness research that is consistent with AMA Policy H-460.909, and in effective methods of translating research findings relating to quality of care into clinical practice.
2. Our AMA will advocate for better methods of data collection, development, reporting and dissemination of practical clinical decision-making tools for patients and physicians, and rapid, confidential feedback about comparative practice patterns to physicians to enable them to make the best use of the information at the local and specialty level.
3. Our AMA urges physician organizations, including state medical associations and national medical specialty societies, to develop and recruit groups of physicians to experiment with diverse ideas for achieving Medicare savings, including the development of organizational structures that maximize participation opportunities for physician practices.
4. Our AMA will continue to advocate for changes in antitrust and other laws that would facilitate shared-savings arrangements, and enable solo and small group practices to make innovations that could enhance care coordination and increase the value of health care delivery.
5. Our AMA supports local innovation and funding of demonstration projects that allow physicians to benefit from increased efficiencies based on practice changes that best fit local needs.
6. Our AMA will work with appropriate public and private officials and advisory bodies to ensure that bundled payments, if implemented, do not lead to hospital-controlled payments to physicians. [CMS 6, A-09 Reaffirmation A-10 Reaffirmation I-13 CMS Rep. 5, I-16 Reaffirmation: A-22]

H-390.849 Physician Payment Reform
1. Our American Medical Association will advocate for the development and adoption of physician payment reforms that adhere to the following principles:
a. Promote improved patient access to high-quality, cost-effective care.
b. Be designed with input from the physician community.
c. Ensure that physicians have an appropriate level of decision-making authority over bonus or shared-savings distributions.
d. Not require budget neutrality within Medicare Part B.
e. Be based on payment rates that are sufficient to cover the full cost of sustainable medical practice.
f. Ensure reasonable implementation timeframes, with adequate support available to assist physicians with the implementation process.
g. Make participation options available for varying practice sizes, patient mixes, specialties, and locales.
h. Use adequate risk adjustment methodologies.
i. Incorporate incentives large enough to merit additional investments by physicians.
j. Provide patients with information and incentives to encourage appropriate utilization of medical care, including the use of preventive services and self-management protocols.
k. Provide a mechanism to ensure that budget baselines are reevaluated at regular intervals and are reflective of trends in service utilization.
l. Attribution processes should emphasize voluntary agreements between patients and physicians, minimize the use of algorithms or formulas, provide attribution information to physicians in a timely manner, and include formal mechanisms to allow physicians to verify and correct attribution data as necessary.
m. Include ongoing evaluation processes to monitor the success of the reforms in achieving the goals of improving patient care and increasing the value of health care services.
2. Our AMA opposes bundling of payments in ways that limit medically necessary care, including institutional post-acute care, or otherwise interfere with a physician's ability to provide high quality care to patients.
3. Our AMA supports payment methodologies that redistribute Medicare payments among providers based on outcomes (including functional improvements, if appropriate), quality and risk-adjustment measures only if measures are scientifically valid, reliable, and consistent with national medical specialty society- developed clinical guidelines/standards.
4. Our AMA will continue to monitor health care delivery and physician payment reform activities and provide resources to help physicians understand and participate in these initiatives.

5. Our AMA supports the development of a public-private partnership for the purpose of validating statistical models used for risk adjustment. [CMS Rep. 6, A-09 Reaffirmation A-10 Appended: Res. 829, I-10 Appended: CMS Rep. 1, A-11 Appended: CMS Rep. 4, A-11 Reaffirmed in lieu of Res. 119, A-12 Reaffirmed in lieu of Res. 122, A-12 Modified: CMS Rep. 6, A-13 Reaffirmation I-15 Reaffirmation: A-16 Reaffirmed in lieu of: Res. 712, A-17 Reaffirmed: BOT Action in response to referred for decision: Res. 237, I-17 Reaffirmation: A-19 Reaffirmed: BOT Action in response to referred for decision Res. 111, A-19 Reaffirmed: BOT Action in response to referred for decision Res. 132, A-19 Reaffirmed: Res. 212, I-21 Reaffirmed: Res. 240, A-22 Reaffirmation: A-22 Modified: CMS Rep. 04, A-23 Reaffirmed: Res. 214, A-23 Reaffirmation: A-23]

D-385.945 Advocacy and Action for a Sustainable Medical Care System
1. Our American Medical Association will declare Medicare physician payment reform as an urgent advocacy and legislative priority for our AMA.
2. Our AMA will prioritize significant increases in funding for federal and state advocacy budgets specifically allocated to achieve Medicare physician payment reform to ensure that physician payments are updated annually at least equal to the annual percentage increase in the Medicare Economic Index.
3. Our AMA Board of Trustees will report back to the House of Delegates at each annual and interim meeting on the progress of our AMA in achieving Medicare payment reform until predictable, sustainable, fair physician payment is achieved. [Res. 214, A-23]

D-390.922 Physician Payment Reform and Equity
Our American Medical Association will implement a comprehensive advocacy campaign, including a sustained national media strategy engaging patients and physicians in promoting Medicare physician payment reform, to achieve enactment of reforms to the Medicare physician payment system consistent with AMA policy and in accord with the principles (Characteristics of a Rational Medicare Payment System) endorsed by over 120 state and medical specialty Federation of Medicine members. [Res. 240, A-22 Modified: Res. 214, A-23]

D-390.946 Sequestration
a. Our American Medical Association will continue to prioritize and actively pursue vigorous and strategic advocacy to prevent sequester and other cuts in Medicare payments due to take effect on January 1, 2022.
b. Our AMA will seek positive inflation-adjusted annual physician payment updates that keep pace with rising practice costs;
c. Our AMA will ensure Medicare physician payments are sufficient to safeguard beneficiary access to care.
d. Our AMA will work towards the elimination of budget neutrality requirements within Medicare Part B.
e. Our AMA will eliminate, replace, or supplement budget neutrality in MIPS with positive incentive payments.
f. Our AMA will advocate strongly to the current administration and Congress that additional funds must be put into the Medicare physician payment system to address increasing costs of physician practices, and that continued budget neutrality is not an option.
g. Our AMA will advocate for payment policies that allow the Centers for Medicare & Medicaid Services to retroactively adjust overestimates of volume of services. [Res. 212, I-21 Reaffirmed: Res. 240, A-22 Reaffirmed: CMS Rep. 02, A-23 Reaffirmed: Res. 214, A-23]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 106
(A-25)

Introduced by: Illinois

Subject: Advocating for All Payer Coverage for Custom Breast Prostheses for Patients with History of Mastectomy Secondary to Breast Cancer Treatment

Referred to: Reference Committee A

Whereas, treatment of breast cancer commonly includes a combination of surgery, chemotherapy, radiation therapy, and/or hormone therapy; and

Whereas, more than 100,000 women in the United States undergo some form of mastectomy to surgically treat breast cancer per year[1]; and

Whereas, patients who undergo mastectomy are often provided the option of breast reconstruction; and

Whereas, an estimated 25-50% of patients opt for breast reconstruction[2,3,4]; and

Whereas, patients who do not undergo breast reconstruction typically opt for a breast prosthesis; and

Whereas, women who use breast prostheses report that prostheses can increase confidence, enhance body image and self-esteem, and provide a sense of normalcy[5]; and

Whereas, the three main types of breast prostheses are leisure prostheses, silicone prostheses, and custom prostheses; and

Whereas, a leisure breast prosthesis is typically made of foam, fiberfill, polyester fiberfill, or beaded materials encased in a cloth shell; designed to slip into a pocketed mastectomy bra; and are lighter in weight which can be helpful for patients when exercising; and

Whereas, a silicone breast prosthesis is heavier, designed to wear inside a pocketed mastectomy bra, but are typically uncomfortable to wear in hot weather; and

Whereas, pocketed mastectomy bras are an added expense that patients must account for when purchasing leisure and silicone breast prostheses; and

Whereas, a custom breast prosthesis is worn directly on the chest wall and allows for a precise fit[6]; and

Whereas, benefits of custom breast prostheses include appropriate weight distribution; alleviation of stress and friction against sensitive areas of the chest wall; and a precise match of skin tone, breast shape, and areola size and color[7]; and

Whereas, alleviation of stress and friction along with a precise fit against the chest wall can be especially helpful, as patients may have scarring secondary to mastectomy or radiation therapy; and

Whereas, patients who wear custom breast prostheses also have less sweating and perceived dislodgement[8]; and

Whereas, patients report that, compared to conventional prostheses, custom prostheses were more satisfying, comfortable, easy to wear, and coupled with a sense of feeling less like a victim[9]; and

Whereas, medicare and some insurance companies do not cover custom breast prostheses[10,11,12]; and

Whereas, the wholesale cost of a breast prosthesis is $1,500[13], and the retail cost of a custom breast prosthesis can be as high $5,000[14] and

Whereas, custom breast prostheses evidently provide a better fit, comfort, and appearance; therefore be it

RESOLVED, that our American Medical Association work with all relevant medical specialty societies, third party payers, including CMS, and other national stakeholders as deemed appropriate to require third party payers to include reimbursement for custom breast prosthesis for patients who have had mastectomy secondary to breast cancer treatment. (Directive to Take Action)

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

Received: 4/16/2025

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RELEVANT AMA POLICY

Symptomatic and Supportive Care for Patients with Cancer H-55.999
Our AMA recognizes the need to ensure the highest standards of symptomatic, rehabilitative, and supportive care for patients with both cured and advanced cancer. The Association supports clinical research in evaluation of rehabilitative and palliative care procedures for the cancer patient, this to include such areas as pain control, relief of nausea and vomiting, management of complications of surgery, radiation and chemotherapy, appropriate hemotherapy, nutritional support, emotional support, rehabilitation, and the hospice concept. Our AMA actively encourages the implementation of continuing education of the practicing American physician regarding the most effective methodology for meeting the symptomatic, rehabilitative, supportive, and other human needs of the cancer patient.
CSA Rep. H, I-78; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: Sub. Res. 514, I-00; Modified: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 01, A-20

Breast Reconstruction H-55.973
Our AMA: (1) believes that reconstruction of the breast for post-treatment rehabilitation of patients with in situ or invasive breast neoplasm should be considered reconstructive surgery rather than aesthetic surgery; (2) supports education for physicians and breast cancer patients on breast reconstruction and its availability; (3) recommends that third party payers provide coverage and reimbursement for medically necessary breast cancer treatments including but not limited to prophylactic contralateral mastectomy and/or salpingo-oophorectomy; and (4) recognizes the validity of contralateral breast procedures needed for the achievement of symmetry in size and shape, and urges recognition of these ancillary procedures by Medicare and all other third parties for reimbursement when documentation of medical necessity is provided.
CCB/CLRPD Rep. 3, A-14; Modified: Res. 912, I-18

Quality Cancer Care Preservation Act H-330.897
Our AMA continues to support existing policy principles in evaluating legislative language on matters relating to Medicare reimbursement for physician acquisition and administration of prescription drugs.
BOT Action in response to referred for decision Res. 129, A-03; Reaffirmed: BOT Rep. 28, A-13; Reaffirmation A-15

Adequacy of Health Insurance Coverage Options H-165.846
1. Our AMA supports the following principles to guide in the evaluation of the adequacy of health insurance coverage options:
A. Any insurance pool or similar structure designed to enable access to age-appropriate health insurance coverage must include a wide variety of coverage options from which to choose.
B. Existing federal guidelines regarding types of health insurance coverage (e.g., Title 26 of the US Tax Code and Federal Employees Health Benefits Program [FEHBP] regulations) should be used as a reference when considering if a given plan would provide meaningful coverage.
C. Provisions must be made to assist individuals with low-incomes or unusually high medical costs in obtaining health insurance coverage and meeting cost-sharing obligations.
D. Mechanisms must be in place to educate patients and assist them in making informed choices, including ensuring transparency among all health plans regarding covered services, cost-sharing obligations, out-of-pocket limits and lifetime benefit caps, and excluded services.
2. Our AMA advocates that the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program be used as the model for any essential health benefits package for children.
3. Our AMA: (a) opposes the removal of categories from the essential health benefits (EHB) package and their associated protections against annual and lifetime limits, and out-of-pocket expenses; and (b) opposes waivers of EHB requirements that lead to the elimination of EHB categories and their associated protections against annual and lifetime limits, and out-of-pocket expenses.
CMS Rep. 7, A-07; Reaffirmation I-07; Reaffirmation A-09; Reaffirmed: Res. 103, A-09; Reaffirmation I-09; Reaffirmed: CMS Rep. 3, I-09; Reaffirmed: CMS Rep. 2, A-11; Appended: CMS Rep. 2, A-11;

Reaffirmed in lieu of Res. 109, A-12; Reaffirmed: CMS Rep. 1, I-12; Reaffirmed: CMS Rep. 3, A-13; Reaffirmed in lieu of Res. 812, I-13; Reaffirmed: CMS Rep. 6, I-14; Reaffirmed: CMS Rep. 6, I-15; Appended: CMS Rep. 04, I-17; Reaffirmed in lieu of: Res. 101, A-19

Insurance Coverage for Compression Stockings H-330.876
Our AMA supports Medicare payment for gradient compression stockings as prescribed by a physician under Medicare benefits coverage.
Res. 126, A-17

Third Party Responsibility for Payment H-185.981
Our AMA (1) will develop, with the assistance of the Blue Cross and Blue Shield Association, the Group Health Association of America, the Health Insurance Association of America, and other relevant health care organizations, guidelines for a standardized system of verifying eligibility for health benefits; (2) will assume a leadership role with these organizations in the development of guidelines for a standardized system of verifying eligibility for health benefits; and (3) following the development of such guidelines, will work with major insurers and managed care plans to promote the development of a standardized, national health benefits verification system based on the guidelines, which would include an obligation on the part of the insurer or managed care plan to pay physicians for any services rendered to patients whose eligibility for benefits have been verified erroneously.
Sub. Res. 721, A-92; Reaffirmed: Sub. Res. 828, A-99; Reaffirmation A-00; Reaffirmed: CMS Rep. 6, A-10; Reaffirmed: Sub. Res. 813, I-13

Reference Pricing H-185.935
Our AMA supports the appropriate use of reference pricing as a possible method of providing health insurance coverage of specific procedures, products or services, consistent with the following principles:
1. Practicing physicians must be actively involved in the identification of services that are appropriate for a reference pricing system.
2. Appropriate reference pricing strategies may be considered for elective services or procedures for which there is evidence of a significant variation in cost that does not correspond
to a variation in quality of care. Additional considerations include the relative complexity of the service, the potential for variation either across patients or during the course of a treatment, and the sufficient availability of providers in a geographic region.
3. Reference prices should be set at a level that reflects current market conditions and ensures that patients have access to a choice of providers. Prices should be reviewed annually and adjusted as necessary based on changes in market conditions.
4. Hospitals or facilities delivering services subject to reference pricing should avoid cost-shifting from one set of services to another.
5. Information about the services subject to reference pricing and the potential patient cost-sharing obligations must be fully transparent and easily accessible to patients and providers, both prior to and at the point of care. Educational materials should be made available to help patients and physicians understand the incentives and disincentives inherent in the reference pricing arrangement.
6. Insurance companies must notify patients of all services subject to reference pricing at the time of health plan enrollment. Patients must be indemnified against any additional charges associated with changes to reference pricing policies for the balance of the contract period.
7. Insurers that use reference pricing must develop and maintain systems that allow patients to effectively and appropriately compare prices among providers, including systems that help patients calculate their estimated costs for each provider prior to seeking care.
8. Plan sponsors should continually monitor and evaluate the effect of reference pricing policies on access to high quality patient care, and ensure that procedures are in place to make plan modifications as necessary.
CMS Rep. 3, I-14

Value-Based Insurance Design H-185.939
Our AMA supports flexibility in the design and implementation of value-based insurance design (VBID) programs, consistent with the following principles:
a. Value reflects the clinical benefit gained relative to the money spent. VBID explicitly considers the clinical benefit of a given service or treatment when determining cost-sharing structures or other benefit design elements.
b. Practicing physicians must be actively involved in the development of VBID programs. VBID program design related to specific medical/surgical conditions must involve appropriate specialists.
c. High-quality, evidence-based data must be used to support the development of any targeted benefit design. Treatments or services for which there is insufficient or inconclusive evidence about their clinical value should not be included in any targeted benefit design elements of a health plan.
d. The methodology and criteria used to determine high- or low-value services or treatments must be transparent and easily accessible to physicians and patients.
e. Coverage and cost-sharing policies must be transparent and easily accessible to physicians and patients. Educational materials should be made available to help patients and physicians understand the incentives and disincentives built into the plan design.
f. VBID should not restrict access to patient care. Designs can use incentives and disincentives to target specific services or treatments, but should not otherwise limit patient care choices.
g. Physicians retain the ultimate responsibility for directing the care of their patients. Plan designs that include higher cost-sharing or other disincentives to obtaining services designated as low-value must include an appeals process to enable patients to secure care recommended by their physicians, without incurring cost-sharing penalties.
h. Plan sponsors should ensure adequate resource capabilities to ensure effective implementation and ongoing evaluation of the plan designs they choose. Procedures must be in place to ensure VBID coverage rules are updated in accordance with evolving evidence.
i. VBID programs must be consistent with AMA Pay for Performance Principles and Guidelines (Policy H-450.947), and AMA policy on physician economic profiling and tiered, narrow or restricted networks (Policies H-450.941 and D-285.972).
CMS Rep. 2, A-13; Reaffirmed in lieu of Res. 122, A-15; Reaffirmed in lieu of: Res. 121, A-16; Reaffirmed: CMS Rep. 05, I-16; Reaffirmation I-16; Reaffirmed: Joint CMS/CSAPH Rep. 01, I-17; Reaffirmed: CMS Rep. 07, A-18; Reaffirmed: Joint CMS CSAPH Rep. 01, I-18; Reaffirmed: CMS Rep. 06, A-19

Oppose Local Coverage Determination for Lower Limb Prostheses H-330.882
Our AMA (1) opposes local coverage determinations on lower limb prostheses that undermine physician judgment and compromise patient access; and (2) will request that the Centers for Medicare and Medicaid Services expeditiously host a national meeting open to all interested parties to focus on appropriate standards for lower limb prostheses that optimize care for patients. Sub. Res. 818, I-15

Survivorship Care Plans H-55.969
Our American Medical Association supports the voluntary use of survivorship care plans for cancer survivors when deemed appropriate by a patient's treating physician and supports reimbursement for physician preparation of survivorship care plans for patients. Res. 108, A-15; Reaffirmation: A-18

Breast Implants H-525.984
Our AMA: (1) supports that individuals be fully informed about the risks and benefits associated with breast implants and that once fully informed the patient should have the right to choose; and (2) based on current scientific knowledge, supports the continued practice of breast augmentation or reconstruction with implants when indicated.
CSA Rep. M, I-91; Modified: Sunset Report, I-01; Reaffirmed: Res. 727, I-02; Modified: CSAPH Rep. 1, A-12; Modified: CSAPH Rep. 1, A-22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 107
(A-25)

Introduced by: Illinois

Subject: Advocating for All Payer Coverage of Reconstructive and Cosmetic Surgical Care Related to Cleft Lip and Palate

Referred to: Reference Committee A

Whereas, Children with cleft lip and palate (CLP) typically require extensive, multidisciplinary care, often utilizing more medical services for longer periods compared to unaffected children[1]; and

Whereas, There is no national standard governing the scope of these benefits, so each state determines the extent of coverage [1]; and

Whereas, In Illinois, individual or group policies of accident and health insurance covers for medically necessary care and treatment of CLP for individuals under the age of 19 [2]; and

Whereas, Many patients with CLP have osseous and dental abnormalities; and

Whereas, Facial abnormalities from CLP can significantly affect social development and psychosocial well-being during adolescence; and

Whereas Patients experience increased anxiety and depression; appearance-related distress; social and functional challenges such as public speaking, being photographed, or participating in school activities; and adverse effects on their peer relationships [3-11]; and

Whereas, Approximately 66% of adults with CLP are concerned about their oral and nasal appearance even after having initial reconstructive surgeries completed which impacts overall psychosocial well-being, leading to decreased self-esteem and impaired social interactions [3-11]; and

Whereas, Certain reparative procedures, such as orthognathic surgery, can only be performed after skeletal maturity and require associated orthodontic treatments, including the use of fixed appliances to align and level the teeth, establish proper occlusion, and prepare the dental arches for surgery[12-16]; and

Whereas, Patients are often only eligible for these procedures in late adolescence or early adulthood; and

Whereas, For example, to address maxillary hypoplasia, patients require orthognathic surgery to advance the maxilla and remedy malocclusion, providing patients with vast medical benefits including improved occlusion and function, enhanced airway function, and speech improvement [17-25]; and

Whereas, After the completion of orthognathic surgeries, revision rhinoplasty is typically the final stage of cleft care, especially for patients with unilateral cleft, to improve nasal structure, function, and aesthetics[26-28]; and

Whereas, These concerns may persist well beyond the age of 18 and warrant continued surgical care and coverage into adulthood [29-31]; and

Whereas, CLP reconstruction procedures (i.e., orthodontic work, orthognathic surgery, revision rhinoplasty, scar revision) address functional and aesthetic concerns which persist into adulthood, as facial growth and development continues to affect the outcomes of previous surgeries [26-28, 31, 32]; and

Whereas, Prior studies demonstrate that comprehensive, long-term treatment for CLP reduces overall healthcare costs by preventing further complications and improves long-term quality of life [33,34]; therefore, be it

RESOLVED, that our American Medical Association work with all relevant medical specialty societies, third party payers, including the Centers for Medicare and Medicaid Services and other national entities as deemed appropriate to require third party payers to include reimbursement for reconstructive medical services for the treatment of cleft lip and palate. (Directive to Take Action)

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

Received: 4/21/2025

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RELEVANT AMA POLICY

Definitions of "Cosmetic" and "Reconstructive" Surgery H-475.992
(1) Our AMA supports the following definitions of "cosmetic" and "reconstructive" surgery: Cosmetic surgery is performed to reshape normal structures of the body in order to improve the patient's appearance and self-esteem. Reconstructive surgery is performed on abnormal structures of the body, caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease. It is generally performed to improve function, but may also be done to approximate a normal appearance. (2) Our AMA encourages third party payers to use these definitions in determining services eligible for coverage under the plans they offer or administer. CMS Rep. F, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed, A-03; Reaffirmed: CMS Rep. 4, A-13

Coverage of Children's Deformities, Disfigurement and Congenital Defects H-185.967
(1)Our American Medical Association declares: (a) that treatment of a minor child's congenital or developmental deformity or disorder due to trauma or malignant disease should be covered by all insurers; (b) that such coverage shall include treatment which, in the opinion of the treating physician, is medically necessary to return the patient to a more normal appearance (even if the procedure does not materially affect the function of the body part being treated); and (c) that such insurability should be portable, i.e., not denied as a pre-existing condition if the patient's insurance coverage changes before treatment has been either initiated or completed. (2) Our AMA will advocate for appropriate funding for comprehensive dental coverage (including dental implants) for children with orofacial clefting. Sub. Res. 119, I-97Reaffirmed, A-03Reaffirmation A-05Reaffirmation A-08Appended: Res. 109, A-13Reaffirmed: CMS Rep. 01, A-23

Insurance Coverage for Adults with Childhood Diseases H-185.963
Our AMA: (1) urges public and private third party payers to increase access to health insurance products for adults with congenital and/or childhood diseases that are designed for the unique needs of this population; and (2) emphasizes that any health insurance product designed for adults with congenital and/or childhood diseases include the availability of specialized treatment options, medical services, medical equipment and pharmaceuticals, as well as the accessibility of an adequate number of physicians specializing in the care of this unique population CMS Rep. 2, I-99Modified and Reaffirmed: CMS Rep. 5, A-09Reaffirmed: CMS Rep. 01, A-19

Evaluating Health System Reform Proposals H-165.888
1. Our AMA will continue its efforts to ensure that health system reform proposals adhere to the following principles: (A) Physicians maintain primary ethical responsibility to advocate for their patients' interests and needs.(B) Unfair concentration of market power of payers is detrimental to patients and physicians, if patient freedom of choice or physician ability to select mode of practice is limited or denied. Single-payer systems clearly fall within such a definition and, consequently, should continue to be opposed by the AMA. Reform proposals should balance fairly the market power between payers and physicians or be opposed.(C) All health system reform proposals should include a valid estimate of implementation cost, based on all health care expenditures to be included in the reform; and supports the concept that all health system reform proposals should identify specifically what means of funding (including employer-mandated funding, general taxation, payroll or value-added taxation) will be used to pay for the reform proposal and what the impact will be. (D) All physicians participating in managed care plans and medical delivery systems must be able without threat of punitive action to comment on and present their positions on the plan's policies and procedures for medical review, quality assurance, grievance procedures, credentialing criteria, and other financial and administrative matters, including physician representation on the governing board and key committees of the plan. (E) Any national legislation for health system reform should include sufficient and continuing financial support for inner-city and rural hospitals, community health centers, clinics, special programs for special populations and other essential public health facilities that serve underserved populations that otherwise lack the financial means to pay for their health care. (F) Health system reform proposals and ultimate legislation should result in adequate resources to enable medical schools and residency

programs to produce an adequate supply and appropriate generalist/specialist mix of physicians to deliver patient care in a reformed health care system. (G) All civilian federal government employees, including Congress and the Administration, should be covered by any health care delivery system passed by Congress and signed by the President. (H) True health reform is impossible without true tort reform. 2. Our AMA supports health care reform that meets the needs of all Americans including people with injuries, congenital or acquired disabilities, and chronic conditions, and as such values function and its improvement as key outcomes to be specifically included in national health care reform legislation. 3. Our AMA supports health care reform that meets the needs of all Americans including people with mental illness and substance use / addiction disorders and will advocate for the inclusion of full parity for the treatment of mental illness and substance use / addiction disorders in all national health care reform legislation. 4. Our AMA supports health system reform alternatives that are consistent with AMA principles of pluralism, freedom of choice, freedom of practice, and universal access for patients. Res. 118, I-91 Res. 102, I-92 BOT Rep. NN, I-92 BOT Rep. S, A-93 Reaffirmed: Res. 135, A-93 Reaffirmed: BOT Reps. 25 and 40, I-93 Reaffirmed in lieu of Res. 714, I-93 Res. 130, I-93 Res. 316, I-93 Sub. Res. 718, I-93 Reaffirmed: CMS Rep. 5, I-93 Res. 124, A-94 Reaffirmed by BOT Rep. 1- I-94 CEJA Rep. 3, A-95 Reaffirmed: BOT Rep. 34, I-95 Reaffirmation A-00 Reaffirmation A-01 Reaffirmed: CMS Rep. 10, A-03 Reaffirmed: CME Rep. 2, A-03 Reaffirmed and Modified: CMS Rep. 5, A-04 Reaffirmed with change in title: CEJA Rep. 2, A-05 Consolidated: CMS Rep. 7, I-05 Reaffirmation I-07 Reaffirmed in lieu of Res. 113, A-08 Reaffirmation A-09 Res. 101, A-09 Sub. Res. 110, A-09 Res. 123, A-09 Reaffirmed in lieu of Res. 120, A-12 Reaffirmation: A-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 108
(A-25)

Introduced by: Indiana

Subject: Firearm Storage Diagnosis and Counseling Reimbursement

Referred to: Reference Committee A

Whereas, firearm-related injuries remain a leading cause of accidental death in children aged 0-17, are the leading cause of death in children aged 1-19, and are the most common cause of completed suicide. These death rates disproportionately affect people of color and are also true for Indiana where firearms were responsible for 1,211 deaths and 61% of completed suicides in 2022; and

Whereas, firearm storage counseling is widely agreed to be a critical intervention for firearm harm reduction and is recommended by multiple specialty organizations, including our American Medical Association; and

Whereas, several disorders and behaviors are recognized as warranting specific screening, diagnosis, and intervention, such as substance use disorders and tobacco use. These have specific diagnostic codes (such as F10.1 for Alcohol Abuse Disorder and Z72.0 for Tobacco Use) which help clarify illness severity for documentation, communicate risk factors between providers, allow for billing of pertinent services provided, and facilitate statistical health care data collection; and

Whereas, no ICD-10 diagnostic code currently exists for unsafe firearm storage. Counseling on unsafe firearm storage can only be documented using code Z71.89 for “Other Specific Counseling,” which includes “guns in the home counseling” but also encompasses over 100 other forms of counseling from Accutane and circumcisions to asthma and routine vaccination; and

Whereas, Current Procedural Terminology (CPT) codes exist for the reimbursement of specific interventions addressing diseases and social determinants of health such as alcohol abuse screening and counseling (CPT codes 99408-99409) and tobacco cessation counseling (CPT codes 99406-99407) including requirements on the type and duration of intervention specific to their diagnoses; and

Whereas, no CPT code currently exists specific to firearm storage counseling. CPT codes 99401-99404 cover “preventive medicine counseling” and can be used but have no requirements specific to firearm storage counseling and mandate a minimum of 8 minutes of counseling which is inappropriate for most firearm counseling; and

Whereas, improving the management of unsafe firearm storage requires enabling its appropriate diagnosis by providers and incentivizing counselling interventions; therefore be it

RESOLVED, that our American Medical Association advocate for the creation of an ICD-10 code specifically designating counseling for firearm storage and a new Current Procedural Terminology coding, which specifically encompasses the provision of Firearm Storage

Counseling, its minimum requirements for qualification, and its reimbursement. (Directive to Take Action)

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

Received: 4/16/25

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 109
(A-25)

Introduced by: Indiana

Subject: Medicare Advantage Plans Double Standard

Referred to: Reference Committee A

Whereas, according to Medicare Advantage and Part D Final Rule (CMS-4201-F), Medicare states that only “coverage criteria based on current evidence in widely used treatment guidelines or clinical literature” may be used to determine insurance company payment to hospitals for the care they provide; and

Whereas, Medicare Advantage plans treat hospitals with a Medicare Advantage plan contract differently than hospitals without a contract; and

Whereas, Medicare Advantage plan denials on hospitals without a Medicare Advantage contract go through five different levels of appeal which include neutral Medicare auditors; and

Whereas, Medicare Advantage plan denials for hospitals contracted with a Medicare Advantage plan are processed by Medicare Advantage plan employees or their subcontractors with limited external oversight; and

Whereas, some of these denials by Medicare Advantage plan employees no longer follow sound scientific principles or the standard of care; and

Whereas, Medicare Advantage plans profit by these unsupervised denials at the expense of hospitals and physicians; and

Whereas, hospitals serving in medically underserved areas including rural hospitals are often forced to choose between terminating contracts with Medicare Advantage plans that are abusing the denials process or leaving their patients with costly out-of-network coverage; therefore be it

RESOLVED, that our American Medical Association seek legislation to require all payors, including Medicare Advantage plans, to use uniform payment denial appeals processes, which includes external review, for all appeals regardless of whether the physician or provider is contracted with the payor. (Directive to Take Action)

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

Received: 4/16/25

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 110
(A-25)

Introduced by: Louisiana

Subject: Study of the Federal Employee Health Benefit Plan (FEHBP)

Referred to: Reference Committee A

Whereas, the Federal Employee Health Benefit Plan (FEHBP) offers an expanded array of health insurance options for its beneficiaries; and

Whereas, FEHBP beneficiaries have the annual opportunity to switch plans if dissatisfied with the previous choice; and

Whereas, the FEHBP provides employees with the same premium support no matter which plan they choose; therefore be it

RESOLVED, that our American Medical Association conduct a thorough study of the FEHBP to understand the successes and failures, strengths and weaknesses of the program (Directive to Take Action); and be it further

RESOLVED, that our AMA determines how the FEHBP compares with AMA policy H-165.881 to see whether it might be an appropriate model to achieve private and public health system reform, with a report back to the I-25 Meeting of our House of Delegates. (Directive to Take Action)

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

Received: 4/17/25

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 111
(A-25)

Introduced by: Mississippi

Subject: New Reimbursement System Needed for Rural Hospital Survival

Referred to: Reference Committee A

Whereas, rural patients require hospitalization by their physicians and deserve to be treated close to their communities; and

Whereas, the current hospital reimbursement system is adversarial to rural hospitals and communities and negatively impacting their access to healthcare, specifically acute hospitalization; and

Whereas, Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs), which are located in underserved and rural areas, qualify for specific reimbursement systems under Medicare and Medicaid; and

Whereas, current efforts to support rural hospitals, such as Critical Care status and Rural Emergency Hospital designation require the closing of acute hospital beds, which results in rural residents having to receive basic acute care long distances from their homes; and

Whereas, rural hospitals, which often operate very efficiently and provide high quality care, need to be reimbursed differently than the current system does to survive; and

Whereas, a reimbursement system for rural hospitals which provides global reimbursement in the manner established for RHCs and FQHCs could be a successful model for the provision of acute hospitalization in rural areas; therefore be it

RESOLVED, that our American Medical Association study the issue and report back the best options for achieving a new reimbursement system for rural hospital survival in our country. (Directive to Take Action)

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

Received: 4/21/2025

RELEVANT AMA POLICY

Rural Hospital Payment Models D-190.969
1. Our American Medical Association supports and encourages efforts to develop and implement proposals for improving payment models to rural hospitals.
2. Our AMA will report back no later than the 2026 Annual Meeting on data analysis and appropriate recommendations for improved rural hospital payments based on innovative payment models such as the Pennsylvania Rural Health Model (PARHM).
CMS Rep. 6, I-23

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 112
(A-25)

Introduced by: New York

Subject: Continuation of Affordable Connectivity Program

Referred to: Reference Committee A

Whereas, funding for the Affordable Connectivity Program (ACP), which offered a monthly discount on broadband internet services, ended on June 1, 2024 for; and

Whereas, there are healthcare disparities and an inability of some patients to afford internet access; and

Whereas, the COVID-19 health pandemic heightened awareness and dramatically increased the need for use of telehealth; and

Whereas, “Telehealth offers patients and providers significant benefits as a lower cost, easier way to access quality care”; and

Whereas, Telehealth has been shown in surveys to benefit both physicians and patients and physicians would be able to maintain continuity of care to those patients who are unable to make in-person visits; and

Whereas, Telehealth would benefit patients as it would increase patient access to a greater number of physicians particularly for the homebound, increase choice of patients for their physicians and has been shown to increase patient satisfaction; and

Whereas, “The rise of telehealth during pandemic boosted mental health treatment rates” in a society where “90% of US adults say the U.S. is experiencing a mental health crisis”; and

Whereas, “An American Medical Association (AMA) survey released shows physicians have enthusiastically embraced telehealth and expect to use it even more in the future and “Nearly 85% of physician respondents indicated they are currently using telehealth to care for patients, and nearly 70% report their organization is motivated to continue using telehealth in their practice”; therefore be it.

RESOLVED, that our American Medical Association advocate for continuing the Affordable Connectivity Program to enable all patients to have access to telehealth and to decrease healthcare disparities. (Directive to Take Action)

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

Received: 4/22/2025

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 113
(A-25)

Introduced by: Ohio

Subject: Improving Patient Access to Pharmacies and Medications in Pharmacy Deserts

Referred to: Reference Committee A

Whereas, multiple pharmacies closed in Ohio in 2024, leaving many small towns without pharmacy services and creating pharmacy deserts; and

Whereas, over 15.8 million people in the U.S. live in areas without adequate access to pharmacies; and

Whereas, pharmacy closures have been associated with reduced patient adherence to cardiovascular medications among older U.S. adults; and

Whereas, multiple factors contribute to pharmacy closures; and

Whereas, pharmacy reimbursement rates for Medicare and Medicaid prescriptions have lagged behind private insurance payments, disproportionately affecting pharmacies in rural and low -income urban areas, especially independent pharmacies; and

Whereas, independent pharmacies are more likely to close than chain pharmacies; and

Whereas, pharmacy closures are more prevalent in rural and low -income urban areas, exacerbating pharmacy deserts; and

Whereas, some insurance companies designate preferred pharmacies that often exclude independent pharmacies; and

Whereas, over 20 states have adopted rules permitting telepharmacy, helping to alleviate pharmacy deserts; therefore be it

RESOLVED, that our American Medical Association support efforts to expand telepharmacy as a potential solution to pharmacy deserts (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for equitable reimbursement rates for pharmaceuticals between Medicare, Medicaid, and private insurers to ensure sustainable pharmacy operations in rural and underserved areas (Directive to Take Action); and be it further

RESOLVED, that our AMA study and address the impact of preferred pharmacy networks on patient access to pharmacy services, particularly in pharmacy deserts, with attention to supporting independent pharmacies. (Directive to Take Action)

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

Received: 4/22/225

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 114
(A-25)

Introduced by: Private Practice Physicians Section

Subject: An Assessment of Physician Support for Value-Based Payment Models and its Impact on Healthcare to Inform AMA Advocacy Efforts—A Survey

Referred to: Reference Committee A

Whereas, value-based payment (VBP)'s impact on care: The Center for Medicare and Medicaid Innovation's VBP models have not only failed to improve quality but have likely led to a decline in the quality of care patients receive[1-6]; and

Whereas, VBP's impact on access: VBP programs such as the Hospital Readmission Reduction Program and the Merit-based Incentive Payment System risk increasing health disparities because they have been shown to disproportionately penalize safety-net hospitals and physicians caring for greater numbers of vulnerable patients[7-9]; and

Whereas, VBP's impact on physicians: Although there may have been response bias, a survey piloted through the New York County Medical Society in 2023 found most physicians thought VBP models would harm patients (78 percent). Few physicians were supporters of VBP (28 percent). It was particularly concerning that 94 percent of physicians believed VBP models would add to physician burnout. Responses to survey questions were remarkably similar for both employed and private practitioners; and

Whereas, VBP's impact on cost: A Congressional Budget Office review of The Center for Medicare and Medicaid Innovation's programs, created to reign in cost, not only resulted in a more than five billion dollar increase in cost but are projected to increase costs over the next ten years[10]; and

Whereas, the Center for Medicare and Medicaid Innovation plans to have all Medicare beneficiaries care for by physicians who are accountable for cost and quality of care by 2030; and

Whereas, county and state medical societies and the American Medical Association have been steadily losing members, likely due in part to physicians' lack of faith that these organizations endeavor to understand their needs, value their opinions, and advocate effectively for their interests and the quality of patient care; therefore be it

RESOLVED, that our American Medical Association conducts a physician survey of adequate size and scope to ascertain the impact of value-based payment models on a wide spectrum of both employed and independent physician practices, exploring its specific effects on the quality of care physicians provide (i.e., help or harm quality), patient access to care (i.e., limit Medicare patients), physician professionalism (i.e., honoring patient preferences, managing conflict of interest), and adequacy of the physician workforce (i.e., availability of primary care, burnout, early retirement) to provide legislators a better understanding and inform future AMA advocacy efforts. (Directive to Take Action)

Fiscal Note: $594,118 – Contract to survey physicians and staffing.

Received: 2/28/2025

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RELEVANT AMA POLICY

Advocacy of Private Practice Options for Healthcare Operations in Large Corporations D-160.909

1. Our American Medical Association will inform corporate efforts about the value of private practices to successfully participate in new “value-based” models.
2. Our AMA will identify and work with a corporate entity that is advancing these models to explore a two year pilot among independent private practices in which our AMA will:
    a. convene physician practices in a community.
    b. provide educational resources and technical assistance to practices to support their participation with the corporate entity.
    c. formally evaluate the pilot for outcomes.
3. Our AMA will advocate with commercial payers and health plans and federal and state payers and policymakers to support private practice through policies and models that provide adequate payment, infrastructure and data to succeed in “value-based” models.
   Citation: BOT Rep. 14, A-23

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 115
(A-25)

Introduced by:	Society for Cardiovascular Angiography and Interventions, American Association of Clinical Urologists, American College of Cardiology, American Vein & Lymphatic Society, American Venous Forum, Outpatient Endovascular and Interventional Society
Subject:	Supporting Legislative Efforts to Remove Certain High-Cost Supplies and Equipment from the Medicare Physician Fee Schedule
Referred to:	Reference Committee A

Whereas, Medicare Physician Fee Schedule (MPFS) reimbursement cuts have become so severe for certain non-facility services that, in 2025, 300 non-facility services are paid at rates less than the direct costs associated with those procedures, according to data from the Centers for Medicare and Medicaid Services (CMS)[1]; and

Whereas, the number of non-facility services reimbursed at less than direct costs grew 50% since 2024[2]; and

Whereas, because these data do not account for other costs, including indirect costs and physician work, the number of services under the MPFS for which reimbursement does not even cover cost likely is much higher than 300 services; and

Whereas, non-facility services are increasingly unsustainable under the MPFS, which is a catalyst for (1) private practice closure[3], (2) site-of-service reimbursement disparities[4], (3) higher Medicare spending and beneficiary coinsurance as services migrate to high-cost sites of service[5], (4) reduced rural access to important specialty care services[6]; and

Whereas, non-facility services are critical to the MPFS (1) as a lowest cost option to Medicare beneficiaries[7], (2) for rural access where ambulatory surgical centers are not typically present[8], and (3) as an option during pandemics so hospitals can focus on the most vulnerable patients; and

Whereas, the migration of non-facility care to higher cost settings results in higher Medicare spending, higher Medicare beneficiary coinsurance, and reduced access to care[9]; and

Whereas, in many states, certificate of need laws and cost considerations are a barrier to ambulatory surgical centers, thus making hospitals the only site-of-service option outside of a non-facility setting[10]; and

Whereas, office-based services under the MPFS for which reimbursement does not cover cost predominantly utilize high-cost supplies and equipment; and

Whereas, the decades-long migration of high-cost supplies and equipment from the Hospital Outpatient Prospective Payment System to the PFS has not been accompanied by corresponding funding allocations and has contributed to the dilution of the MPFS; and

Whereas, in 2010, CMS removed high-cost Part B drugs from the PFS in 2010 due to similar concerns relating to the impact on the MPFS[11]; and

Whereas, the AMA RUC has recommended for many years that CMS separately identify and pay for high-cost disposable supplies priced more than $500, but, since 2011, CMS has consistently stated its inability to adopt such recommendations[12]; and

Whereas, CMS also has noted its concern with very expensive equipment items[13]; and

Whereas, removing certain high-cost supplies priced more than $500 as well as certain high-cost equipment from the PFS would (1) help to address the ongoing closures of non-facility centers, (2) bolster resources available for the PFS, and (3) meaningfully address site-of-service reimbursement differences; therefore be it

RESOLVED, that our American Medical Association support legislative proposals to reform the Medicare Physician Fee Schedule by removing and separately paying for certain services containing high-cost supplies priced more than $500 as well as certain services containing high-cost equipment from the Medicare Physician Fee Schedule. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Received: 4/22/2025

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RELEVANT AMA POLICY

H-400.957 Medicare Reimbursement of Office-Based Procedures
Our AMA will: (1) encourage CMS to expand the extent and amount of reimbursement for procedures performed in the physician's office, to shift more procedures from the hospital to the office setting, which is more cost effective; (2) seek to have the RBRVS practice expense RVUs reflect the true cost of performing office procedures; and (3) work with CMS to develop consistent regulations to be followed by carriers that include reimbursement for the costs of disposable supplies and surgical tray fees incurred with office-based procedures and surgery. (Sub. Res. 103, I-93 Reaffirmed by Rules & Credentials Cmt., A-96 Reaffirmation A-04 Reaffirmation I-04 Reaffirmed: CMS Rep. 1, A-14 Reaffirmed: CMS Rep. 3, A-14)

H-330.925 Appropriate Payment Level Differences by Place and Type of Service
Our AMA (1) encourages CMS to adopt policy and establish mechanisms to fairly reimburse physicians for office-based procedures; (2) encourages CMS to adopt a site neutral payment policy for hospital outpatient departments and ambulatory surgical centers; (3) advocates for the use of valid and reliable data in the development of any payment methodology for the provision of ambulatory services; (4) advocates that in place of the Consumer Price Index for all Urban Consumers (CPI-U), CMS use the hospital market basket index to annually update ambulatory surgical center payment rates; (5) encourages the use of CPT codes across all sites-of-service as the only acceptable approach to payment methodology; and (6) will join other interested organizations and lobby for any needed changes in existing and proposed regulations affecting payment for ambulatory surgical centers to assure a fair rate of reimbursement for ambulatory surgery. [Sub. Res. 104, A-98Reaffirmation I-98Appended: CMS Rep. 7, A-99Reaffirmation A-00Reaffirmation I-03Reaffirmation A-11Reaffirmed: CMS Rep. 3, A-13Reaffirmed: Sub. Res. 104, A-14Reaffirmed: Res. 116, A-14Modified: CMS Rep. 3, A-14Reaffirmation A-14 Reaffirmation A-15Reaffirmation: I-17]

D-330.902 The Site-of-Service Differential
1. Our American Medical Association supports Medicare payment policies for outpatient services that are site-neutral without lowering total Medicare payments.

2. Our AMA supports Medicare payments for the same service routinely and safely provided in multiple outpatient settings (eg, physician offices, HOPDs, and ASCs) that are based on sufficient and accurate data regarding the actual costs of providing the service in each setting.

3. Our AMA will urge CMS to update the data used to calculate the practice expense component of the Medicare physician fee schedule by administering a physician practice survey (similar to the Physician Practice Information Survey administered in 2007-2008) every five years, and that this survey collect data to ensure that all physician practice costs are captured.

4. Our AMA encourages CMS to both:
a. Base disproportionate share hospital payments and uncompensated care payments to hospitals on actual uncompensated care data.
b. Study the costs to independent physician practices of providing uncompensated care.

5. Our AMA will collect data and conduct research both:
a. to document the role that physicians have played in reducing Medicare spending.
b. to facilitate adjustments to the portion of the Medicare budget allocated to physician services that more accurately reflects practice costs and changes in health care delivery.

6. Our AMA will produce a graphic report illustrating the fiscal losses and inequities that practices without facility fees have endured for decades as a result of the site of service differential factoring in inflation.

7. Our AMA will consider disseminating the resulting educational materials and graphics.
[CMS Rep. 04, I-18Reaffirmed: BOT Action in response to referred for decision Res. 111, A-19Reaffirmed: BOT Action in response to referred for decision Res. 132, A-19Appended: Res. 826, I-22]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 116
(A-25)

Introduced by: Senior Physicians Section

Subject: Medicare Coverage of Registered Dietitian (RD) and Certified Nutrition Support Specialist (CNSS) Visits Beyond Type 2 Diabetes and Renal Disease

Referred to: Reference Committee A

Whereas, Medicare coverage for dietary counseling is currently restricted to individuals with type 2 diabetes and renal disease under existing regulations[1]; and

Whereas, Medicare lack of coverage for dietary consult visits, including those for obesity, pancreatic insufficiency, hyperlipidemia, irritable bowel syndrome (IBS), small intestinal bacterial overgrowth (SIBO), gout, and allergies places a financial strain on both patients and their physicians; and

Whereas, the American Medical Association should advocate for patients to access personalized, evidence-based advice that complement medical treatments improving health outcomes and potentially reducing the need for more costly interventions in the future[2,3]; and

Whereas, it is essential that a licensed registered dietitian (RD) or certified nutrition support specialist (CNSS) provides dietary counseling, as many individuals with minimal or no training wrongly identify themselves as nutritionists; therefore be it

RESOLVED, that our American Medical Association support legislation for Medicare coverage for registered dietitian (RD) or certified nutrition support specialist (CNSS) visits referred by physicians for conditions such as obesity, pancreatic insufficiency, hyperlipidemia, irritable bowel syndrome (IBS), small intestinal bacterial overgrowth (SIBO), gout, and allergies, recognizing that other significant chronic conditions can also benefit from tailored dietary interventions (Directive to Take Action); and be it further

RESOLVED, that our AMA specify that payment for registered dietician or certified nutrition support specialist services should be made separately from Medicare physician services (i.e. outside the Medicare physician fee schedule) to avoid having a negative impact on the conversion factor that would impact payment for all physician services. (Directive to Take Action)

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

Received: 4/20/2025

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RELEVANT AMA POLICY

H-440.859 American's Health

1. Our American Medical Association will make improving health through increased activity and proper diet a priority.
2. Our AMA will propose legislation calling on the federal government and state governments to develop new and innovative programs in partnership with the private sector that encourage personal responsibility for proper dietary habits and physical activity of individual Americans.
3. Our AMA will continue to work in conjunction with the American College of Sports Medicine, American Heart Association, US Department of Health and Human Services and any other concerned organizations to provide educational materials that encourage a healthier America through increased physical activity and improved dietary habits.

[Res. 201, A-09; Reaffirmation A-12; Reaffirmed: BOT Rep. 9, A-22]

H-440.866 The Clinical Utility of Measuring Body Mass Index, Body Composition, Adiposity, and Waist Circumference in the Diagnosis and Management of Adult Overweight and Obesity

1. Our American Medical Association supports greater emphasis in physician educational programs on the risk differences within and between demographic groups at varying levels of adiposity, BMI, body composition, and waist circumference and the importance of monitoring these in all individuals.
2. Our AMA supports additional research on the efficacy of screening for overweight and obesity, using different indicators, in improving various clinical outcomes across populations, including morbidity, mortality, mental health, and prevention of further weight gain.
3. Our AMA supports more research on the efficacy of screening and interventions by physicians to promote healthy lifestyle behaviors, including healthy diets and regular physical activity, in all of their patients to improve health and minimize disease risks.

[CSAPH Rep. 1, A-08; Reaffirmed: CSAPH Rep. 3, A-13; Modified: CSAPH Rep. 07, A-23; Reaffirmed: CSAPH Rep. 08, A-23]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 117
(A-25)

Introduced by: Mississippi

Subject: Liberalized Remorse Period for Medicare Advantage Plan Insureds

Referred to: Reference Committee A

Whereas, healthcare is a vital component of wellbeing; and

Whereas, the healthcare system is increasingly complicated, expensive, and difficult for the average adult to navigate in their favor; and

Whereas, health insurance is, for most Americans currently, necessary to access standard of care treatment and prevention for acute and chronic diseases; and

Whereas, health insurance costs and coverage options vary greatly, even within the same company; and

Whereas, currently, patients are allowed to leave their Medicare Advantage plan from January through March of each year; and

Whereas, patients covered by Medicare Advantage plans often experience “buyer’s remorse” after March of each year due to unanticipated health crises that increase or change the healthcare resources they need and, thusly, cause Traditional Medicare to be a better option for their needs; and

Whereas, the harm caused by these changes and lack of access to unanticipated needs are not simply remedied; therefore be it

RESOLVED, that our American Medical Association advocate for the Centers for Medicare Services to expand the period that Medicare Advantage (MA) plan insureds can leave their MA plan and obtain coverage by traditional Medicare part B and D plans from the current policy of January through March to any month for any reason with plan changes becoming effective on the first day of the next month (Directive to Take Action); and be it further

RESOLVED, that our AMA prepare a “tool-kit” for both patients and physicians to help patients make an informed choice regarding their Medicare coverage options. (Directive to Take Action)

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

Received: 4/21/2025

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 118
(A-25)

Introduced by: Women Physicians Section

Subject: Improving Access to Peripartum Pelvic Floor Physical Therapy

Referred to: Reference Committee A

Whereas, pelvic floor disorders during and after childbirth have significant lifelong consequences for women, including pelvic organ prolapse, urinary incontinence, bowel dysfunction, and pelvic-perineal pain syndrome, and is common among adult women[1–5]; and

Whereas, pelvic floor injuries occur in roughly 1 in 5 primiparous women, and prevalence is projected to increase 46% by 2050 due to an aging pregnant population and increasing rates of comorbidities during delivery[3,4,6,7]; and

Whereas, pelvic floor physical therapy is recommended in the peripartum period as a first-line treatment for pelvic floor dysfunction, yet more than 300,000 women – 10% of all women who give birth vaginally each year – have surgery to correct pelvic floor disorders annually[3,8]; and

Whereas, many pelvic floor injuries after childbirth go underdiagnosed and under-repaired, with lack of insurance coverage, and time constraints reported as the most significant barriers to care[3,5,9]; and

Whereas, while Federally Qualified Health Centers (FQHCs) provide care to one-third of all low-income women of reproductive age (who are at higher risk for pelvic floor disorders), only 5% of FQHCs have access to pelvic floor physical therapy and have identified cost to patient, insurance status, and wait times as barriers to care[10,11]; and

Whereas, pelvic floor physical therapist providers are increasingly operating out-of-network or through cash- based services due to low reimbursement rates, non-coverage by insurance, and discrepancies in what insurance companies deem “medically necessary”[12]; and

Whereas, multiple bills have previously been introduced to the United States Congress supporting Medicaid and the Children’s Health Insurance Program (CHIP) coverage for postpartum pelvic health services, including pelvic floor physical therapy[13,14]; therefore be it

RESOLVED, that our American Medical Association advocates for all relevant payers to cover timely access to comprehensive pelvic floor physical therapy during the antepartum and postpartum period in all health care facilities (Directive to Take Action); and be it further

RESOLVED, that our AMA supports efforts to improve education for clinicians and patients on the risk factors of pelvic floor dysfunction during childbirth and the benefits and indications of pelvic floor physical therapy. (New HOD Policy)

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

Date Received: 04/21/2025

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RELEVANT AMA POLICY

Extending Medicaid Coverage for One Year Postpartum D-290.974
Our AMA will work with relevant stakeholders to: (1) support and advocate, at the state and federal levels, for extension of Medicaid and Children's Health Insurance Program (CHIP) coverage to at least 12 months after the end of pregnancy; and (2) expand Medicaid and CHIP eligibility for pregnant and postpartum non-citizen immigrants.
[Res. 221, A-19; Modified: Joint CMS/CSAPH Rep. 1, I-21; Modified: Res. 701, I-21]

Reducing Inequities and Improving Access to Insurance for Maternal Health Care H-185.917
1. Our American Medical Association acknowledges that structural racism and bias negatively impact the ability to provide optimal health care, including maternity care, for people of color.
2. Our AMA encourages physicians to raise awareness among colleagues, residents and fellows, staff, and hospital administrators about the prevalence of racial and ethnic inequities and the effect on health outcomes, work to eliminate these inequities, and promote an environment of trust.

3. Our AMA encourages physicians to pursue educational opportunities focused on embedding equitable, patient-centered care for patients who are pregnant and/or within 12 months postpartum into their clinical practices and encourages physician leaders of health care teams to support similar appropriate professional education for all members of their teams.
4. Our AMA will continue to monitor and promote ongoing research regarding the impacts of societal (e.g., racism or unaffordable health insurance), geographical, facility-level (e.g., hospital quality), clinician-level (e.g., implicit bias), and patient-level (e.g., comorbidities, chronic stress or lack of transportation) barriers to optimal care that contribute to adverse and disparate maternal health outcomes, as well as research testing the effectiveness of interventions to address each of these barriers.
5. Our AMA will promote the adoption of federal standards for clinician collection of patient-identified race and ethnicity information in clinical and administrative data to better identify inequities. The federal data collection standards should be:

Informed by research (including real-world testing of technical standards and standardized definitions of race and ethnicity terms to ensure that the data collected accurately reflect diverse populations and highlight, rather than obscure, critical distinctions that may exist within broad racial or ethnic categories),
Carefully crafted in conjunction with clinician and patient input to protect patient privacy and provide non-discrimination protections.
Lead to the dissemination of best practices to guide respectful and non-coercive collection of accurate, standardized data relevant to maternal health outcomes.

6. Our AMA supports the development of a standardized definition of maternal mortality and the allocation of resources to states and Tribes to collect and analyze maternal mortality data (i.e., Maternal Mortality Review Committees and vital statistics) to enable stakeholders to better understand the underlying causes of maternal deaths and to inform evidence-based policies to improve maternal health outcomes and promote health equity.
7. Our AMA encourages hospitals, health systems, and state medical associations and national medical specialty societies to collaborate with non-clinical community organizations with close ties to minoritized and other at-risk populations to identify opportunities to best support pregnant persons and new families.
8. Our AMA encourages the development and funding of resources and outreach initiatives to help pregnant individuals, their families, their communities, and their workplaces to recognize the value of comprehensive prepregnancy, prenatal, peripartum, and postpartum care. These resources and initiatives should encourage patients to pursue both physical and behavioral health care, strive to reduce barriers to pursuing care, and highlight care that is available at little or no cost to the patient.
9. Our AMA supports adequate payment from all payers for the full spectrum of evidence-based prepregnancy, prenatal, peripartum, and postpartum physical and behavioral health care.
10. Our AMA encourages hospitals, health systems, and states to participate in maternal safety and quality improvement initiatives such as the Alliance for Innovation on Maternal Health program and state perinatal quality collaboratives.
11. Our AMA will advocate for increased access to risk-appropriate care by encouraging hospitals, health systems, and states to adopt verified, evidence-based levels of maternal care.
[Joint CMS/CSAPH Rep. 1, I-21]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 119
(A-25)

Introduced by: Women Physicians Section

Subject: Cancer Survivorship Program Coverage

Referred to: Reference Committee A

Whereas, per the National Cancer Institute and American Cancer Society, an individual is considered a cancer survivor from the time of diagnosis through life regardless of their stage of treatment or remission status[1,14]; and

Whereas, cancer survivors have the ethical right to continued follow-up with basic standards of care that address their specific needs[10]; and

Whereas, cancer survivors are at an elevated risk for both recurrence of their previous cancer as well as development of new primary cancers[12]; and

Whereas, cancer survivors experience a combination of physical and psychosocial symptoms, related to their cancer survivorship status that necessitate specialized care[5]; and

Whereas, survivorship care is a complex, multidisciplinary process requiring coordination among multiple providers[13]; and

Whereas, per the National Cancer Institute, the status of current survivorship care is suboptimal, leaving survivors with persistent symptoms and unmet needs while perpetuating healthcare disparities[14]; and

Whereas, among surveys and interviews conducted by the American Society of Clinical Oncology Cancer Survivorship Committee concerning insurance coverage, more than half of respondents reported denials for symptom management and supportive care services, with fertility services, indicated dental services, and mental health services being denied “always” or “most of the time” in 23.1%, 22.5%, and 12.8% of cases, respectively[4]; and

Whereas, facilities reported coverage denials for numerous survivorship related screenings and treatments for breast cancer survivors (63.46%), for Hodgkin lymphoma survivors (49.04%), and for maintenance therapies (41.74%)[4]; and

Whereas, recent studies suggest that established breast cancer survivorship care interventions that improve patient-provider communication are especially promising[6]; and

Whereas, care of the gynecologic cancer survivor extends beyond cancer treatment to encompass multisystem health; management of fertility, contraception, and vasomotor symptoms; and genetic counseling[8]; and

Whereas, as of 2022, over 50% of cancer survivors between 18-65 years old experience financial hardship, have higher annual out-of-pocket medical expenses (more than double than

those without cancer), and over 50% carry some medical debt from cancer related treatment[2]; and

Whereas, reductions in disparities after implementation of the Affordable Care Act were present, in terms of sociodemographic factors in noninsurance and care unaffordability among cancer survivors under age 65 with largest decreases in women, those with low or medium income, multiple comorbid conditions, the unemployed, and those residing in Medicaid expansion states, disparities still remain in coverage, including the uptick of 82,750 uninsured survivors in 2017 in mainly non-expansion states[9,11]; and

Whereas, cancer survivors were more likely than those without cancer history to report delays in care, forgone medical care, and experience inability to afford medications and medical care[15]; and

Whereas, cancer survivorship care standards recommend that health systems serve survivors by providing resources related to financial hardship and insurance coverage as well as cancer treatment sequelae[13]; and

Whereas, although, 74% of identified NIH grants are focused on cancer survivors from underrepresented populations, there is a clear lack of grants focused on cancer survivors from Pacific Islander populations as well as sexual and gender minorities[13]; and

Whereas, there are currently no established billing codes categorized specifically for survivorship care[3]; and

Whereas, the Comprehensive Cancer Survivorship Act, introduced in 2023, would establish programs and requirements to support services for cancer survivors, including Medicare coverage for cancer care planning and coordination services, employment assistance, and Medicaid and CHIP coverage of fertility services[7]; therefore be it

RESOLVED, that our American Medical Association recognizes cancer survivorship as a critical component of comprehensive cancer care and supports insurance coverage for prevention and early detection of new primary cancers and recurrences, as well as for supportive care services aimed at managing the long-term consequences and sequelae of cancer and its treatment (New HOD Policy); and be it further

RESOLVED, that our AMA advocates for work with key stakeholders to achieve adequate coverage for cancer survivorship care. (Directive to Take Action)

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

Received: 04/21/2025

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RELEVANT AMA POLICY

Survivorship Care Plans H-55.969

Our American Medical Association supports the voluntary use of survivorship care plans for cancer survivors when deemed appropriate by a patient's treating physician and supports reimbursement for physician preparation of survivorship care plans for patients.
[Res. 108, A-15 Reaffirmation: A-18]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 120
(A-25)

Introduced by: Association for Clinical Oncology, American College of Rheumatology

Subject: Medigap, Pre-Existing Conditions, and Medicare Coverage Education

Referred to: Reference Committee A

Whereas, patients may be attracted to Medicare Advantage (MA) plans because of the low premiums and other benefits; and

Whereas, many of these patients may be unaware that many MA plans may deny coverage for specialty drugs or cover specialty drugs with a coinsurance (a percentage of the drug cost) instead of copays (a fixed amount); and

Whereas, the median coinsurance for specialty drugs is 25% for Medicare Part D (linked to Medicare Fee-for-Service (FFS)) enrollees and is 30% for MA enrollees, which can lead to higher out-of-pocket costs for the same drug for MA enrollees; and

Whereas, patients who wish to switch back to Medicare FFS find that they frequently cannot purchase a Medicare Supplement Insurance (Medigap) plan that covers their pre-existing condition(s) because these plans are allowed to deny coverage or adjust premiums based on pre-existing conditions if not purchased within a limited timeframe from first eligibility for Medicare or do not afterwards fall within limited exceptions that allow for guaranteed issue; and

Whereas, the Patient Protection and Affordable Care Act (ACA) prohibited other plans from denying patients coverage because of pre-existing conditions; therefore be it

RESOLVED, that our American Medical Association compile information to supply to practices and patients about Medicare Supplement Insurance (Medigap) plans' policies regarding noncoverage for pre-existing health conditions if these plans are not purchased at specific times (Directive to Take Action); and be it further

RESOLVED, that our AMA create an educational campaign on both Medicare Advantage (MA) and Medicare Fee-for-Service (FFS) coverage (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for the elimination of Medigap insurers' ability to deny coverage due to a patient's pre-existing health conditions and work with Congress and the Centers for Medicare & Medicaid Services (CMS) to ensure coverage in MA is, at a minimum, no less than coverage provided under Medicare FFS. (Directive to Take Action).

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

Received: 4/22/25

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1. Medicare Part D in 2025: A First Look at Prescription Drug Plan Availability, Premiums, and Cost Sharing | KFF
2. A Snapshot of Sources of Coverage Among Medicare Beneficiaries | KFF
3. Medigap May Be Elusive for Medicare Beneficiaries with Pre-Existing Conditions | KFF
4. CMS NAIC Q and A And Follow-Ups
5. What Are the Medicare Out-of-Pocket Costs for 2025? – NCOA

RELEVANT AMA POLICY

Medigap Patient Protections H-330.866

1. Our American Medical Association supports annual open enrollment periods and guaranteed lifetime enrollment eligibility for Medigap plans.
2. Our AMA will extend advocacy efforts to ensure federal “guaranteed issue” protections are enacted, allowing beneficiaries the freedom to switch from Medicare Advantage to Traditional Medicare plans without facing prohibitive barriers.
3. Our AMA will 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.
4. Our AMA supports efforts to expand access to Medigap plans to all individuals who qualify for Medicare benefits.
5. Our AMA supports efforts to improve the affordability of Medigap supplemental insurance for lower income Medicare beneficiaries.

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.

Health Insurance Market Regulation H-165.856

Our American Medical Association 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.