AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (A-25)

Final Report of Reference Committee A

Cheryl Hurd, MD, Chair

Your Reference Committee recommends the following consent calendar for acceptance:

RECOMMENDED FOR ADOPTION

1. *Council on Medical Service Report 9 – Minimum Requirements for Medication Formularies
2. Resolution 101 - Uniform Adoption of Service Intensity Tools to Support Medical Decision-making and Service Gap Analysis
3. Resolution 102 - Access to Single Maintenance and Reliever Therapy for Asthma
4. Resolution 109 - Medicare Advantage Plans Double Standard
5. Resolution 111 - New Reimbursement System Needed for Rural Hospitals to Survive
6. Resolution 120 - Medigap, Pre-Existing Conditions, and Medicare Coverage Education
7. *Resolution 121 - Opposing Pharmacy Benefit Manager Spread Pricing

RECOMMENDED FOR ADOPTION AS AMENDED

8. *Council on Medical Service Report 2 – Reconsidering AMA Policy on the Affordable Care Act (ACA) Eligibility Firewall
9. *Council on Medical Service Report 5 – Medicaid Estate Recovery Reform
10. *Council on Medical Service Report 6 – Prescription Medication Price Negotiation
11. *Resolution 105 - Development of an Educational Resource on Opting Out of Medicare for Physicians
12. *Resolution 106 - Advocating for All Payer Coverage for Custom Breast Prostheses for Patients with History of Mastectomy Secondary to Breast Cancer Treatment
13. *Resolution 107 - Advocating for All Payer Coverage of Reconstructive and Cosmetic Surgical Care Related to Cleft Lip and Palate
14. *Resolution 108 - Firearm Storage Diagnosis and Counseling Reimbursement
15. *Resolution 110 - Study of the Federal Employee Health Benefit Plan (FEHBP)
16. *Resolution 115 - Supporting Legislative Efforts to Remove Certain High-Cost Supplies and Equipment from the Medicare Physician Fee Schedule
17. *Resolution 118 - Improving Access to Peripartum Pelvic Floor Physical Therapy
18. *Resolution 119 - Cancer Survivorship Program Coverage

RECOMMENDED FOR REFERRAL

19. Resolution 103 - Inadequate Reimbursement for Biosimilars
20. Resolution 113 - Improving Patient Access to Pharmacies and Medications in Pharmacy Deserts

21. *Resolution 116 - Medicare Coverage of Registered Dietitian (RD) and Certified Nutrition Support Specialist (CNSS) Visits Beyond Type 2 Diabetes and Renal Disease
22. Resolution 117 - Liberalized Remorse Period for Medicare Advantage Plan Insureds

RECOMMENDED FOR REFERRAL FOR DECISION

23. *Resolution 114 - An Assessment of Physician Support for Value-Based Payment Models and its Impact on Healthcare to Inform AMA Advocacy Efforts—A Survey

RECOMMENDED FOR NOT ADOPTION

24. Resolution 104 - Study of Whether the HSA Model Could Become an Option for Medicaid Beneficiaries

RECOMMENDED FOR REAFFIRMATION IN LIEU OF

25. Resolution 112 - Continuation of Affordable Connectivity Program

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

***Denotes Reference Committee recommendation has changed from the Preliminary Report**

RECOMMENDED FOR ADOPTION

(1) *CMS REPORT 9 – MINIMUM REQUIREMENTS FOR MEDICATION FORMULARY

RECOMMENDATION:

Your Reference Committee recommends that the Recommendations in Council on Medical Service Report 9 be adopted and the remainder of the report be filed.

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:

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)

Your Reference Committee heard exclusively supportive testimony on Council on Medical Service Report 9. Testimony explained the importance of ensuring that formularies are sufficient to include the medications prescribed by physicians and vital to patients. An individual proffered an amendment to ensure that different delivery devices or formulations are also adequately covered in formularies. Your Reference Committee found the proffered amendment to be a logical extension of the work done by the Council however; in-person testimony outlined that this amendment could have adverse consequences and end up inadvertently raising drug prices. Therefore, your Reference Committee recommends that recommendations in Council on Medical Service Report 6 be adopted and the remainder of the report filed.

(2) RESOLUTION 101 – UNIFORM ADOPTION OF SERVICE INTENSITY TOOLS TO SUPPORT MEDICAL DECISION-MAKING AND SERVICE GAP ANALYSIS

RECOMMENDATION:

Your Reference Committee recommends that Resolution 101 be adopted.

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)

Your Reference Committee heard limited but supportive testimony related to Resolution 101. Testimony explained the importance of ensuring that there is payment parity for medically necessary mental health and substance use disorder treatment. In-person testimony was also limited but supportive. Testimony reiterated the importance of ensuring that mental health and substance use disorder treatment have parity and follow best practice. Due to the supportive testimony both in-person and online, your Reference Committee recommends that Resolution 101 be adopted.

(3) RESOLUTION 102 – ACCESS TO SINGLE MAINTENANCE AND RELIEVER THERAPY FOR ASTHMA

RECOMMENDATION:

Your Reference Committee recommends that Resolution 102 be adopted.

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)

Testimony was supportive of Resolution 102 and the need to address payer quantity limits for combination inhalers that are used for both maintenance and rescue. Testimony did not support two proffered amendments to the first Resolved clause. The first asked to delete “remove or” and second, which the author and another delegation opposed, recommended deletion of “evidence-based guidelines.” Although there was limited support for an amendment to replace “long-acting beta-agonist” with “Formorterol,” your Reference Committee prefers the broader term “long-acting beta-agonist” and recommends that Resolution 102 be adopted.

(4) RESOLUTION 109 – MEDICARE ADVANTAGE PLANS DOUBLE STANDARD

RECOMMENDATION:

Your Reference Committee recommends that Resolution 109 be adopted.

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)

Testimony on Resolution 109 was generally supportive but mixed in suggested disposition. Testimony from sections, delegations, and individuals outlined the importance of ensuring that all payers, including Medicare Advantage (MA) plans, are required to follow uniform standards for utilization management practices. However, other delegations expressed concern as to the specific wording of the resolution and suggested the procedures outlined in the resolution need to be studied in greater detail before policy is adopted. Testimony also reflected the need to ensure that AMA reform and advocacy efforts on utilization management are focused on the most feasible wins, which would require additional study to determine. A delegation proffered an amendment to remove reference to uniform payment denial appeals; however, your Reference Committee was not convinced that the proffered amendment fully addresses the ask of the resolution. Additionally, your Reference Committee believes that the implementation of similar uniform denial requirements in states is evidence that the ask of the resolution is feasible.

In-person testimony on Resolution 109 was generally supportive of the intent, but some concern was raised regarding states or systems that have already implemented better procedures than outlined in the resolution. However, positive testimony outlined how vital it is to reduce administrative burden on physicians by streamlining the process and this resolution would work to reduce utilization management burdens. Additionally, testimony explained that the appeals process can be particularly burdensome for physicians practicing in medically underserved areas and/or in smaller settings. Your Reference Committee wishes to remind the House that the adoption of this policy will not force any state or system to alter current procedures. Rather, the adoption of this policy will allow for AMA advocacy to support states or systems, when invited, in implementing a standardized process. Your Reference Committee believes that this resolution will result in policy that can support physicians and patients in underserved communities and reduce administrative burden, while not forcing change on any one state or system, therefore it is recommended that Resolution 109 be adopted.

(5) RESOLUTION 111 – NEW REIMBURSEMENT SYSTEM NEEDED FOR RURAL HOSPITAL SURVIVAL

RECOMMENDATION:

Your Reference Committee recommends that Resolution 111 be adopted.

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)

Testimony on Resolution 111 was divided between adoption and referral. All testimony echoed the importance of ensuring that rural hospitals remain financially viable and open. Additionally, much of the testimony highlighted the growing need to address the impact of Medicare Advantage on rural hospitals. A delegation and individual testified that the current resolution would better serve the House if referred, allowing the AMA to complete the forthcoming Council on Medical Service report prior to decision on Resolution 111. However, other delegations testified to the importance of this resolution

being adopted at the current meeting and not delayed. In-person testimony on this resolution was supportive, including the Council on Medical Service indicating that this resolution, if adopted, will be folded into an existing report to be presented to the House at Interim 2025. Testimony reiterated the need to include how Medicare Advantage plans have grown in popularity and negatively impacted rural physicians, patients, and practices. Your Reference Committee agrees that this resolution is timely, important, and could be incorporated into the forthcoming Interim 2025 Council on Medical Service report and, therefore, recommends that Resolution 111 be adopted.

(6) RESOLUTION 120 – MEDIGAP, PRE-EXISTING CONDITIONS, AND MEDICARE COVERAGE EDUCATION

RECOMMENDATION:

Your Reference Committee recommends that Resolution 120 be adopted.

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).

Your Reference Committee heard testimony that strongly supported Resolution 120, which is intended to addresses gaps in transparency and access to care within Medicare coverage. Although a delegation asked that Resolution 120 be referred, most of the testimony supported adoption. Accordingly, your Reference Committee recommends that Resolution 120 be adopted.

(7) *RESOLUTION 121 – OPPOSING PHARMACY BENEFIT MANAGER SPREAD PRICING

RECOMMENDATION:

Your Reference Committee recommends that Resolution 121 be adopted.

RESOLVED, that our American Medical Association:
(1) oppose the use of spread pricing by Pharmacy Benefit Managers (PBMs);
(2) advocate for federal and state legislation and regulation that prohibits the use of spread pricing by PBMs; and
(3) support policies requiring PBMs to use transparent, pass-through pricing models that ensure fair and consistent reimbursement to pharmacies, physicians, and patients.
(Directive to Take Action)

Testimony on Resolution 121 was supportive and highlighted the issues around pharmacy benefit managers (PBMs) generally and their use of spread pricing. Testimony from sections highlighted the importance of ensuring that the AMA has clear policy to advocate against spread pricing, especially in the current context of bipartisan PBM reform legislation. An individual did speak to caution regarding the complexity of the issue, however testimony indicated that this resolution is in line with both existing policy and current AMA advocacy efforts. Therefore, your Reference Committee recommends that Resolution 121 be adopted.

RECOMMENDED FOR ADOPTION AS AMENDED

(8) *CMS REPORT 2 – RECONSIDERING AMA POLICY ON THE AFFORDABLE CARE ACT (ACA) ELIGIBILITY FIREWALL

RECOMMENDATION A:

Your Reference Committee recommends that the second Recommendation of Council on Medical Service Report 2 be amended by addition to read as follows:

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, while promoting meaningful coverage and the application of vital consumer and provider protections, such as prompt pay and network adequacy requirements;

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)

RECOMMENDATION B:

Your Reference Committee recommends that the third Recommendation of Council on Medical Service Report 2 be amended by addition and deletion to read as follows:

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~~ fair and equitable rates. (New HOD Policy)

RECOMMENDATION C:

Your Reference Committee recommends that Council on Medical Service Report 2 be amended by addition of a new Recommendation to read as follows:

That our AMA support incrementally lifting the ESI firewall with continual monitoring and consideration of insurance marketplace stability, physician practice sustainability, and other relevant parameters, with the goal of maximizing the number of individuals able to freely choose the health insurance plan that is best for themselves and their families. (New HOD Policy)

RECOMMENDATION D:

Your Reference Committee recommends that the Recommendations in Council on Medical Service Report 2 be adopted as amended and the remainder of the report be filed.

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 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)

Your Reference Committee heard mixed testimony on Council on Medical Service Report 2. A member of the Council on Medical Service noted that the Council's previous report on this topic was referred back at the 2024 Annual Meeting to ensure that the recommendations maximize patient access to care while protecting physician practice revenue and sustainability. Supportive testimony cited the Council's balanced approach to the firewall while prioritizing the needs of patients least able to afford health care.

A former President of the AMA asked that the report be referred back so that AMA policy on individually selected health insurance can be amended to require a cap on insurance company profits. This individual also asked for a study of the affordability of policies that pay for the cost of care with a margin sufficient to allow independent physician practices to thrive. The Council on Medical Service opposed referral and emphasized that these requests are beyond the scope of this report, which focuses specifically on AMA policy on the Affordable Care Act (ACA) firewall.

Testimony was generally supportive of proffered amendments to Recommendations 2 and 3, including language that replaces "prevailing Medicare rates" with "fair and equitable rates" in Recommendation 3. The Council supported these changes but did not support an amendment to Recommendation 1 from a section as the amendment would commit our AMA to supporting the complete elimination of the firewall without fully understanding the implications of even modest adjustments. The Council testified that the question of whether the AMA should ultimately endorse further reductions or elimination of the firewall deserves careful consideration at a future meeting once pertinent data is available for evaluation. The Council also spoke against a proffered new Recommendation that supports incrementally lifting the ESI firewall with continual monitoring of certain indicators; however, this new Recommendation received supportive in-person testimony. Your Reference Committee supports the amendments that were

supported in testimony and recommends that Council on Medical Service Report 2 be adopted as amended and the remainder of the report filed.

(9) *CMS REPORT 5 – MEDICAID ESTATE RECOVERY REFORM

RECOMMENDATION A:

Your Reference Committee recommends that Recommendation 1 of Council on Medical Service Report 5 be amended by addition and deletion to read as follows:

1. That our AMA ~~support making Medicaid estate recovery optional, instead of mandatory, for states.)~~ oppose federal or state efforts to impose liens on or seek adjustment or recovery from the estate of individuals who received long-term services or supports coverage under Medicaid. (New HOD Policy)

RECOMMENDATION B:

Your Reference Committee recommends that Council on Medical Service Report 5 be adopted as amended and the remainder of the report filed.

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.
   g. Collecting and making publicly available important data regarding estates that have been pursued and amounts that have been recovered. (New HOD Policy)

Testimony on Council on Medical Service Report 5 was mixed. There was some support for the recommendations and the concept of Medicaid estate recovery being optional for states. A section proffered a substitute Recommendation 1 that would direct our AMA to oppose federal or state Medicaid estate recovery efforts. The Council on Medical Service opposed this change, emphasizing that states should have the option to continue pursuing estates, with guardrails in place, if they choose to do so, such as when people with financial means have shielded assets to access Medicaid long-term services and supports that they could have paid for themselves. However, your Reference Committee heard testimony that was supportive of this change and recommends that Council on Medical Service Report 5 be adopted as amended and the remainder of the report filed.

(10) *CMS REPORT 6 – PRESCRIPTION MEDICATION PRICE NEGOTIATION

RECOMMENDATION A:

Your Reference Committee recommends that the Recommendations of Council on Medical Service Report 6 be amended by addition of a new recommendation to read as follows:

That our AMA oppose drug payment methodologies that result in physician practices being paid at less than the cost of acquisition, inventory, storage, and administration of relevant drugs and other necessary related clinical services. (New HOD Policy)

RECOMMENDATION B:

Your Reference Committee recommends that the Recommendations in Council on Medical Service Report 6 be adopted as amended and the remainder of the report be filed.

The Council on Medical Service recommends that the following be adopted in lieu of 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)

Reference Committee testimony on Council on Medical Service Report 6 was generally supportive. Amendments were proffered by delegations that aimed to reaffirm additional policy, accelerate the timeline in which drugs are added to the negotiation schedule, and allow for the government negotiated prices to be available to all payers. Another delegation outlined concerns surrounding the impact of price negotiation on physician practices. The Council on Medical Service explained that the AMA has an incredibly robust body of policy related to drug pricing negotiation that ensures patients have access to medications and that physicians/physician practices are not unduly harmed. Additionally, the Council on Medical Service, the authors of the report, explained that a rapidly accelerated negotiation schedule would have the potential to significantly harm patients, physicians, and drug innovation. The Council also clarified that the report details the anticipated impact that price negotiation could have on patients and physicians/physician practices. Finally, the authors explained that the government negotiated prices are currently available to all payers and as a result any payer has the ability to utilize these rates in their own negotiations. Your Reference Committee believes that the addition of another reaffirmation is extraneous as the Council has worked to create a well-rounded body of recommendations.

In-person testimony on Council on Medical Service report 6 was also supportive of the intent, but a number of amendments were proffered. Two delegations proffered similar amendments to ensure that physician practices are not losing money on payment for drugs due to storage, acquisition, inventory, or administrative costs. This amendment was supported by other individuals and delegations. Additionally, an amendment was proffered to enable all payers to access Medicare negotiated prices. Your Reference Committee echoes concern from testimony that this could be interpreted as a price mandate and reiterates that there is no reason that all payers cannot utilize negotiated prices in their negotiations as they are made publicly available. A third amendment was proffered by a delegation asking for an additional report back on the impact of the Inflation Reduction Act reforms on delivery system of expensive drugs on both independent hospitals and hospital-based practices. Your Reference Committee believes that this amendment raises an issue of particular importance, but the submission of this as a new resolution at a future AMA HOD meeting would not only be more appropriate, but allow the asks of this amendment to be fully explored and not overshadowed by the remainder of the report.

As a result of the testimony presented, both in-person and online, and the response by the authors of the report, your Reference Committee recommends that the recommendations in Council on Medical Service Report 6 be adopted as amended and the remainder of the report filed.

(11) *RESOLUTION 105 – DEVELOPMENT OF AN EDUCATIONAL RESOURCE ON OPTING OUT OF MEDICARE FOR PHYSICIANS

RECOMMENDATION A:

Your Reference Committee recommends that the first Resolved of Resolution 105 be amended by deletion to read as follows:

RESOLVED, that our AMA 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

RECOMMENDATION B:

Your Reference Committee recommends that the third Resolved of Resolution 105 be deleted.

~~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)~~

RECOMMENDATION C:

Your Reference Committee recommends that Resolution 105 be adopted as amended.

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)

Your Reference Committee heard mixed testimony on Resolution 105. Supporters highlighted the need to help interested physicians better understand the concept of opting out of Medicare participation. A call for referral was not supported. Your Reference Committee believes that a proffered amendment to re-allocate the marketing budget used to promote the AMA and its achievements to promoting resources on opting out of Medicare is beyond the scope and intent of this resolution. In response to a commenter's request for information from the AMA's Office of General Counsel (OGC) on how to accomplish the aims of the resolution without causing concerns about anti-competitive behavior, your Reference Committee notes that OGC stated that a legal comment was not necessary.

Your Reference Committee also heard testimony in opposition to Resolution 105, noting that the AMA should not be promoting tools on opting out of Medicare, which could decrease access to care in some communities. Your Reference Committee suggests amending the first Resolved and deleting the third Resolved as a compromise that would allow the AMA to provide the requested information while recognizing the importance of physician choice in Medicare participation. Your Reference Committee recommends that Resolution 105 be adopted as amended.

(12) *RESOLUTION 106 – ADVOCATING FOR ALL PAYER COVERAGE FOR CUSTOM BREAST PROSTHESES FOR PATIENTS WITH HISTORY OF MASTECTOMY SECONDARY TO BREAST CANCER TREATMENT

RECOMMENDATION A:

Your Reference Committee recommends that Resolution 106 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA 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 prostheses ~~for patients who have had mastectomy secondary to breast cancer treatment~~ and other custom prostheses for patients who have had extirpative, ablative, and/or reconstructive surgery.

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 106 be adopted as amended.

RECOMMENDATION C:

The Title of Resolution 106 be changed:

ADVOCATING FOR ALL PAYER COVERAGE FOR CUSTOM BREAST AND OTHER PROSTHESES

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)

Your Reference Committee heard unanimously supportive testimony with amendments offered on Resolution 106. A delegation testified in support explaining that expanding coverage would address inequity in women's health, with a section testifying that this is as much a functional issue as it is a cosmetic issue. An amendment was proffered to broaden coverage beyond patients who have had mastectomy secondary to breast cancer treatment to include custom prostheses for patients who have had extirpative, ablative, and reconstructive surgery, patients who may not be candidates for surgical reconstruction, and other subgroups of patients. Your Reference Committee agreed that the amended language fulfilled the intent of the resolution and, therefore, recommends that Resolution 106 be adopted as amended with a title change.

(13) *RESOLUTION 107 – ADVOCATING FOR ALL PAYER COVERAGE OF RECONSTRUCTIVE AND COSMETIC SURGICAL CARE RELATED TO CLEFT LIP AND PALATE

RECOMMENDATION A:

Your Reference Committee recommends that Resolution 107 be amended by addition to read as follows:

RESOLVED, that our AMA 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 without restriction as to patient age.

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 107 be adopted as amended.

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)

Your Reference Committee heard unanimously supportive testimony with an amendment on Resolution 107. An individual proffered an amendment to explicitly mention that this coverage should apply to all patients regardless of age, which was considered friendly by the author. Your Reference Committee agreed that the amended language fulfilled the intent of the resolution and, therefore, recommends that Resolution 107 be adopted as amended.

(14) *RESOLUTION 108 – FIREARM STORAGE DIAGNOSIS AND COUNSELING REIMBURSEMENT

RECOMMENDATION A:

Your Reference Committee recommends that Resolution 108 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA advocate for the creation of an ICD-10-CM code specifically designating counseling for firearm storage and encourage interested national medical specialty societies to seek a new *Current Procedural Terminology* (CPT®) codinge which specifically encompasses the provision of Firearm Storage Counseling, its minimum requirements for qualification, and its reimbursement, and other actions required to determine appropriate payment for this service.

RECOMMENDATION B:

Your Reference Committee recommends that the first Resolved of Resolution 108 be adopted as amended.

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 1 its reimbursement. (Directive to Take Action)

Your Reference Committee heard supportive testimony for Resolution 108, with some amendments suggested to better align the resolution with existing AMA policy. Many delegations, sections, and individuals detailed the importance of ensuring that firearms are properly stored and the important role that physicians play in increasing safe storage. To better align the portion of the resolution that requests the development of a new *Current Procedural Terminology* (CPT®) code with AMA Policy H-70.919, the authors of the resolution proffered amended language. In the same vein, another delegation suggested the removal of reference to CPT® altogether. This delegation explained that while the introduction of the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) codes would be a meaningful tool for researchers, public health officials, and clinicians, the creation of a CPT® code is solely for billing and could potentially confound clinical services with surveillance efforts. In-person testimony reiterated the importance of this resolution and highlighted the need for the inclusion of CPT® codes to ensure that physicians are paid for this service. Some testimony did indicate support for the Preliminary Report language, however your Reference Committee was swayed by the importance of enabling physicians to be paid for their work and therefore recommends that Resolution 108 be adopted as amended.

(15) *RESOLUTION 110 – STUDY OF THE FEDERAL EMPLOYEE HEALTH BENEFIT PLAN (FEHBP)

RECOMMENDATION A:

Your Reference Committee recommends that of Resolution 110 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA conduct a thorough study of the FEHBP to understand the successes and failures, strengths and weaknesses of the program and determine~~s~~ 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 A-26 Meeting of our House of Delegates. (Directive to Take Action)

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 110 be adopted as amended.

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)

Testimony on Resolution 110 was unanimously supportive, emphasizing the potential that this resolution has to improve coverage, patient satisfaction, and competition between insurers. Multiple delegations supported the resolution with an amendment to extend the timeline to A-26. Noting that the second Resolved does not stand on its own, your Reference Committee combined both into one Resolved. Your Reference Committee agreed that the extended timeline fulfilled the intent of the resolution and, therefore, recommends that Resolution 110 be adopted as amended.

(16) *RESOLUTION 115 – SUPPORTING LEGISLATIVE EFFORTS TO REMOVE CERTAIN HIGH-COST SUPPLIES AND EQUIPMENT FROM THE MEDICARE PHYSICIAN FEE SCHEDULE

RECOMMENDATION A:

Your Reference Committee recommends that Resolution 115 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA support the *Current Procedural Terminology* (CPT®) Editorial Panel / RVS Update Committee (RUC) recommendation to the Centers for Medicare & Medicaid Services (CMS) to separately pay for high-cost supplies priced more than $500 ~~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~~.

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 115 be amended by addition of a new Resolved to read as follows:

RESOLVED, that our AMA work with the federal government to address flaws in the Medicare Physician Fee Schedule practice expense methodology resulting in reimbursement being less than direct costs for hundreds of services in the office-based setting.

RECOMMENDATION C:

Your Reference Committee recommends that Resolution 115 be adopted as amended.

RECOMMENDATION D:

The Title of Resolution 115 be changed:

SUPPORTING LEGISLATIVE EFFORTS TO REMOVE CERTAIN HIGH-COST SUPPLIES FROM THE MEDICARE PHYSICIAN FEE SCHEDULE

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)

Testimony on Resolution 115 was extensive and somewhat mixed. Multiple delegations and an individual expressed support for the resolution noting their reasoning echoed the resolution's whereas clauses and, as sponsors, felt that the resolution was timely and essential to providing adequate payment for physicians. Testimony in support of the resolution explained that due to cuts to physician payment, certain non-facility services experience deficits in payment and actual cost for certain procedures requiring high-cost supplies. One delegation suggested that the item be referred; however, many other individuals and delegations voiced serious concern for the resolution's original language or its referral. Testimony explained that there are extensive ongoing efforts from the AMA and the *Current Procedural Terminology* (CPT®) Editorial Panel/Relative Value Scale Update Committee (RUC) to address this issue. Testimony from these delegations and individuals agreed that the issue brought up in the resolution is correct to be classified as a reaffirmation of existing AMA policy and efforts. Experts from the RUC explained that should reaffirmation not be recommended by the Reference Committee; an amendment would be suggested over the original language. Testimony from CPT and RUC experts and delegations supporting reaffirmation and/or amendment explained that in February 2025, the CPT Editorial Panel and RUC recommended that the Centers for Medicare & Medicaid Services (CMS) address the pricing of high-cost supplies by reviewing the costs annually and paying for these specific supplies using separate Healthcare Common Procedure Coding System (HCPCS) codes. Testimony supported a regulatory versus legislative approach. Additionally, many testifiers voiced serious concern about the potential implications of significantly altering the CPT®/RUC recommendation on the payment for all other physician services and that the implementation of the resolution's original language could actually lead to physician net losses. Other testimony echoed these concerns and voiced worry that the adoption of the resolution as written could be misconstrued by current legislative and executive leaders and lead to widespread harmful results for physician payment.

In-person testimony was also extensive and all supportive of the intent of the resolution and the existing Preliminary Report recommendation. However, a delegation proffered an additional amendment asking that the AMA continue to advocate to address flaws in the Medicare Physician Fee Schedule. The majority of testimony on this amendment, including from the RUC and two Councils, was supportive. Additionally, testimony asked that reference to equipment be removed from the title of the resolution as the focus was on high-cost supplies, not equipment. Based on the testimony provided, your Reference Committee feels that the proffered amendments address the concerns voiced on either side of the issue and thus recommends that Resolution 115 be adopted as amended with a title change.

(17) *RESOLUTION 118 – IMPROVING ACCESS TO PERIPARTUM PELVIC FLOOR PHYSICAL THERAPY

RECOMMENDATION A:

Your Reference Committee recommends that the first Resolve of Resolution 118 be amended by deletion to read as follows:

RESOLVED, that our AMA advocate 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

RECOMMENDATION B:

Your Reference Committee recommends that the second Resolve of Resolution 118 be amended by addition and deletion to read as follows:

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

RECOMMENDATION C:

Your Reference Committee recommends that Resolution 118 be adopted as amended.

RECOMMENDATION D:

The Title of Resolution 118 be changed.

IMPROVING ACCESS TO PELVIC FLOOR THERAPY

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)

Testimony on Resolution 118 was generally supportive, but expansion for coverage beyond childbearing was recommended. One individual opposed the resolution and testified that payers are obligated to cover pelvic floor therapy when medically necessary

and that payment is the actual problem. However, multiple sections, delegations, and an individual outlined the importance of this coverage and explained that it addresses significant barriers to care and the limited awareness of the benefits of pelvic floor therapy. Among the supportive testimony, an amendment to broaden the resolution to allow coverage for pelvic floor therapy beyond pregnancy or a single gender was proffered. In-person testimony by multiple delegations and sections reiterated the support to broaden this resolution because pelvic floor dysfunction has become more common and patients from all genders would benefit from this coverage. Due to supportive testimony, your Reference Committee recommends that Resolution 118 be adopted as amended with a title change.

(18) *RESOLUTION 119 – CANCER SURVIVORSHIP PROGRAM COVERAGE

RECOMMENDATION A:

Your Reference Committee recommends that the first Resolve of Resolution 116 be amended by addition to read as follows:

RESOLVED, that our AMA recognizes cancer survivorship and cancer rehabilitation 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 medical care services and supportive care services, including, but not limited to, genetic screening and testing, counseling for those with known pathogenic variants (mutations) as well as discussion of fertility options before and after cancer treatment, aimed at managing the long-term consequences and sequelae of cancer and its treatment (New HOD Policy); and be it further

RECOMMENDATION B:

Your Reference Committee recommends that the second Resolve of Resolution 116 be amended by addition to read as follows:

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

RECOMMENDATION C:

Your Reference Committee recommends that Resolution 119 be adopted as amended.

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)

Testimony strongly supported Resolution 119 and the need to ensure adequate coverage of cancer survivorship services. Two amendments were proffered online to include specific services in this resolution. The first asked to include “genetic screening and testing, counseling for those with known pathogenic variants (mutations) as well as discussion of fertility options before and after cancer treatment” after “supportive care services” in Resolved 1. The second amendment asked that “cancer rehabilitation” be added to each Resolved clause. An amendment offered in-person asked that “medical care services” be added to the first Resolved clause. Your Reference Committee recommends that Resolution 119 be adopted as amended.

RECOMMENDED FOR REFERRAL

(19) RESOLUTION 103 – INADEQUATE REIMBURSEMENT FOR BIOSIMILARS

RECOMMENDATION:

Your Reference Committee recommends that Resolution 103 be referred.

RESOLVED, that our American Medical Association work with stakeholders to advocate 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)

Testimony on Resolution 103 was mixed. Some delegations explained that this proposed policy would help ensure that physicians are adequately reimbursed for biosimilar usage and that this is vital to patient access and sustainability of physician practice. However, one delegation explained that existing AMA policies already address the ask of this resolution and therefore reaffirmation would be more appropriate. Another delegation encouraged amending the language of the resolution to cover all medications, not just biologics. Finally, a section suggested that this resolution be referred to fully explore the challenges surrounding biosimilar implementation and payment.

In-person testimony on this item was supportive of the Preliminary recommendation to refer and echoed the online testimony regarding the importance and timeliness of the resolution and report back. Due to the complexity of the issue, the potential for expansion beyond biologics, and the possible challenges related to implementation your Reference Committee recommends that Resolution 103 be referred.

(20) RESOLUTION 113 – IMPROVING PATIENT ACCESS TO PHARMACIES AND MEDICATIONS IN PHARMACY DESERTS

RECOMMENDATION:

Your Reference Committee recommends that Resolution 113 be referred.

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)

Your Reference Committee heard testimony supportive of the intent of Resolution 113, but with concerns for the potential consequences. Along with a delegation and section, the Council on Medical Service testified that this resolution should be referred to ensure that there are not unintended consequences on patients or physicians. Testimony echoed the need to ensure that patients in pharmacy deserts have access to medication, but voiced concern around potential for expanded pharmacist scope of practice and conflicts with regulatory authority.

In-person testimony echoed the importance of studying issue and highlighted the potential for pharmacist scope creep. Due to the potential for significant unintended consequences and testimony supporting referral, your Reference Committee recommends that Resolution 113 be referred.

(21) *RESOLUTION 116 – MEDICARE COVERAGE OF REGISTERED DIETITIAN (RD) AND CERTIFIED NUTRITION SUPPORT SPECIALIST (CNSS) VISITS BEYOND TYPE 2 DIABETES AND RENAL DISEASE

RECOMMENDATION:

Your Reference Committee recommends that Resolution 116 be referred.

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)

Testimony on Resolution 116 was mixed. Most commenters supported the goal of expanding Medicare coverage for nutrition services to include a range of conditions beyond diabetes and renal disease. However, in-person testimony cited concerns with each Resolved clause and there were several calls for referral. The Council on Legislation raised scope of practice concerns regarding the first Resolved and the Council on Medical Service and others noted that the second Resolved is not realistic since registered dietician services are already paid under the Medicare Physician Fee Schedule. Both Councils urged referral. Online testimony that shared feedback from the association representing registered dieticians pointed to several concerns with the language used in the resolution and the payment structure cited in the second Resolved

that could unintentionally undermine access or introduce confusion if not refined. Your Reference Committee heard significant support for referral and therefore recommends that Resolution 116 be referred.

(22) RESOLUTION 117 – LIBERALIZED REMORSE PERIOD FOR MEDICARE ADVANTAGE PLAN INSUREDS

RECOMMENDATION:

Your Reference Committee recommends that Resolution 117 be referred.

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)

Testimony on Resolution 117 was primarily supportive of the intent, ensuring patients have autonomy and information to select the most advantageous Medicare plan, but concerned about the complexity of the issue. Two delegations voiced support for the resolution as written, explaining the importance of flexibility between Medicare Advantage (MA) and traditional Medicare plans. Testimony explained that some individuals may not realize the full scope of an MA plan or may experience life changes, like new illness, that would make transitioning from MA to traditional Medicare advantageous. However, multiple other delegations and the Council on Medical Service explained that the resolution’s original language could disrupt the stability of medical groups and health plans, negatively impacting both patients and physicians. Additionally, testimony outlined the uncertainty in how extension of time to change plans could impact patients and physicians. Your Reference Committee agrees that patients should have autonomy and choice in selecting plan coverage but feels that concerns regarding the complexity of the issue warrants further study of the item. In-person testimony was limited to the authors of this resolution who testified in support of referral. Therefore, your Reference Committee recommends that Resolution 117 be referred.

RECOMMENDED FOR REFERRAL FOR DECISION

(23) *RESOLUTION 114 – AN ASSESSMENT OF PHYSICIAN SUPPORT FOR VALUE-BASED PAYMENT MODELS AND ITS IMPACT ON HEALTHCARE TO INFORM AMA ADVOCACY EFFORTS—A SURVEY

RECOMMENDATION:

Your Reference Committee recommends that Resolution 114 be referred for decision.

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)

Your Reference Committee heard mixed testimony on Resolution 114. A section, delegation, and individual expressed support for the resolution, explaining that there is a need to better understand value-based payment models and their impact on care quality, patient access, and health care sustainability. Multiple delegations expressed opposition to the adoption of this resolution, stating that it duplicates existing research efforts and would lead to unnecessary spending and utilization of staff resources.

However, in-person testimony by multiple delegations, including the resolution's sponsors reiterated support for this resolution based on the value of the data that can be obtained and, therefore, requested that Resolution 114 be referred for decision. Based on online and in-person testimony, your Reference Committee recommends that Resolution 114 be referred for decision.

RECOMMENDED FOR NOT ADOPTION

(24) RESOLUTION 104 – STUDY OF WHETHER THE HSA MODEL COULD BECOME AN OPTION FOR MEDICAID BENEFICIARIES

RECOMMENDATION:

Your Reference Committee recommends that Resolution 104 be not adopted.

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)

Your Reference Committee heard mixed testimony on Resolution 104. Although the resolution's author and another delegation requested adoption, an individual expressed doubts about the use of Health Savings Accounts (HSAs) in Medicaid. A section and a delegation testified in strong opposition to Resolution 104, noting that funding for HSAs for Medicaid patients would inevitably be at the expense of traditional Medicaid benefits. Although the Council on Medical Service did not take a position, a Council member testified that a report on HSAs is currently being developed and will be considered at the 2025 Interim Meeting. Due to the concerns raised, along with in-person testimony noting that the House of Delegates voted to not adopt a similar resolution at the 2024 Interim Meeting, your Reference Committee recommends that Resolution 104 be not adopted.

RECOMMENDED FOR REAFFIRMATION IN LIEU OF

(25) RESOLUTION 112 – CONTINUATION OF AFFORDABLE CONNECTIVITY PROGRAM

RECOMMENDATION:

Your Reference Committee recommends that Policies H-478.980 and D-480.963 be reaffirmed in lieu of Resolution 112.

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)

Testimony strongly supported the intent of Resolution 112 and the ongoing need to expand access to high-speed internet connectivity so that everyone can have access to telehealth. The Council on Medical Service shared AMA policies that advocate for the expansion of broadband and wireless connectivity to all rural and underserved areas (Policy H-478.980) and also advocate for equitable access to telehealth services including increased funding for broadband and internet-connected devices (Policy D-480.963). The Council suggested reaffirmation of these policies in lieu of Resolution 112. The Council also suggested amending the resolution by deletion of "the Affordable Connectivity Program" since this program ceased to exist a year ago and is unlikely to be brought back, but there are other programs supporting internet connectivity that the AMA supports. Your Reference Committee believes that the aforementioned AMA policies adequately direct the AMA to advocate for programs that seek to ensure that all patients can access telehealth. Therefore, your Reference Committee recommends that Policies H-478.980 and D-480.963 be reaffirmed in lieu of Resolution 112.

> INCREASING ACCESS TO BROADBAND INTERNET TO REDUCE HEALTH DISPARITIES H-478.980
> Our American Medical Association will advocate for the expansion of broadband and wireless connectivity to all rural and underserved areas of the United States while at all times taking care to protecting existing federally licensed radio services from harmful interference that can be caused by broadband and wireless services.
>
> COVID-19 EMERGENCY AND EXPANDED TELEMEDICINE REGULATIONS D-480.963
> 1. Our American Medical Association will continue to advocate for the widespread adoption of telehealth services in the practice of medicine for physicians and physician-led teams post SARS-COV-2. 2. Our AMA will advocate that the Federal government, including the Centers for Medicare & Medicaid Services (CMS) and other agencies, state governments and state agencies, and the health insurance industry, adopt clear and uniform laws, rules, regulations, and policies relating to

telehealth services that: a. Provide equitable coverage that allows patients to access telehealth services wherever they are located. b. Provide for the use of accessible devices and technologies, with appropriate privacy and security protections, for connecting physicians and patients. 3. Our AMA will advocate for equitable access to telehealth services, especially for at-risk and under-resourced patient populations and communities, including but not limited to supporting increased funding and planning for telehealth infrastructure such as broadband and internet-connected devices for both physician practices and patients. 4. Our AMA supports the use of telehealth to reduce health disparities and promote access to health care.

Madam Speaker, this concludes the report of Reference Committee A. I would like to thank Ilana Addis, MD, Allan Anderson, MD, Christopher Garofalo, MD, Richard Geline, MD, Neil Rens, MD, MBA, MSc, and Jane Simpson, DO.

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