DISCLAIMER

The following is a preliminary report of actions taken by the House of Delegates at its 2026 Annual Meeting and should not be considered final. Only the Official Proceedings of the House of Delegates reflect official policy of the Association.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (A-26)

Final Report of Reference Committee A

Christine Kim, MD, Chair

Your Reference Committee recommends the following consent calendar for acceptance:

RECOMMENDED FOR ADOPTION

1. Board of Trustees Report 23 – Liberalized Remorse Period for Medicare Advantage Plan Insureds
2. Council on Medical Service Report 5 - Inclusion of Discounted Prescription Medication in Patient Cost-Sharing
3. Council on Medical Service Report 8 - Rural Health Transformation Program Update & Workforce Challenges
4. Resolution 104 – Improving Choice, Competition, and Affordability in the ACA Marketplaces
5. Resolution 105 – Oppose Medicare Advantage Auto Enrollment
6. Resolution 109 – Insurance Coverage for Pediatric Intercranial Neuromodulation for Drug-Resistant Epilepsy
7. Resolution 112 – Ensuring Coverage and Access to Adult Strabismus Surgery

RECOMMENDED FOR ADOPTION AS AMENDED

8. Council on Medical Service Report 3 - Improving Patient Access to Pharmacies and Medications in Pharmacy Deserts
9. Resolution 101 - Revise the Use of Language Stigmatizing Obesity in ICD-10 Code E66.01“Morbid (Severe) Obesity Due to Excess Calories”
10. *Resolution 103 - Supporting Non-Insurance Directed Sales of Pharmaceuticals to Patients to Improve Access and Reduce Costs
11. Resolution 108 – Ensuring Physician Input in the Development of CMMI Models
12. *Resolution 110 – Medicaid Coverage for Incarcerated Individuals
13. Resolution 114 – Opposing Alternative Funding Programs
14. Resolution 115 – Patient Continuity Protections During Payer, PBM Changes
15. Resolution 116 – Study of Cost Implications of Medicaid Managed Care Organizations Compared with State-Administered Medicaid Programs

RECOMMENDED FOR ADOPTION IN LIEU OF

16. Resolution 106 – Insurance Coverage for Scalp Cooling (Cold Capping) Therapy
    Resolution 111 – Advocating for Insurance Coverage of Scale Cooling Therapy to Prevent Chemotherapy-Induced Alopecia

RECOMMENDED FOR REFERRAL

17. Resolution 107 – Oversight of Medicare Advantage Plan
18. *Resolution 113 – Health Insurance Coverage of Hearing Devices and Related Services
19. Resolution 118 - Addressing Proposals to Implement International Reference Pricing for Physician-Administered Drugs

RECOMMENDED FOR NOT ADOPTION

20. Resolution 102 – Study for EMTALA Relief in Psychiatric Facilities

RECOMMENDED FOR REAFFIRMATION IN LIEU OF

21. Resolution 117 – Universal Out of Network Benefits

RECOMMENDED FOR ADOPTION

(1) BOARD OF TRUSTEES REPORT 23 – LIBERALIZED REMORSE PERIOD FOR MEDICARE ADVANTAGE PLAN INSUREDS

RECOMMENDATION:

Your Reference Committee recommends that the Recommendations in Board of Trustees Report 23 be adopted and the remainder of the report be filed.

HOD ACTION: Board of Trustees Report 23 is adopted and the remainder of the report filed.

The Board of Trustees recommends that the following be adopted in lieu of Resolution 117-A-25 and the remainder of the report be filed:

1) That our American Medical Association (AMA) urge the Centers for Medicare & Medicaid Services to create a comprehensive strategy to educate people approaching the age of Medicare eligibility and for annual enrollment periods about key aspects of Medicare affecting choices between traditional Medicare and Medicare Advantage (MA) plans. (Directive to Take Action)

2) That our AMA support a Medicare policy that allows beneficiaries who enroll in MA for the first time to disenroll for any reason and return to traditional Medicare within the first 12 months of enrollment in the plan. (New HOD Policy)

3) That our AMA reaffirm Policy H-330.866, “Medigap Patient Protections.” (Reaffirm HOD Policy)

A majority of testimony supported the recommendations in Board of Trustees Report 23 as written. A delegation’s request to refer the second recommendation was not supported in testimony. Several commenters noted that the proposed “first 12 months” remorse period seems reasonable, and an amendment to delete “for the first time” in the second resolve did not garner support. Your Reference Committee believes that amendments proffered by an individual to add new recommendations are unnecessary as they are sufficiently addressed in Policy H-330.866, which is recommended for reaffirmation. Therefore, your Reference Committee recommends that the recommendations in Board of Trustees Report 23 be adopted and the remainder of the report be filed.

(2) COUNCIL ON MEDICAL SERVICE REPORT 5 – INCLUSION OF DISCOUNTED PRESCRIPTION MEDICATION IN PATIENT COST SHARING

RECOMMENDATION:

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

HOD ACTION: Council on Medical Service Report 5 is adopted and the remainder of the report filed.

The Council on Medical Service recommends that the following recommendation be adopted in lieu of Resolution 710-A-25, and the remainder of the report be filed:

1. Our American Medical Association supports efforts to ensure that all payers and pharmacy benefit managers include any out-of-pocket prescription drug spending related to a covered benefit submitted by the patient, or on behalf of the patient, in cost-sharing, and/or out-of-pocket spending calculations. (New HOD Policy)

Testimony on Council on Medical Service Report 5 was generally supportive of the recommendation's adoption. One delegation voiced concern related to the potential for fraud related to patient payments and the use of independent online physician prescription services, suggesting referral back to the Council. The Council responded by explaining that federal law addresses the concerns around fraud and the issue of online prescription services is altogether separate from the current report. Further, an individual proffered an amendment to encourage education around alternative funding programs and their impact, however, the Council pointed out that this is covered by current AMA policy. Aside from the aforementioned concern and amendment, the remainder of testimony was strongly in support of adoption of the recommendation as written. Therefore, your Reference Committee recommends that the recommendation in Council on Medical Service Report 5 be adopted and the remainder of the report be filed.

(3) COUNCIL ON MEDICAL SERVICE REPORT 8 – RURAL HEALTH TRANSFORMATION PROGRAM UPDATE & WORKFORCE CHALLENGES

RECOMMENDATION:

Your Reference Committee recommends that the Recommendations in Council on Medical Service Report 8 be adopted and the remainder of the report be filed.

HOD ACTION: Council on Medical Service Report 8 is adopted and the remainder of the report filed.

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

1. That our American Medical Association (AMA) monitor legislative and regulatory proposals related to the rural health transformation program or similar rural health initiatives to educate physicians and policymakers regarding the potential opportunities and challenges associated with such programs. (New HOD Policy)

2. That our AMA support the development of funding avenues designated to support costs associated with telehealth in rural hospitals and medical practices. (New HOD Policy)

3. That our AMA support the development and implementation of programs that ensure physicians practicing in rural settings have access to opportunities to meet continuing medical education and continuing professional development requirements. (New HOD Policy)

4. That our AMA encourage the expansion of programs designed to define physician shortage areas and support physicians working in these areas to include specialties necessary to the functioning of a rural medical practice or hospital. (New HOD Policy)

5. That our AMA reaffirm Policy H-465.994, which details efforts to support, promote, and innovate solutions to improve rural health. (Reaffirm HOD Policy)

6. That our AMA reaffirm Policy D-200.980, which outlines support for various strategies to bolster the physician workforce in underserved areas, including rural communities. (Reaffirm HOD Policy)

7. That our AMA reaffirm Policy H-465.988, which specifies strategies and efforts to improve the physician workforce that focus on education and practice solutions. (Reaffirm HOD Policy)

Testimony on Council on Medical Service Report 8 was overwhelmingly supportive. Testifiers reiterated the importance of rural health care and the need to ensure that rural health systems, providers, and physicians have the support they need to succeed. Testimony also suggests directions for future Council reports on rural health including supporting practice equity, further updates on the Rural Health Transformation program, and potential options to “offset” cuts that

many rural hospitals are experiencing. Due to the supportive testimony on this report, your Reference Committee recommends that the recommendations in Council on Medical Service Report 8 be adopted and the remainder of the report be filed.

(4) RESOLUTION 104 - IMPROVING CHOICE, COMPETITION, AND AFFORDABILITY IN THE ACA MARKETPLACES

RECOMMENDATION:

Your Reference Committee recommends that Resolution 104 be adopted.

HOD ACTION: Resolution 104 is adopted.

RESOLVED, that our American Medical Association support expanding choice and competition on ACA Marketplaces, including by allowing ACA premium tax credits to be applied to the entire premium for qualifying Marketplace health plans, including the portion of the premium attributable to benefits that are not considered Essential Health Benefits (New HOD Policy)

RESOLVED, that our AMA support improving the benchmark plan on the ACA Marketplaces from the second-lowest cost silver plan to at least the second-lowest cost gold plan. (New HOD Policy)

A majority of testimony supported Resolution 104, although two commenters testified against it. Supporters emphasized that the proposed structural reforms to the ACA would make marketplace plans more affordable and flexible, while opponents noted that the resolution would not expand access to coverage but could lead to higher premiums and increased costs to the federal government. Because supporters of Resolution 104 outnumbered opponents, your Reference Committee recommends that it be adopted.

(5) RESOLUTION 105 - OPPOSE MEDICARE ADVANTAGE AUTO ENROLLMENT

RECOMMENDATION:

Your Reference Committee recommends that Resolution 105 be adopted.

HOD ACTION: Resolution 105 is adopted.

RESOLVED, that our American Medical Association oppose efforts to force Medicare recipients to be auto enrolled into Medicare Advantage plans, thus making Medicare Advantage plans the default option. (New HOD Policy)

Your Reference Committee heard testimony in strong support of Resolution 105. Commenters agreed that current AMA policy (Policy H-285.905) directs the AMA to work to end auto-enrollment in Medicare Advantage but expressed a preference for the stronger language in Resolution 105. Although testimony also requested that the resolution be labeled a "Directive for Action," your Reference Committee points out that such labeling is typically not determined by reference committees but instead is assigned after the House of Delegates meeting. Your Reference Committee highlights the preference in testimony that Resolution 105 become a Directive and recommends that Resolution 105 be adopted.

(6) RESOLUTION 109 - INSURANCE COVERAGE FOR PEDIATRIC INTRACRANIAL NEUROMODULATION FOR DRUG-RESISTANT EPILEPSY

RECOMMENDATION:

Your Reference Committee recommends that Resolution 109 be adopted.

HOD ACTION: Resolution 109 is adopted.

RESOLVED, that our American Medical Association advocate for insurance coverage of intracranial neuromodulation as an acceptable treatment for appropriate pediatric patients with drug-resistant epilepsy (Directive to Take Action)

RESOLVED, that our AMA advocate for insurance coverage of chronic pain neuromodulation therapies such as intracranial, spinal cord and peripheral stimulation, as acceptable treatment for appropriate pediatric patients with chronic refractory pain. (Directive to Take Action)

Testimony was strongly supportive of Resolution 109. Testimony explained that for many patients these treatments may be the only options and often significantly improve quality of life. One delegation suggested that the second resolve should be deleted as it represented a separate issue. However, the remainder of the testimony was in strong support of both resolve clauses and explained that intracranial modulation treatment is a form of non-opioid intervention for pediatric patients experiencing severe, refractory disease. Therefore, your Reference Committee recommends that Resolution 109 be adopted.

(7) RESOLUTION 112 - ENSURING COVERAGE AND ACCESS TO ADULT STRABISMUS SURGERY

RECOMMENDATION:

Your Reference Committee recommends that Resolution 112 be adopted.

HOD ACTION: Resolution 112 is adopted.

RESOLVED, that our American Medical Association advocate for national insurer recognition of adult strabismus surgery as medically necessary, and to oppose insurer policies that misclassify such surgery as cosmetic. (Directive to Take Action)

Testimony was supportive of Resolution 112 and the need for appropriate coverage of adult strabismus surgery. Testimony outlined the need for broader national insurer recognition that adult strabismus surgery is not a cosmetic procedure but is a medical necessity that can otherwise cause debilitating impairment and distress for the patient. As a result of supportive testimony, your Reference Committee recommends that Resolution 112 be adopted.

RECOMMENDED FOR ADOPTION AS AMENDED

(8) COUNCIL ON MEDICAL SERVICE REPORT 3 – IMPROVING PATIENT ACCESS TO PHARMACIES AND MEDICATIONS IN PHARMACY DESERTS

RECOMMENDATION A:

Your Reference Committee recommends that the first Recommendation of Council on Medical Service Report 3 be amended by addition to read as follows:

1. Our American Medical Association (AMA) supports efforts to ensure that pharmacy reimbursement by all payers covers the actual cost of obtaining and dispensing the medication, including necessary staffing and operational costs with a sufficient margin to ensure pharmacy viability.

RECOMMENDATION B:

Your Reference Committee recommends that the second Recommendation of Council on Medical Service Report 3 be amended by addition and deletion to read as follows:

2. Our AMA supports the establishment and enforcement of a minimum preferred pharmacy network adequacy standard requiring all health plans to contract with sufficient numbers of pharmacies, including, ~~when possible,~~ independent and/or physician-owned pharmacies, such that patient medications or medical products are accessible without unreasonable travel or delay. (New HOD Policy)

RECOMMENDATION C:

Your Reference Committee recommends that the third Recommendation of Council on Medical Service Report 3 be amended by addition to read as follows:

3. Our AMA recognizes telepharmacy and remote dispensing as avenues to improve access to prescription medications and supports their expansion and encourages payer coverage when the following criteria are met:
a. Services are provided by pharmacists within a clearly defined scope of practice that does not constitute the practice of medicine without appropriate physician supervision.

b. Medications are delivered to patients accurately and in a timely manner.
c. Communication between pharmacy systems is maintained to ensure an accurate medication list so that patients are educated on all their medications with key safety information.
d. Patients are not subjected to increased cost-sharing or major shipping and handling fees to receive their medications.
e. Existing community pharmacies are not displaced.
f. Patients and physicians are able to opt out of telepharmacy and remote dispensing

RECOMMENDATION D:

Your Reference Committee recommends that the Recommendations in Council on Medical Service Report 3 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Council on Medical Service Report 3 is adopted as amended and remainder of report filed.

ADOPTED LANGUAGE:

1. **Our American Medical Association (AMA) supports efforts to ensure that pharmacy reimbursement by all payers covers the actual cost of obtaining and dispensing the medication, including necessary staffing and operational costs with a sufficient margin to ensure pharmacy viability.**
2. **Our AMA supports the establishment and enforcement of a minimum preferred pharmacy network adequacy standard requiring all health plans to contract with sufficient numbers of pharmacies, including independent and/or physician-owned pharmacies, such that patient medications or medical products are accessible without unreasonable travel or delay. (New HOD Policy)**
3. **Our AMA recognizes telepharmacy and remote dispensing as avenues to improve access to prescription medications and supports their expansion and encourages payer coverage when the following criteria are met:**
    a. **Services are provided by pharmacists within a clearly defined scope of practice that does not constitute the practice of medicine without appropriate physician supervision.**
    b. **Medications are delivered to patients accurately and in a timely manner.**
    c. **Communication between pharmacy systems is maintained to ensure an accurate medication list so that patients are educated on all their medications with key safety information.**
    d. **Patients are not subjected to increased cost-sharing or major shipping and handling fees to receive their medications.**
    e. **Existing community pharmacies are not displaced.**
    f. **Patients and physicians are able to opt out of telepharmacy and remote dispensing**

4. **Our AMA supports the development of innovative programs designed to improve access to pharmacies and the appropriate regulatory changes to allow for these programs to be implemented while ensuring high-quality, physician-led care in alignment with AMA policy. (New HOD Policy)**

5. **Our AMA supports practices by payers/insurers or pharmacy benefit managers (PBMs) that promote fair market competition, patient access and choice of pharmacy, and supports the financial viability of full-service independent/community pharmacies. (New HOD Policy)**

6. **That our AMA reaffirm Policy H-120.989, which recognizes mail order pharmacy services as legitimate method for drug distribution and outlines its appropriate use. (Reaffirm HOD Policy)**

7. **That our AMA reaffirm Policy D-110.987, which outlines AMA advocacy and support for PBM regulation. (Reaffirm HOD Policy)**

The Council on Medical Service recommends that the following recommendations be adopted in lieu of Resolution 113-A-25, and the remainder of the report be filed:

1. Our American Medical Association (AMA) supports efforts to ensure that pharmacy reimbursement by all payers covers the actual cost of obtaining and dispensing the medication, including necessary staffing and operational costs. (New HOD Policy)

2. Our AMA supports the establishment and enforcement of a minimum preferred pharmacy network adequacy standard requiring all health plans to contract with sufficient numbers of pharmacies, including, when possible, independent pharmacies, such that patient medications or medical products are accessible without unreasonable travel or delay. (New HOD Policy)

3. Our AMA recognizes telepharmacy and remote dispensing as avenues to improve access to prescription medications and supports their expansion and encourages payer coverage when the following criteria are met:
a. Services are provided by pharmacists within a clearly defined scope of practice that does not constitute the practice of medicine without appropriate physician supervision.
b. Medications are delivered to patients accurately and in a timely manner.
c. Communication between pharmacy systems is maintained to ensure an accurate medication list so that patients are educated on all their medications with key safety information.
d. Patients are not subjected to increased cost-sharing or major shipping and handling fees to receive their medications.
e. Existing community pharmacies are not displaced. (New HOD Policy)

4. Our AMA supports the development of innovative programs designed to improve access to pharmacies and the appropriate regulatory changes to allow for these programs to be implemented while ensuring high-quality, physician-led care in alignment with AMA policy. (New HOD Policy)

5. Our AMA supports practices by payers/insurers or pharmacy benefit managers (PBMs) that promote fair market competition, patient access and choice of pharmacy, and supports the financial viability of full-service independent/community pharmacies. (New HOD Policy)

6. That our AMA reaffirm Policy H-120.989, which recognizes mail order pharmacy services as legitimate method for drug distribution and outlines its appropriate use. (Reaffirm HOD Policy)

7. That our AMA reaffirm Policy D-110.987, which outlines AMA advocacy and support for PBM regulation. (Reaffirm HOD Policy)

Testimony on Council on Medical Service Report 3 was supportive of the report and its recommendations. While supportive, commenters did proffer a number of amendments to the recommendations in the report. First, three relatively minor amendments were proffered, which the Council accepted as friendly amendments. Second, an amendment was proffered by a delegation to Recommendation 3a that sought to clarify the wording, however the Council on Medical Service explained that the new wording could indicate support for expanded pharmacist scope of practice. Third, an individual proffered alternative third and fifth recommendations that would only allow for telepharmacy expansion in communities that do not have a community pharmacy and to prohibit pharmacy benefit managers from owning pharmacies. The Council responded to the first of these points and explained that the original wording of this recommendation protect community pharmacies while supporting patient choice. Further, in response to the second point, the Council explained that the original wording of the fourth Recommendation covers anti-competitive practices beyond only vertical integration and existing AMA Policy details advocacy to move away from vertical integration between pharmacy benefit managers and pharmacies. Finally, amendments were proffered for additional recommendations that were designed to support continuity of care for patients and support the use of long-acting injectables in outpatient pharmacies. In response to these suggested new recommendations, the Council testified that they are beyond the scope of this report and thus should not be added. Your Reference Committee wishes to note that an amendment proffered to the sixth recommendation is not possible as this recommendation is simply reaffirming existing policy. Your Reference Committee was swayed by the testimony from the Council related to the proffered amendments, the fact that amendments got no or limited support outside of the delegation or individual who proffered them, and the overwhelming testimony in support of the report. Therefore, your Reference Committee recommends that the recommendations in Council on Medical Service Report 3 be adopted as amended and the remainder of the report be filed.

(9) RESOLUTION 101 - REVISE THE USE OF LANGUAGE STIGMATIZING OBESITY IN ICD-10 CODE E66.01"MORBID (SEVERE) OBESITY DUE TO EXCESS CALORIES"

RECOMMENDATION A:

Your Reference Committee recommends that Resolution 101 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association will advocate to the Centers for Medicare & Medicaid Services and other ~~payors~~payers to utilize ~~for~~ equivalent, ~~risk-adjusted payment for alternate~~ ICD-10-CM codes ~~with more~~ that are patient-centered, neutral, and non-stigmatizing for payment, quality measures, and risk adjustment~~language in place of ICD-10 code E66.01~~.

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 101 be adopted as amended.

RECOMMENDATION C:

The Title of Resolution 101 be changed:

PAYER COVERAGE OF NON-STIGMATIZING LANGUAGE IN ICD-10-CM

HOD ACTION: Resolution 101 is amended with a title change.

ADOPTED LANGUAGE:

PAYER COVERAGE OF NON-STIGMATIZING LANGUAGE IN ICD-10-CM

RESOLVED, that our American Medical Association will advocate to the Centers for Medicare & Medicaid Services and other payers to utilize equivalent, ICD-10-CM codes that are patient-centered, neutral, and non-stigmatizing for payment, quality measures, and risk adjustment.

RESOLVED, that our American Medical Association will advocate to the Centers for Medicare & Medicaid Services and other payors for equivalent, risk-adjusted payment for alternate codes with more patient-centered, neutral, and non-stigmatizing language in place of ICD-10 code E66.01. (Directive to Take Action)

Testimony on Resolution 101 was supportive of the resolution's intent but mixed in suggested outcome. All testimony agreed that it was important for physicians to be able to use and be paid

for codes that are non-stigmatizing to patients. Testimony from a delegation, the Council on Medical Service, and individuals supported the reaffirmation of existing AMA policy proffered by staff. However, testimony from other delegations, including the resolution's author, explained that the intent of Resolution 101 was not only code language but also payment. As a result, the Council on Medical Service proffered amended language that would allow for advocacy for all ICD-10-CM codes. Further, to ensure the title of this resolution match the amended language, the Council suggested a title change. This amendment was supported by the resolution authors and therefore, your Reference Committee recommends that Resolution 101 be adopted as amended with a title change.

(10) *RESOLUTION 103 - SUPPORTING NON-INSURANCE DIRECTED SALES OF PHARMACEUTICALS TO PATIENTS TO IMPROVE ACCESS AND REDUCE COSTS

RECOMMENDATION A:

Your Reference Committee recommends that the second resolve of Resolution 103 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA advocate that health insurers, pharmacy benefit managers, pharmacies, and affiliated distribution entities should ensure that when a patient is using their insurance benefits, they cannot be charged more than the lowest publicly available cash ~~match the lowest available bona fide patient~~ price for the same drug, strength, dosage form, and quantity available through a valid prescription, whether offered through the patient's insurance benefit, a coupon-based retail program, a direct-to-consumer pharmacy, or a direct manufacturer-to-patient sales channel (Directive to Take Action)

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 103 be adopted as amended.

HOD ACTION: Resolution 103 is amended.

ADOPTED LANGUAGE:

RESOLVED, that our American Medical Association advocate for legislation and regulation to ensure that when a patient with health insurance purchases an FDA-approved prescription medication pursuant to a valid prescription through a lawful cash-pay, coupon-based, direct-to-consumer pharmacy, or direct manufacturer-to-patient sales platform, the patient's out-of-pocket payment for that medication shall be credited toward the patient's deductible and annual out-of-pocket maximum to the same extent as

if the medication had been obtained through the patient's insurance-arranged pharmacy or distribution channel.

RESOLVED, that our AMA advocate that health insurers, pharmacy benefit managers, pharmacies, and affiliated distribution entities should ensure that when a patient is using their insurance benefits, they cannot be charged more than the lowest publicly available cash price for the same drug, strength, dosage form, and quantity available through a valid prescription, whether offered through the patient's insurance benefit, a coupon-based retail program, a direct-to-consumer pharmacy, or a direct manufacturer-to-patient sales channel.

RESOLVED, that our AMA advocate that patients and prescribing physicians receive transparent point-of-sale disclosure of the patient's expected out-of-pocket cost through the insurance benefit and any lower lawful cash or direct-purchase price available for the prescribed medication.

RESOLVED, that our American Medical Association advocate for legislation and regulation to ensure that when a patient with health insurance purchases an FDA-approved prescription medication pursuant to a valid prescription through a lawful cash-pay, coupon-based, direct-to-consumer pharmacy, or direct manufacturer-to-patient sales platform, the patient's out-of-pocket payment for that medication shall be credited toward the patient's deductible and annual out-of-pocket maximum to the same extent as if the medication had been obtained through the patient's insurance-arranged pharmacy or distribution channel (Directive to Take Action)

RESOLVED, that our AMA advocate that health insurers, pharmacy benefit managers, pharmacies, and affiliated distribution entities should match the lowest available bona fide patient price for the same drug, strength, dosage form, and quantity available through a valid prescription, whether offered through the patient's insurance benefit, a coupon-based retail program, a direct-to-consumer pharmacy, or a direct manufacturer-to-patient sales channel (Directive to Take Action)

RESOLVED, that our AMA advocate that patients and prescribing physicians receive transparent point-of-sale disclosure of the patient's expected out-of-pocket cost through the insurance benefit and any lower lawful cash or direct-purchase price available for the prescribed medication. (Directive to Take Action)

Testimony on Resolution 103 was generally in support of the intent, with some testimony voicing reservations. Generally, testimony outlined the importance of ensuring that patients are able to afford medications and that appropriate spending should be included in patient cost-sharing calculations. The Council on Medical Service testified that the recommendation in Council Report 5, currently before the House, has significant overlap with Resolution 103 resolve one and encouraged the removal of the first resolve, and the adoption of the recommendation in Council Report 5, to avoid duplicative policy. Two delegations voiced concern that the resolution, particularly the first resolve clause, could increase utilization management and weaken formulary protections. One of these delegations agreed with the Council on Medical Service, preferring the language in the Council's recommendation to the first resolve clause of 103. Further, in-person testimony offered an amendment of the phrasing for a portion of the second resolve designed to clarify the language. Testimony was supportive of the amendment and explained it retained the intent of the original resolution but strengthened the language.

Your Reference Committee believes that while the language of Resolution 103 does somewhat overlap with the language in Council Report 5, the resolution is additive and complements the report language and that the amended language does strengthen the resolution. Therefore, your Reference Committee recommends that Resolution 103 be adopted as amended.

(11) RESOLUTION 108 - ENSURING PHYSICIAN INPUT IN THE DEVELOPMENT OF CMMI MODELS

RECOMMENDATION A:

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

RESOLVED, that our American Medical Association seek meaningful and transparent involvement of actively practicing physicians, nominated by relevant national specialty societies, ~~who could potentially be participants~~ in the development of Center for Medicare and Medicaid Innovation (CMMI) models throughout the model development process, prior to approval for testing or implementation. (Directive to Take Action)

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 108 be adopted as amended.

HOD ACTION: Resolution 108 is amended.

ADOPTED LANGUAGE:

RESOLVED, that our American Medical Association seek meaningful and transparent involvement of actively practicing physicians, nominated by relevant national specialty societies, in the development of Center for Medicare and Medicaid Innovation (CMMI) models throughout the model development process, prior to approval for testing or implementation.

RESOLVED, that our American Medical Association seek meaningful and transparent involvement of physicians who could potentially be participants in Center for Medicare and Medicaid Innovation (CMMI) models throughout the model development process, prior to approval for testing or implementation. (Directive to Take Action)

Testimony on Resolution 108 was entirely in support of the resolution and its intent. Testifiers explained the challenges of the downstream impacts of CMMI models and how physician involvement could mitigate issues. One delegation offered an amendment intended to clarify the wording and how physicians would be nominated to participate. Although no other testimony directly addressed this amendment, your Reference Committee believes that the amendment is

germane to the original resolution and improves its clarity. Therefore, your Reference Committee recommends that Resolution 108 be adopted as amended.

(12) *RESOLUTION 110 - MEDICAID COVERAGE FOR INCARCERATED INDIVIDUALS

RECOMMENDATION A:

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

RESOLVED, that our American Medical Association advocate such that Medicaid programs ensure continued financial coverage for ongoing medications during incarceration~~, in order to prevent adverse and potentially irreversible health outcomes resulting from the discontinuation of established and evidence-based medication therapies~~.

RECOMMENDATION B:

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

HOD ACTION: Resolution 110 is amended.

ADOPTED LANGUAGE:

RESOLVED, that our American Medical Association advocate such that Medicaid programs ensure continued financial coverage for ongoing medications during incarceration.

RESOLVED, that our American Medical Association advocate such that Medicaid programs ensure continued financial coverage for ongoing medications during incarceration, in order to prevent adverse and potentially irreversible health outcomes resulting from the discontinuation of established and evidence-based medication therapies. (Directive to Take Action)

Testimony on Resolution 110 was supportive of the intent of the resolution. All testifiers were in agreement that it is essential to ensure that incarcerated individuals have access to necessary medical care. Testimony did explain the implementation challenges that would be faced due to a provision in the Social Security Act that prohibits federal Medicaid and Medicare health spending on incarcerated individuals unless they are in an inpatient setting. To combat this, some testimony suggested reaffirmation may be more appropriate as existing policy already calls for the repeal of this prohibition and the full coverage of health care during incarceration. In-person testimony suggested that the second portion of the resolution had the potential to be interpreted offensively and therefore suggested its removal. Further, testimony explained that the removal of the second half of the resolve does not change the intent of the resolution. Since the majority of testimony was in support of the intent of this resolution and the removal of the

second portion does not impact its implementation, your Reference Committee recommends Resolution 110 be adopted as amended.

(13) RESOLUTION 114 - OPPOSING ALTERNATIVE FUNDING PROGRAMS

RECOMMENDATION A:

Your Reference Committee recommends that Resolution 114 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association oppose the use of Alternative Funding Programs (AFPs) and similarly functioning benefit designs including but not limited to those that condition patient access to covered medications on enrollment in third-party assistance programs or reclassify covered drugs as non-essential health benefits to avoid plan payment and be it further; ~~and advocate for federal and state legislation and regulation prohibiting their use~~.

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 114 be amended by addition of a new resolve to read as follows:

RESOLVED, that our AMA advocate for federal and state legislation or regulation prohibiting insurance benefit designs that condition patient access to a covered medication on enrollment in a third-party assistance program or that reclassify a covered prescription drug as a non-essential health benefit to avoid plan payment obligations. (New HOD Policy)

RECOMMENDATION C:

Your Reference Committee recommends that Resolution 114 be adopted as amended.

HOD ACTION: Resolution 114 is amended.

ADOPTED LANGUAGE:

RESOLVED, that our American Medical Association oppose the use of Alternative Funding Programs (AFPs) and similarly functioning benefit designs including but not limited to those that condition patient access to covered medications on enrollment in

third-party assistance programs or reclassify covered drugs as non-essential health benefits to avoid plan payment and be it further;

RESOLVED, that our AMA advocate for federal and state legislation or regulation prohibiting insurance benefit designs that condition patient access to a covered medication on enrollment in a third-party assistance program or that reclassify a covered prescription drug as a non-essential health benefit to avoid plan payment obligations.

RESOLVED, that our American Medical Association oppose the use of Alternative Funding Programs (AFPs) and similarly functioning benefit designs and advocate for federal and state legislation and regulation prohibiting their use. (New HOD Policy)

Testimony on Resolution 114 was supportive of the intent of the resolution. Testimony explained the harm that is caused by alternative funding programs and the lack of transparency in the practice. One delegation offered an amendment to generalize the language, however one of the resolution co-sponsors explained that the language was intentionally specific to ensure that alternative funding programs would not be able to be easily modified to fall outside of regulation. The resolution co-sponsors offered an alternative amendment that captured both the intent of the original resolution and the amendment to generalize language. Your Reference Committee agrees that the amendment proffered by the resolution co-sponsors is best representative of testimony and therefore recommends that Resolution 114 be adopted as amended.

(14) RESOLUTION 115 - PATIENT CONTINUITY PROTECTIONS DURING PAYER, PBM CHANGES

RECOMMENDATION A:

Your Reference Committee recommends that the first resolve of Resolution 115 be amended by addition to read as follows:

RESOLVED, that our American Medical Association seek federal and state legislation and regulation mandating a minimum 90-day transition-of-care grace period for patients with chronic or life-threatening conditions during which their existing treatment plan, including treatment location, physician/non-physician provider, prior authorizations, utilization management strategies, and formulary status, must be honored without interruption and that patients be notified of any changes in a clear and timely manner (Directive to Take Action); and be it further

RECOMMENDATION B:

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

RESOLVED, that our AMA advocate that ~~these~~90-day transition-of-care protections specifically apply to instances where a patient's health plan or pharmacy benefit manager undergoes structural changes, including but not limited to corporate mergers, acquisitions, or pharmacy benefit manager contract transitions, to prevent non-medical switching and ensure continuity of care.

RECOMMENDATION C:

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

HOD ACTION: Resolution 115 is amended.

ADOPTED LANGUAGE:

RESOLVED, that our American Medical Association seek federal and state legislation and regulation mandating a minimum 90-day transition-of-care grace period for patients with chronic or life-threatening conditions during which their existing treatment plan, including treatment location, physician/non-physician provider, prior authorizations, utilization management strategies, and formulary status, must be honored without interruption and that patients be notified of any changes in a clear and timely manner; and be it further

RESOLVED, that our AMA advocate that 90-day transition-of-care protections specifically apply to instances where a patient's health plan or pharmacy benefit manager undergoes structural changes, including but not limited to corporate mergers, acquisitions, or pharmacy benefit manager contract transitions, to prevent non-medical switching and ensure continuity of care.

RESOLVED, that our American Medical Association seek federal and state legislation and regulation mandating a minimum 90-day transition-of-care grace period for patients with chronic or life-threatening conditions during which their existing treatment plan, including prior authorizations and formulary status, must be honored without interruption (Directive to Take Action);

RESOLVED, that our AMA advocate that these 90-day protections specifically apply to instances where a patient's health plan or pharmacy benefit manager undergoes structural changes, including but not limited to corporate mergers, acquisitions, or pharmacy benefit manager contract transitions, to prevent non-medical switching and ensure continuity of care. (Directive to Take Action)

Testimony on Resolution 115 was strongly in support. Testimony explained the importance of ensuring that patients have a reasonable amount of time to, in conjunction with their physician(s), develop and implement an alternative treatment plan when their health plan/pharmacy benefit manager undergoes structural changes. Amendments were proffered to ensure that the second resolve is able to stand independently and to remove specificity of the

90-day continuity period. While the editorial change to the second resolve was accepted by the resolution authors, the removal of the 90-day continuity period was refuted as testimony felt this specificity was crucial. Further, amendments were proffered to ensure that utilization management is not increased during the transition period, patients are notified of changes, and that in-network coverage is maintained for different practice settings and physician/provider. While the original amendments were proffered as three new resolve clauses, your Reference Committee believes that the presented amended language encompasses the intent of the amendment in a more efficient manner. Since the majority of testimony was in support of this resolution and the intent of the amendments, your Reference Committee recommends that Resolution 115 be adopted as amended.

(15) RESOLUTION 116 - STUDY OF COST IMPLICATIONS OF MEDICAID MANAGED CARE ORGANIZATIONS COMPARED WITH STATE-ADMINISTERED MEDICAID PROGRAMS

RECOMMENDATION A:

Your Reference Committee recommends that Resolution 116 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association study and report back to the HOD at ~~I-26~~ A-27 on Medicaid managed care organizations and state-administered Medicaid programs, including:

- The comparative fiscal implications of programs administered through Medicaid managed care organizations versus those administered directly by states, including administrative costs, medical expenditures, and program oversight costs.
- Whether Medicaid managed care arrangements result in net cost savings, increased costs, or cost neutrality compared with state-administered models.
- The administrative impact of Medicaid managed care participation on physicians and health systems, including prior authorization requirements, network contracting, and claims administration.
- Whether Medicaid managed care arrangements result in increased payments to physicians, including achievement of Medicare-to-Medicaid payment parity.
- Whether Medicaid managed care impacts patient access to care, including in rural areas. (Directive to Take Action)

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 116 be adopted as amended.

HOD ACTION: Resolution 116 is amended.

ADOPTED LANGUAGE:

RESOLVED, That our American Medical Association study and report back to the HOD at A-27 on Medicaid managed care organizations and state-administered Medicaid programs, including:

- **The comparative fiscal implications of programs administered through Medicaid managed care organizations versus those administered directly by states, including administrative costs, medical expenditures, and program oversight costs.**
- **Whether Medicaid managed care arrangements result in net cost savings, increased costs, or cost neutrality compared with state-administered models.**
- **The administrative impact of Medicaid managed care participation on physicians and health systems, including prior authorization requirements, network contracting, and claims administration.**
- **Whether Medicaid managed care arrangements result in increased payments to physicians, including achievement of Medicare-to-Medicaid payment parity.**
- **Whether Medicaid managed care impacts patient access to care, including in rural areas.**

RESOLVED, That our American Medical Association study and report back to the HOD at I-26 on Medicaid managed care organizations and state-administered Medicaid programs, including:

- The comparative fiscal implications of programs administered through Medicaid managed care organizations versus those administered directly by states, including administrative costs, medical expenditures, and program oversight costs.
- Whether Medicaid managed care arrangements result in net cost savings, increased costs, or cost neutrality compared with state-administered models.
- The administrative impact of Medicaid managed care participation on physicians and health systems, including prior authorization requirements, network contracting, and claims administration. (Directive to Take Action)

Testimony was supportive of Resolution 116. Three amendments were proffered, including a request to change the due date from the 2026 Interim Meeting to the 2027 Annual Meeting. Your Reference Committee recommends this change, along with new bullet points that commenters suggested be addressed in the requested study. Your Reference Committee recommends that Resolution 116 be adopted as amended.

RECOMMENDED FOR ADOPTION IN LIEU OF

(16) RESOLUTION 106 - INSURANCE COVERAGE FOR SCALP COOLING (COLD CAPPING) THERAPY
RESOLUTION 111 - ADVOCATING FOR INSURANCE COVERAGE OF SCALP COOLING THERAPY TO PREVENT CHEMOTHERAPY-INDUCED ALOPECIA

RECOMMENDATION:

Your Reference Committee recommends that Alternate Resolution 106 be adopted in lieu of Resolutions 106 and 111.

RESOLVED, that our American Medical Association encourage insurance coverage, and reduced cost-sharing, for scalp cooling therapy for patients undergoing chemotherapy regimens for which scalp cooling is supported by evidence-based clinical guidelines to prevent chemotherapy-induced alopecia; and be it further

RESOLVED, that our AMA work with interested national medical specialty societies to support the development of clinical guidance on appropriate patient selection criteria for scalp cooling therapy, promote broad and equitable access to scalp cooling therapy, advance public awareness and legislative advocacy supporting insurance coverage of scalp cooling, and encourage research into additional evidence-based interventions for chemotherapy-induced alopecia. (New HOD Policy)

HOD ACTION: Alternate Resolution 106 is adopted in lieu of Resolutions 106 and 111.

ADOPTED LANGUAGE:

RESOLVED, that our American Medical Association encourage insurance coverage, and reduced cost-sharing, for scalp cooling therapy for patients undergoing chemotherapy regimens for which scalp cooling is supported by evidence-based clinical guidelines to prevent chemotherapy-induced alopecia; and be it further

RESOLVED, that our AMA work with interested national medical specialty societies to support the development of clinical guidance on appropriate patient selection criteria for scalp cooling therapy, promote broad and equitable access to scalp cooling therapy, advance public awareness and legislative advocacy supporting insurance coverage of scalp cooling, and encourage research into additional evidence-based interventions for chemotherapy-induced alopecia. (New HOD Policy)

RESOLUTION 106

RESOLVED, that our American Medical Association supports insurance coverage for scalp cooling ("cold capping") for patients undergoing chemotherapy in order to minimize cost-sharing and ensure equitable access to this evidence-based intervention. (New HOD Policy)

RESOLUTION 111

RESOLVED, that our American Medical Association advocate for all payers to provide insurance coverage for scalp cooling systems for patients receiving chemotherapy who are at risk of chemotherapy-induced alopecia (Directive to Take Action)

RESOLVED, that our AMA engage in continued national advocacy to promote broad and equitable access to scalp cooling therapy through public and private health insurance plans (Directive to Take Action)

RESOLVED, that our AMA collaborate with relevant dermatology organizations (such as the American Academy of Dermatology), oncology organizations (such as the American Society of Clinical Oncology), and other appropriate medical societies and patient advocacy groups to advance public awareness and legislative action supporting insurance coverage for scalp cooling therapy. (Directive to Take Action)

Testimony on Resolutions 106 and 111 was mixed. Although commenters agreed that the resolutions should be combined and considered together, testimony did not coalesce around a particular disposition. Supporters of Resolutions 106 and 111 noted that alopecia is a serious consequence of chemotherapy and, furthermore, that scalp cooling systems are FDA-approved, supported by strong safety and efficacy data, and endorsed by reputable national organizations. However, a commenter proffering alternate language cautioned that available evidence supports the efficacy of scalp cooling for many chemotherapy regimens but it is contraindicated for certain patients. One delegation argued that coverage of scalp cooling will crowd out coverage of more important services and further increase the cost of insurance. This same delegation requested referral. Based upon the range of opinions and alternate language offered in testimony, your Reference Committee crafted an alternate resolution that encourages insurance coverage of scalp cooling without calling for a new mandate, and maintains that coverage should be supported by evidence-based clinical guidelines. Your Reference Committee recommends that Alternate Resolution 106 be adopted in lieu of Resolutions 106 and 111.

RECOMMENDED FOR REFERRAL

(17) RESOLUTION 107 – OVERSIGHT OF MEDICARE ADVANTAGE PLAN

RECOMMENDATION:

Your Reference Committee recommends that Resolution 107 be referred.

HOD ACTION: Resolution 107 is referred.

RESOLVED, that our American Medical Association support equivalence in treatment and prior-authorization guidelines between Medicare Advantage plans and Traditional Medicare (New HOD Policy)

RESOLVED, that our AMA support and seek legislation that proprietary criteria shall not supersede the professional judgment of the patient's physician when determining Medicare and Medicare Advantage patient eligibility for procedures and admissions (Directive to Take Action)

RESOLVED, that our AMA support the revision of Medicare Advantage risk adjustment formulas to ensure that claims data is based on the actual cost of providing care (New HOD Policy);

RESOLVED, that our AMA lobby in support of Medicare Payment Advisory Commission recommendations to develop an improved risk adjustment model and change the current benchmark policy to one that bases federal payments to Medicare Advantage organizations and Medicare Advantage payments to physicians/healthcare centers on more accurate fee-for-service-derived benchmarks (Directive to Take Action)

RESOLVED, that our AMA support the allocation of federal funds to study how financial savings generated through enactment of Medicare Payment Advisory Commission recommendations and AMA policies for reform of the Medicare Advantage program can be used to improve Traditional Medicare. (New HOD Policy)

Testimony on Resolution 107 was mixed. Testimony noted that the first three resolve clauses are addressed in existing AMA policy (Policies D-285.959 and H-330.867), with some testimony also noting that the first two resolves are unnecessary and should be deleted. Testimony on the fourth and fifth resolve clauses was mixed, with some commenters supporting, and others cautioning against MedPAC's recommended approach to risk adjustment in Medicare Advantage. Several amendments were proffered to the various resolve clauses, and referral was also suggested. Your Reference Committee agrees that the resolution is complex and warrants further study before new policy is adopted on a preferred risk adjustment approach. We therefore recommend that Resolution 107 be referred.

(18) *RESOLUTION 113 - HEALTH INSURANCE COVERAGE OF HEARING DEVICES AND RELATED SERVICES

RECOMMENDATION:

Your Reference Committee recommends that Resolution 113 be referred.

HOD ACTION: Resolution 113 is referred.

RESOLVED, that our American Medical Association support public and private health insurance coverage of hearing services and devices, including digital hearing aids and routine replacements, for hearing-impaired adults aged 18-64. (New HOD Policy)

Testimony on Resolution 113 was mixed. Supporters highlighted the need to close a gap in AMA policy with regard to hearing coverage for adults aged 18-64. Some spoke in favor of covering all individuals regardless of age. Cost concerns were raised, especially due to budget neutrality requirements in Medicare. Additionally, your Reference Committee recognizes that the coverage landscape is complex and has concerns about unintended consequences on state Medicaid budgets which could affect other physician services. Several speakers, including practicing physicians who provide hearing services, requested referral of the resolution so that scope of practice issues could be addressed with assurances that hearing services must be provided by appropriate physician-led teams. Your Reference Committee agrees that these issues are complex and recommends that Resolution 113 be referred.

(19) RESOLUTION 118 – ADDRESSING PROPOSALS TO IMPLEMENT INTERNATIONAL REFERENCE PRICING FOR PHYSICIAN-ADMINISTERED DRUGS

RECOMMENDATION:

Your Reference Committee recommends that Resolution 118 be referred.

HOD ACTION: Resolution 118 is referred.

RESOLVED, that our American Medical Association remain committed to the position that international price indices or averages should not be used in isolation to set or determine prescription drug prices or payments (New HOD Policy)

RESOLVED, that our AMA work with state medical societies and specialty societies to educate policymakers on the risks of misaligned reimbursement under international reference pricing models and to promote approaches that reduce drug costs without jeopardizing patient access or practice sustainability (Directive to Take Action); and be it further

RESOLVED, that our AMA amend policy H-110.980 by addition to read as follows:

1. Our American Medical Association 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 by:

<u>1. Ensuring reimbursement at or above acquisition cost for physician-administered drugs.</u>

<u>2. Protecting patient access to in-office treatments.</u>

<u>3. Avoiding shifting care to higher-cost settings.</u>

<u>4. Minimizing administrative and financial burdens on physician practices.</u>

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. (Modify Current HOD Policy)

Testimony on Resolution 118 was focused on the need for further study in order to understand the issue presented. Testimony explained concerns that the resolution may impact practice sustainability, drug supply chains, and could block drug innovation. Further, testimony voiced concern that the language of the resolution may be too prescriptive and block effective avenues for advocacy. The resolution's authors responded to these pieces of testimony explaining that the resolution only seeks to clarify existing AMA policy without changing the organization's position. In-person testimony was mixed on this issue, with some testimony explaining the importance of this issue being addressed in a timely fashion. Testimony in support of the resolution explained potential issues with international reference pricing impacting physician

practices and patients access. However, other delegations and the Council on Medical Service supported referral and reiterated how complex the issue is. In order to minimize the potential for unintended consequences, this testimony suggested that the item be studied further and a report presented to the House. Your Reference Committee agrees with the testimony encouraging study of this report due to its complexity and therefore recommends that Resolution 118 be referred.

RECOMMENDED FOR NOT ADOPTION

(20) RESOLUTION 102 - STUDY FOR EMTALA RELIEF IN PSYCHIATRIC FACILITIES

RECOMMENDATION:

Your Reference Committee recommends that Resolution 102 be not adopted.

HOD ACTION: Resolution 102 is not adopted.

RESOLVED, that our American Medical Association perform a study to determine whether it would be appropriate to seek EMTALA relief, exemption, or modifications for exclusively psychiatric hospital facilities. (Directive to Take Action)

Testimony on Resolution 102 was mixed. The resolution was supported by the authors and some other delegations with testimony explaining the importance of assessing the potential appropriateness for a study on psychiatric Emergency Medical Treatment & Labor Act (EMTALA) relief. However, a number of other delegations voiced strong opposition to the report explaining that this could have a serious weakening impact on EMTALA and did not believe that the study was warranted nor appropriate. Since the quorum of testimony centered on opposing this resolution, your Reference Committee recommends that Resolution 102 be not adopted.

RECOMMENDED FOR REAFFIRMATION IN LIEU OF

(21) RESOLUTION 117 - UNIVERSAL OUT OF NETWORK BENEFITS

RECOMMENDATION:

Your Reference Committee recommends that AMA Policies H-285.904, H-285.907, D-285.958, D-285.963, H-165.838, H-180.952, D-165.989, and H-285.908 be reaffirmed in lieu of Resolution 117.

HOD ACTION: Policies H-285.904, H-285.907, D-285.958, D-285.963, H-165.838, H-180.952, D-165.989, and H-285.908 reaffirmed in lieu of Resolution 117.

RESOLVED, that our American Medical Association will advocate for state and federal laws and regulations that require all insurers to offer plans that include out-of-network benefits. (Directive to Take Action)

Testimony on Resolution 117 was mixed. Some commenters noted that Resolution 117 is addressed by existing AMA policies that support requirements that insurers offer plans that include out-of-network benefits. Concerns about the resolution were also expressed regarding its feasibility, enforceability, and inconsistency with the existing coverage landscape that includes Health Maintenance Organizations (HMOs), which by definition have closed networks. A commenter noted that adopting the resolution as written would suggest that the AMA believes HMOs should no longer exist, which would be inconsistent with AMA policy on patient choice of insurance. This commenter also noted that this exact resolution was just considered by the House of Delegates at the 2025 Interim Meeting. An individual proposed the addition of new policy opposing 1) narrow networks and 2) unreasonable financial barriers to medically necessary out-of-network care. However, your Reference Committee points out that existing policy opposes narrow networks (Policies H-450.941 and H-285.901), and Policies H-285.904 and H-285.908 already state that patients must not be financially penalized for receiving out-of-network care. Accordingly, your Reference committee recommends that Policies H-285.904, H-285.907, D-285.958, D-285.963, H-165.838, H-180.952, D-165.989, and H-285.908 be reaffirmed in lieu of Resolution 117.

Out-of-Network Care H-285.904

1. Our American Medical Association adopts the following principles related to unanticipated out-of-network care:

a. Patients must not be financially penalized for receiving unanticipated care from an out-of-network provider.

b. Insurers must meet appropriate network adequacy standards that include adequate patient access to care, including access to hospital-based physician specialties. State regulators should enforce such standards through active regulation of health insurance company plans.

c. Insurers must be transparent and proactive in informing enrollees about all deductibles, copayments and other out-of-pocket costs that enrollees may incur.
d. Prior to scheduled procedures, insurers must provide enrollees with reasonable and timely access to in-network physicians.
e. Patients who are seeking emergency care should be protected under the "prudent layperson" legal standard as established in state and federal law, without regard to prior authorization or retrospective denial for services after emergency care is rendered.
f. Out-of-network payments must not be based on a contrived percentage of the Medicare rate or rates determined by the insurance company.
g. Minimum coverage standards for unanticipated out-of-network services should be identified. Minimum coverage standards should pay out-of-network providers at the usual and customary out-of-network charges for services, with the definition of usual and customary based upon a percentile of all out-of-network charges for the particular health care service performed by a provider in the same or similar specialty and provided in the same geographical area as reported by a benchmarking database. Such a benchmarking database must be independently recognized and verifiable, completely transparent, independent of the control of either payers or providers and maintained by a non-profit organization. The non-profit organization shall not be affiliated with an insurer, a municipal cooperative health benefit plan or health management organization.
h. Independent Dispute Resolution (IDR) should be allowed in all circumstances as an option or alternative to come to payment resolution between insurers and physicians.
2. Our AMA will advocate for the principles delineated in Policy H-285.904 for all health plans, including ERISA plans.
3. Our AMA will advocate that any legislation addressing surprise out of network medical bills use an independent, non-conflicted database of commercial charges.

Out of Network Restrictions of Physicians H-285.907
Our American Medical Association opposes the denial of payment for a medically necessary prescription of a drug or service covered by the policy based solely on the network participation of the duly licensed physician ordering it.

Patient Access to Covered Benefits Ordered by Out-of-Network Physicians D-285.958
1. Our American Medical Association will develop model legislation to protect patients managed by out-of-network physicians by prohibiting insurance plans from denying payment for covered services, including imaging, laboratory

testing, referrals, medications, and other medically-necessary services for patients under their commercial insurance, based solely on the network participation of the ordering physician while preserving evidence based high quality care and healthcare affordability.
2. Our AMA will collaborate with other physician organizations to develop resources, toolkits, and education to support out-of-network care models.

Out of Network Coverage Denials for Physician Prescriptions and Ordered Services D-285.963
Our American Medical Association will pursue regulation or legislation to prohibit any insurer from writing individual or group policies which deny or unreasonably delay coverage of medically necessary prescription drugs or services based on network distinctions of the licensed health care provider ordering the drug or service.

Health System Reform Legislation H-165.838
…5. AMA policy is that insurance coverage options offered in a health insurance exchange be self-supporting, have uniform solvency requirements; not receive special advantages from government subsidies; include payment rates established through meaningful negotiations and contracts; not require provider participation; and not restrict enrollees' access to out-of-network physicians.

Physician Penalties for Out-of-Network Services H-180.952
Our AMA vehemently opposes any penalties implemented by insurance companies against physicians when patients independently choose to obtain out-of-network services.

Managed Care Organization Reimbursement Formulas D-165.989
Our AMA will continue to assist states medical associations in their efforts to enact meaningful legislation that protects patients and patient access through network adequacy provisions.

Network Adequacy H-285.908
1. Our AMA supports state regulators as the primary enforcer of network adequacy requirements.
2. Our AMA supports requiring that provider terminations without cause be done prior to the enrollment period, thereby allowing enrollees to have continued access throughout the coverage year to the network they reasonably relied upon when purchasing the product. Physicians may be added to the network at any time.

3. Our AMA supports requiring health insurers to submit and make publicly available, at least quarterly, reports to state regulators that provide data on several measures of network adequacy, including the number and type of providers that have joined or left the network; the number and type of specialists and subspecialists that have left or joined the network; the number and types of providers who have filed an in network claim within the calendar year; total number of claims by provider type made on an out-of-network basis; data that indicate the provision of Essential Health Benefits; and consumer complaints received.
4. Our AMA supports requiring health insurers to indemnify patients for any covered medical expenses provided by out-of-network providers incurred over the co-payments and deductibles that would apply to in-network providers, in the case that a provider network is deemed inadequate by the health plan or appropriate regulatory authorities.
5. Our AMA advocates for regulation and legislation to require that out-of-network expenses count toward a participant's annual deductibles and out-of-pocket maximums when a patient is enrolled in a plan with out-of-network benefits, or forced to go out-of-network due to network inadequacies.
6. Our AMA supports fair and equitable compensation to out-of-network providers in the event that a provider network is deemed inadequate by the health plan or appropriate regulatory authorities.
7. Our AMA supports health insurers paying out-of-network physicians fairly and equitably for emergency and out-of-network bills in a hospital. AMA policy is that any legislation which addresses this issue should assure that insurer payment for such care be based upon a number of factors, including the physicians' usual charge, the usual and customary charge for such service, the circumstances of the care and the expertise of the particular physician.
8. Our AMA provides assistance upon request to state medical associations in support of state legislative and regulatory efforts, and disseminate relevant model state legislation, to ensure physicians and patients have access to adequate and fair appeals processes in the event that they are harmed by inadequate networks.
9. Our AMA supports the development of a mechanism by which health insurance enrollees are able to file formal complaints about network adequacy with appropriate regulatory authorities.
10. Our AMA advocates for legislation that prohibits health insurers from falsely advertising that enrollees in their plans have access to physicians of their choosing if the health insurer's network is limited.
11. Our AMA advocates that health plans should be required to document to regulators that they have met requisite

standards of network adequacy including hospital-based physician specialties (i.e. radiology, pathology, emergency medicine, anesthesiologists and hospitalists) at in-network facilities, and ensure in-network adequacy is both timely and geographically accessible.

12. Our AMA supports requiring that health insurers that terminate in-network providers: (a) notify providers of pending termination at least 90 days prior to removal from network; (b) give to providers, at least 60 days prior to distribution, a copy of the health insurer's letter notifying patients of the provider's change in network status; and (c) allow the provider 30 days to respond to and contest if necessary the letter prior to its distribution.

This concludes the report of Reference Committee A. I would like to thank Landon Combs, MD, Nancy Fan, MD, Tra'Chella Johnson Foy, MD, Jerry Halverson, MD, Joanne Loethen, MD, MA, and Maximiliam Pany, MD, PhD.

Landon Combs, MD
Tennessee

Jerry Halverson, MD
American Psychiatric Association

Nancy Fan, MD
Organized Medical Staff Section

Joanne Loethen, MD, MA
Missouri

Tra'Chella Johnson Foy, MD (Alternate)
Florida

Maximilian Pany, MD, PhD
Massachusetts

Christine Kim, MD
American College of Radiology
Chair