

DISCLAIMER

The following is a preliminary report of actions taken by the House of Delegates at its 2022 Interim 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 (I-22)

Report of Reference Committee J

Brigitta J. Robinson, MD, Chair

1 Your Reference Committee recommends the following consent calendar for acceptance:

2

3 **RECOMMENDED FOR ADOPTION**

4

5 1. CMS Report 01 – Incentives to Encourage the Efficient Use of Emergency

6 Departments

7 2. Resolution 805 – COVID Vaccine Administration Fee

8 3. Resolution 820 – Third-Party Pharmacy Benefit Administrators

9

10 **RECOMMENDED FOR ADOPTION AS AMENDED**

11

12 4. CMS Report 02 – Corporate Practice of Medicine

13 5. Resolution 801 – Parity in Military Reproductive Health Insurance Coverage for

14 All Service Members and Veterans

15 6. Resolution 802 – FAIR Health Database

16 7. Resolution 809 – Uniformity and Enforcement of Medicare Advantage Plans and

17 Regulations

18 8. Resolution 811 – Covering Vaccinations for Seniors through Medicare Part B

19 9. Resolution 812 – Implant-Associated Anaplastic Large Cell Lymphoma

20 10. Resolution 816 – Medicaid and CHIP Coverage for Glucose Monitoring Devices

21 for Patients with Diabetes

22 11. Resolution 821 – PrEP is an Essential Health Benefit

23 12. Resolution 826 – Leveling the Playing Field

24

25 **RECOMMENDED FOR ADOPTION IN LIEU OF**

26

27 13. Resolution 806 – Healthcare Marketplace Plan Selection

28 14. Resolution 813 – Amending Policy on a Public Option to Maximize AMA

29 Advocacy

30 15. Resolution 814 – Socioeconomics of CT Coronary Calcium: Is it Scored or

31 Ignored?

32 16. Resolution 815 – Opposition to Debt Litigation Against Patients

33 17. Resolution 817 – Promoting Oral Anticancer Drug Parity

34 18. Resolution 818 – Pediatric Obesity Treatment Insurance Coverage

1 19. Resolution 819 – Advocating for the Implementation of Updated U.S. Preventive
2 Services Task Force Recommendations for Colorectal Cancer Screening Among
3 Primary Care Physicians and Major Payors by the AMA
4

5 **RECOMMENDED FOR REFERRAL**

6
7 20. Resolution 823 – Health Insurers and Collection of Co-Pays and Deductibles
8 21. Resolution 824 – Enabling and Enhancing the Delivery of Continuity of Care
9 When Physicians Deliver Care Across Diverse Problem Sets
10

11 **RECOMMENDED FOR REAFFIRMATION IN LIEU OF**

12
13 22. Resolution 804 – Centers for Medicare & Medicaid Innovation Projects
14 23. Resolution 808 – Reinstatement of Consultation Codes
15 24. Resolution 810 – Medicare Drug Pricing and Pharmacy Costs
16 25. Resolution 822 – Monitoring of Alternative Payment Models within Traditional
17 Medicare
18

1 RECOMMENDED FOR ADOPTION 2

3 (1) CMS REPORT 01 - INCENTIVES TO ENCOURAGE
4 EFFICIENT USE OF EMERGENCY DEPARTMENTS

5 RECOMMENDATION:

6 CMS Report 1 be adopted and the remainder of the report
7 be filed.

8
9 **HOD ACTION: CMS Report 1 adopted and the remainder of
10 the report filed**

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

13 1. That our American Medical Association (AMA) support continued monitoring, by the
14 Centers for Medicare & Medicaid Services and other stakeholders, of strategies and best
15 practices for reducing non-emergency emergency department (ED) use among
16 Medicaid/Children's Health Insurance Program (CHIP) enrollees, including frequent ED
17 users. (New HOD Policy)

18 2. That our AMA support state efforts to encourage appropriate emergency department
19 (ED) use among Medicaid/CHIP enrollees that are consistent with the standards and
20 safeguards outlined in AMA policy on ED services. (New HOD Policy)

21 3. That our AMA reaffirm Policy H-130.970, which supports the prudent layperson
22 standard and directs the AMA to work with state insurance regulators, insurers, and
23 other stakeholders to halt the implementation of policies that violate the prudent
24 layperson standard of determining when to seek emergency care. (Reaffirm HOD Policy)

25 4. That our AMA reaffirm Policy H-290.985, which advocates that numerous criteria be
26 used in Medicaid managed care monitoring and oversight, including that enrollees are
27 educated about appropriate use of services, including ED services; plans are responsive
28 to cultural, language and transportation barriers to access; off-hours, walk-in primary
29 care is available; and intensive case management is provided to high utilizers. (Reaffirm
30 HOD Policy)

31 5. That our AMA reaffirm Policy H-290.976, which affirms that AMA's commitment to
32 advocating that Medicaid should pay physicians at minimum 100 percent of Medicare
33 rates. (Reaffirm HOD Policy)

34 6. That our AMA rescind Policy D-130.959, which called for the development of this
35 report. (Rescind HOD Policy)

36 Testimony was overwhelmingly supportive of CMS Report 01. There was an amendment
37 proposed by the Medical Student Section (MSS) to address co-pays and other cost-
38 sharing measures for Medicaid patients receiving care in the Emergency Department.
39 The Council on Medical Service commented that the MSS amendment goes beyond the
40

1 purview of this report. Your Reference Committee agrees. Therefore, your Reference
2 Committee thanks the Council on Medical Service for a well-written report and
3 recommends the report be adopted the remainder of the report be filed.
4

5 (2) RESOLUTION 805 - COVID VACCINE ADMINISTRATION
6 FEE
7

8 RECOMMENDATION:
9

10 Resolution 805 be adopted.
11

12 **HOD ACTION: Resolution 805 adopted**
13

14 RESOLVED, That American Medical Association Policy D-440.981, "Appropriate
15 Reimbursements and Carve-outs for Vaccines," be amended by addition to read as
16 follows:
17

18 **Appropriate Reimbursements and Carve-outs for Vaccines D-440.981**

19 Our AMA will: (1) continue to work with the Centers for Medicare and Medicaid Services
20 (CMS) and provide comment on the Medicare Program payment policy for vaccine
21 services; (2) continue to pursue adequate reimbursement for vaccines and their
22 administration from all public and private payers, including federal funds to reimburse for
23 administration of the COVID-19 vaccine to uninsured patients; (3) encourage health
24 plans to recognize that physicians incur costs associated with the procurement, storage
25 and administration of vaccines that may be beyond the average wholesale price of any
26 one particular vaccine; (4) seek legislation mandating that health insurance companies
27 in applicable states either adequately pay for vaccines recommended by the Advisory
28 Committee on Immunization Practices, or clearly state in large bold font in their notices
29 to patients and businesses that they do not follow the federal advisory body on vaccine
30 recommendations, the Advisory Committee on Immunization Practices; and (5) advocate
31 that a physician's office can bill Medicare for all vaccines administered to Medicare
32 beneficiaries and that the patient shall only pay the applicable copay to prevent
33 fragmentation of care. (Modify Current HOD Policy)

34 Your Reference Committee heard mostly supportive testimony for Resolution 805.
35 Contrary testimony from the Council on Medical Service called for reaffirmation of
36 existing policy. Your Reference Committee did not find this compelling. The topic of
37 vaccine reimbursement is important policy should be strengthened to specifically call out
38 including federal funds to reimburse for the administration of the COVID-19 vaccine to
39 uninsured patients. Several state and specialty delegations spoke in favor of adopting
40 this resolution. Your Reference Committee recommends Resolution 805 be adopted.
41

42 (3) RESOLUTION 820 - THIRD-PARTY PHARMACY
43 BENEFIT ADMINISTRATORS
44

45 RECOMMENDATION:
46

47 Resolution 820 be adopted.
48

49 **HOD ACTION: Resolution 820 adopted**
50

1 RESOLVED, That our American Medical Association recommend that third-party
2 pharmacy benefit administrators that contract to manage the specialty pharmacy portion
3 of drug formularies be included in existing pharmacy benefit manager (PBM) regulatory
4 frameworks and statutes, and be subject to the same licensing, registration, and
5 transparency reporting requirements (New HOD Policy); and be it further
6 RESOLVED, That our AMA advocate that third-party pharmacy benefit administrators be
7 included in future PBM oversight efforts at the state and federal levels. (Directive to Take
8 Action)

9
10 Testimony was unanimously supportive of Resolution 820 as written. Speakers raised
11 the importance of the expansion of existing regulations covering PBMs to cover third-
12 party pharmacy benefit administrators. Testimony explained that many PBMs utilize the
13 lack of regulation of third-party benefit administrators as a loophole to skirt existing
14 regulations. A number of specialty societies outlined the negative impact that these
15 actions have on patients and their access to necessary medications. Therefore, your
16 Reference Committee recommends that Resolution 820 be adopted.

17

1 RECOMMENDED FOR ADOPTION AS AMENDED

2

3 (4) CMS REPORT 02 - CORPORATE PRACTICE OF
4 MEDICINE

5 RECOMMENDATION A:

6 Recommendation 3 of CMS Report 02 be amended by
7 deletion to read as follows:

8 3. That our AMA amend Policy H-160.891 by addition of
9 two new clauses, as follows: j. Each individual physician
10 should have the ultimate decision for medical judgment in
11 patient care and medical care processes, including the use
12 of mandated patient care algorithms or supervision of non-
13 physician practitioners.

14 k. Physicians should retain primary and final responsibility
15 for structured medical education inclusive of
16 undergraduate medical education including the structure of
17 the program, program curriculum, selection of faculty and
18 trainees, as well as education and disciplinary issues
19 related to these programs. (Modify Current HOD Policy)

20 RECOMMENDATION B:

21 CMS Report 02 be adopted as amended and the
22 remainder of the report be filed.

23 **HOD ACTION: CMS Report 02 adopted as amended and the**
24 **remainder of report filed**

25 The Council on Medical Service recommends that the following be adopted in lieu of
26 Resolution 721-A-22, and the remainder of the report be filed:

27 1. That our American Medical Association (AMA) acknowledge that :
28 the corporate practice of medicine has the potential to erode the patient-physician
29 relationship. (New HOD Policy)

30 2. That our AMA acknowledge that the corporate practice of medicine may create a
31 conflict of interest between profit and best practices in residency and fellowship training.
32 (New HOD Policy)

33 3. That our AMA amend Policy H-160.891 by addition of two new clauses, as follows:
34 j. Each individual physician should have the ultimate decision for medical judgment in
35 patient care and medical care processes, including the use of mandated patient care
36 algorithms or supervision of non-physician practitioners.

37 k. Physicians should retain primary and final responsibility for structured medical
38 education inclusive of undergraduate medical education including the structure of the

1 program, program curriculum, selection of faculty and trainees, as well as education and
2 disciplinary issues related to these programs. (Modify Current HOD Policy)

3 Your Reference Committee heard supportive testimony for CMS Report 02. There were
4 two amendments proffered by the Integrated Practice Physicians Section (IPPS). There
5 was mixed testimony heard on these amendments. Your Reference Committee heard
6 testimony to strike "use of mandated patient care algorithms" because this topic was not
7 adequately covered by the body of the report. A second amendment to change "Each
8 individual physician" to "Physicians" was offered, but contrary testimony argued against
9 that change. Your Reference Committee concurs that current wording presents no threat
10 to team-based care. Your Reference Committee thanks the Council on Medical Service
11 for a well-written report and recommends the report be adopted as amended and the
12 remainder of the report be filed.

13
14 (5) RESOLUTION 801 – PARITY IN MILITARY
15 REPRODUCTIVE HEALTH INSURANCE COVERAGE
16 FOR ALL SERVICE MEMBERS AND VETERANS

17
18 RECOMMENDATION A:

19
20 Resolution 801 be amended by addition to read as follows:

21
22 RESOLVED, That our American Medical Association
23 support expansion of reproductive health insurance
24 coverage to all active-duty service members and veterans
25 eligible for medical care regardless of service-connected
26 disability, marital status, gender or sexual orientation. (New
27 HOD Policy)

28
29 RECOMMENDATION B:

30
31 Resolution 801 be adopted as amended.

32
33 **HOD ACTION: Resolution 801 adopted as amended**

34
35 RESOLVED, That our American Medical Association support expansion of reproductive
36 health insurance coverage to all active-duty service members and veterans eligible for
37 medical care regardless of marital status, gender or sexual orientation. (New HOD
38 Policy)

39
40 Testimony was overwhelmingly supportive of Resolution 801, with several delegations
41 speaking in support. No contrary testimony was heard. There was suggestion for
42 reaffirmation of existing policy, but an amendment was proffered by the American
43 Society of Reproductive Medicine. The Reference Committee believes that with this
44 amendment the resolution is important and novel. Compelling testimony was heard
45 stating that Resolution 801 protects diversity outside of heteronormative identities of
46 those who voluntarily serve our country. We believe this is crucial and thus recommend
47 that Resolution 801 be adopted as amended.

1 (6) RESOLUTION 802 - FAIR HEALTH DATABASE
2

3 RECOMMENDATION A:
4

5 The first Resolve of Resolution 802 be amended by
6 addition and deletion to read as follows:
7

8 RESOLVED, That our American Medical Association
9 advocate to for independent non-conflicted medical charge
10 databases of allowed amounts and charges FAIR Health to
11 ensure the continued identification of provider type and the
12 frequency by which a particular CPT© codes are used.
13 (New HOD Policy)
14

15 RECOMMENDATION B:
16

17 Resolution 802 be amended by addition of a second
18 Resolve clause to read as follows:
19

20 RESOLVED, That our American Medical Association
21 advocate that independent medical charge databases of
22 allowed amounts and charges be transparent on the
23 source of their data, and must validate the data that they
24 directly receive from payors for accuracy against what is
25 actually paid to health care clinicians. (Directive to Take
26 Action)
27

28 RECOMMENDATION C:
29

30 Resolution 802 be adopted as amended.
31

32 RECOMMENDATION D:
33

34 The title of Resolution 802 be changed:
35

36 “INDEPENDENT MEDICAL CHARGE DATABASES OF
37 ALLOWED AMOUNTS AND CHARGES”
38

39 **HOD ACTION: Resolution 802 adopted as amended with a**
40 **change in title to read as follows:**
41

42 “INDEPENDENT MEDICAL CHARGE DATABASES OF
43 ALLOWED AMOUNTS AND CHARGES”
44

45
46 RESOLVED, That our American Medical Association advocate to FAIR Health to ensure
47 the continued identification of the frequency by which a particular CPT code is used.
48 (New HOD Policy)
49

1 Testimony on Resolution 802 was primarily in support. The importance of independent
2 medical charge databases making available frequency codes to identify and assess low
3 volume data cells, as well as the need for transparency of data sources and the provider
4 type of each CPT code were raised by the Dermatology Section Council. The Council on
5 Medical Service testified that to remain consistent across policy, the proprietary
6 language of the original resolution should be replaced with "independent medical charge
7 databases." This amendment was supported by testimony. Testimony further supported
8 the addition of a second resolve that the AMA advocate for transparency as to the
9 source and validation of data from payors. Your Reference Committee recommends that
10 Resolution 802 be adopted as amended.

11

12 (7) RESOLUTION 809 - UNIFORMITY AND ENFORCEMENT
13 OF MEDICARE ADVANTAGE PLANS AND
14 REGULATIONS

15 RECOMMENDATION A:

16 The first Resolve of Resolution 809 be amended by
17 deletion to read as follows:

18 RESOLVED, That our American Medical Association
19 advocate for better enforcement of Medicare Advantage
20 regulations to hold the Centers for Medicare & Medicaid
21 Services (CMS) accountable for presenting transparency
22 of minimum standards and to determine if those standards
23 are being met for senior physicians and their patients
24 (Directive to Take Action); and be it further

25 RECOMMENDATION B:

26 Mr. Speaker, your Reference Committee recommends that
27 the second Resolve of Resolution 809 be amended by
28 addition to read as follows:

29 RESOLVED, That our AMA advocate that Medicare
30 Advantage plans be required to post all components of
31 Medicare covered and not covered in all plans across the
32 US on their website along with the additional benefits
33 provided (Directive to Take Action); and be it further

34

35

1 RECOMMENDATION C:

2
3 The third Resolve of Resolution 809 be amended by
4 addition and deletion to read as follows:

5
6 RESOLVED, That our American Medical Association
7 advocate that CMS maintain a publicly available database
8 of physicians in network under Medicare Advantage and
9 the status of each of these physicians in regard to
10 accepting new patients in a manner least burdensome to
11 physicians. ~~provide an accurate, up-to-date list of~~
12 ~~physicians and the plans with which they may or may not~~
13 ~~be accepting as well as if the practice is no longer~~
14 ~~participating, continuing on with current patients, or taking~~
15 ~~new patients for plans that they are contracted for under~~
16 ~~Medicare Advantage.~~ (Directive to Take Action)

17
18 RECOMMENDATION D:

19
20 Resolution 809 be adopted as amended.

21
22 **HOD ACTION: Resolution 809 adopted as amended**

23
24 RESOLVED, That our American Medical Association advocate for better enforcement of
25 Medicare Advantage regulations to hold the Centers for Medicare & Medicaid Services
26 (CMS) accountable for presenting transparency of minimum standards and to determine
27 if those standards are being met for senior physicians and their patients (Directive to
28 Take Action); and be it further

29
30 RESOLVED, That our AMA advocate that Medicare Advantage plans be required to post
31 all components of Medicare covered in all plans across the US on their website along
32 with additional benefits provided (Directive to Take Action); and be it further

33
34 RESOLVED, That our AMA advocate that CMS provide an accurate, up-to-date list of
35 physicians and the plans with which they may or may not be accepting as well as if the
36 practice is no longer participating, continuing on with current patients, or taking new
37 patients for plans that they are contracted for under Medicare Advantage. (Directive to
38 Take Action)

39
40 Testimony on Resolution 809 was primarily supportive of the first two Resolves and
41 expressed opposition to the third Resolve as written. The importance of transparency
42 and standardization of provider networks was raised. Specifically, testimony supported
43 the need for patients to have access to what is and is not covered in their plans and for
44 comparison to be possible when selecting a plan.

45
46 Testimony expressed concern for the feasibility of Resolve three as written and the
47 Council on Medical Service suggested alternative language that was supported by
48 further testimony. This language states that the AMA will advocate for CMS to maintain a
49 database of providers and the status of providers accepting new patients in a manner
50 that is least burdensome to physicians. Additional concern was expressed about the

1 original language limiting the database to "senior" physicians and testimony supported
2 the removal of this language. Therefore, your Reference Committee recommends
3 Resolution 809 be adopted as amended.
4

5 (8) RESOLUTION 811 - COVERING VACCINATIONS FOR
6 SENIORS THROUGH MEDICARE PART B
7

8 RECOMMENDATION A:
9

10 Resolution 811 be amended by deletion to read as follows:
11
12 RESOLVED, That our American Medical Association
13 advocate that Medicare ~~Part B~~ cover the full cost of all
14 vaccinations administered to Medicare patients that are
15 recommended by the Advisory Committee on
16 Immunization Practices (ACIP).~~—the US Preventive~~
17 ~~Services Task Force (USPSTF), or based on prevailing~~
18 ~~preventive clinical health guidelines. at the point of care~~
19 ~~and outside of budget neutrality requirements.~~ (Directive to
20 Take Action)

21 RECOMMENDATION B:
22

23 Resolution 811 be adopted as amended.
24

25 RECOMMENDATION C:
26

27 The title of Resolution 811 be changed:

28 "COVERING VACCINATIONS THROUGH MEDICARE
29 ~~PART B~~"
30

31 **HOD ACTION: Resolution 811 adopted as amended with a**
32 **change in title to read as follows:**
33

34 "COVERING VACCINATIONS THROUGH MEDICARE
35 ~~PART B~~"
36

37 RESOLVED, That our American Medical Association advocate that Medicare Part B
38 cover the full cost of all vaccinations administered to Medicare patients that are
39 recommended by the Advisory Committee on Immunization Practices (ACIP), the US
40 Preventive Services Task Force (USPSTF), or based on prevailing preventive clinical
41 health guidelines. (Directive to Take Action)
42

43 Testimony on Resolution 811 was mostly supportive. Several delegations supported the
44 spirit of the resolution, but there was concern raised about budget neutrality. There
45 was compelling testimony heard from the U.S. Public Health Service that called for
46 striking "or based on prevailing preventive clinical health guidelines" as this language
47 was ambiguous and unclear. There were amendments proposed to address budget
48 neutrality by a few delegations, including the Council on Medical Service; however, your
49
50

1 Reference Committee heard testimony that AMA policy adequately covers our stance on
2 budget neutrality and repeating that here would be redundant. There was testimony from
3 a representative from the RUC also suggesting that this is not the place to address
4 budget neutrality. Your Reference Committee recommends that Resolution 811 be
5 adopted as amended.

6
7 (9) RESOLUTION 812 - IMPLANT-ASSOCIATED
8 ANAPLASTIC LARGE CELL LYMPHOMA

9
10 RECOMMENDATION A:

11
12 Resolution 812 be amended by addition and deletion to
13 read as follows:

14
15 RESOLVED, That our American Medical Association
16 support appropriate coverage of the workup for potential
17 cancer diagnosis, staging, treating surgery locoregional
18 treatment (e.g., surgery or radiation therapy), and other
19 systemic treatment options for breast implant-associated
20 anaplastic large cell lymphoma, breast implant associated
21 squamous cell carcinoma, and other implant associated
22 malignancies. anaplastic large cell lymphoma. (New HOD
23 Policy)

24
25 RECOMMENDATION B:

26
27 Resolution 812 be adopted as amended.

28
29 RECOMMENDATION C:

30
31 The title of Resolution 812 be changed:

32
33 "COVERAGE FOR IMPLANT ASSOCIATED
34 MALIGNANCIES"

35
36 **HOD ACTION: Resolution 812 adopted as amended**

37
38 "COVERAGE FOR IMPLANT ASSOCIATED
39 MALIGNANCIES"

40
41 RESOLVED, That our American Medical Association support appropriate coverage of
42 cancer diagnosis, treating surgery and other systemic treatment options for implant-
43 associated anaplastic large cell lymphoma. (New HOD Policy)

44
45 Testimony on Resolution 812 was supportive of the spirit of the resolution, however
46 there were amendments proffered from the American Society of Breast Surgeons and
47 the American Society of Plastic Surgeons to broaden and clarify this language. Your
48 Reference Committee felt that both proffered amendments had merit and we
49 incorporated the language. We recommend that Resolution 812 be adopted as
50 amended.

1
2 (10) RESOLUTION 816 - MEDICAID AND CHIP COVERAGE
3 FOR GLUCOSE MONITORING DEVICES FOR
4 PATIENTS WITH DIABETES

5
6 RECOMMENDATION A:

7
8 The first Resolve of Resolution 816 be amended by
9 addition and deletion to read as follows:

10
11 RESOLVED, That our American Medical Association
12 advocate for broadening the classification criteria of
13 Durable Medical Equipment to include all clinically effective
14 ~~and cost-saving diabetic continuous or flash glucose~~
15 ~~monitorings devices~~ (Directive to Take Action); and be it
16 further

17
18 RECOMMENDATION B:

19
20 The second Resolve of Resolution 816 be amended by
21 addition and deletion to read as follows:

22
23 RESOLVED, That our American Medical Association
24 amend Policy H-330.885 by addition and deletion to read
25 as follows:

26
27 Medicare Public Insurance Coverage of Continuous
28 Glucose Monitoring Devices for Patients with Insulin
29 Dependent Diabetes H-330.885

30
31 Our AMA supports efforts to achieve Medicare coverage of
32 continuous and flash glucose monitoring devices systems
33 for all patients with insulin dependent diabetes by all public
34 insurance programs when it is evidence-based and
35 determined appropriate by physicians. (Modify Current
36 HOD Policy)

37
38 RECOMMENDATION C:

39
40 Resolution 816 be adopted as amended.

41
42 RECOMMENDATION D:

43
44 The title of Resolution 816 be changed:

45
46 "COVERAGE FOR CONTINUOUS OR FLASH GLUCOSE
47 MONITORING DEVICES"

48
49 **HOD ACTION: Resolution 816 adopted as amended with a**
50 **change in title to read as follows**

1
2 "COVERAGE FOR CONTINUOUS OR FLASH
3 GLUCOSE MONITORING DEVICES"
4

5 RESOLVED, That our American Medical Association (AMA) advocate for broadening the
6 classification criteria of Durable Medical Equipment to include all clinically effective and
7 cost-saving diabetic glucose monitors (Directive to Take Action); and be it further

8 RESOLVED, That our AMA amend AMA Policy H-330.885 by addition and deletion to
9 read as follows:

10 Medicare Public Insurance Coverage of Continuous Glucose Monitoring Devices for
11 Patients with Insulin-Dependent Diabetes H-330.885

12 Our AMA supports efforts to achieve Medicare coverage of continuous and flash glucose
13 monitoring systems for all patients with insulin-dependent diabetes by all public
14 insurance programs. (Modify Current HOD Policy)

15 Testimony on Resolution 816 was mixed. Delegations supporting the resolution
16 highlighted the success of using continuous glucose monitoring devices with patients,
17 while delegations opposing the resolution noted that this was a very complicated issue
18 that could come with a very high price tag. Testimony from the American College of
19 Obstetricians and Gynecologists noted that this can be used as a method to support
20 patients in managing their glucose and preventing the development of gestational
21 diabetes. The delegation from Florida recommended referral of this item. Testimony
22 largely focused on our proposed amendments to clarify the language, broaden the
23 resolution, and keep physician decision-making at the forefront. The testimony also
24 reflected the use of continuous glucose monitoring devices should be based on well-
25 supported evidence of their effectiveness. Your Reference Committee recommends that
26 Resolution 816 be adopted as amended.

27 (11) RESOLUTION 821 - PREP IS AN ESSENTIAL HEALTH
28 BENEFIT

29 RECOMMENDATION A:

30 Resolution 821 be amended by addition and deletion to
31 read as follows:

32 RESOLVED, That our American Medical Association
33 supports the continued inclusion of Pre-Exposure
34 Prophylaxis (PrEP) for Human Immunodeficiency Virus
35 (HIV) as an Essential Health Benefit under the
36 Patient Protection and Affordable Care Act (Directive to
37 Take Action); and be it further

38 RECOMMENDATION B:

39 Resolution 821 be adopted as amended.

40 **HOD ACTION: Resolution 821 adopted as amended**

1
2 RESOLVED, That our American Medical Association supports the continued inclusion of
3 Pre-Exposure Prophylaxis (PrEP) for Human Immunodeficiency Virus (HIV) as an
4 Essential Health Benefit under the Patient Protection and Affordable Care Act (Directive
5 to Take Action); and be it further

6
7 RESOLVED, That our AMA support and join legal efforts to overturn the judgment
8 rendered in *Braidwood v. Becerra* in the U.S. District Court for the Northern District of
9 Texas (Directive to Take Action).

10
11 Testimony on Resolution 821 was unanimously supportive. Pro testimony highlighted
12 that both access to and the affordability of PrEP need to be considered as they are
13 equally important. The new language clarifies that PrEP should be considered a
14 Preventive Essential Health Benefit under the Affordable Care Act, to ensure first-dollar
15 coverage of this life-saving treatment. We recommend Resolution 821 be adopted as
16 amended.

17
18 (12) RESOLUTION 826 - LEVELING THE PLAYING FIELD

19
20 RECOMMENDATION A:

21
22 Resolution 826 be amended by addition of a second
23 Resolve clause to reads as follows:

24
25 RESOLVED, That our AMA consider disseminating the
26 resulting educational materials and graphics. (Directive to
27 Take Action)

28
29 RECOMMENDATION B:

30
31 Resolution 826 be adopted as amended.

32
33 **HOD ACTION: Resolution 826 adopted as amended**

34
35 RESOLVED, That our American Medical Association produce a graphic report
36 illustrating the fiscal losses and inequities that practices without facility fees have
37 endured for decades as a result of the site of service differential factoring in inflation.
38 (Directive to Take Action)

39
40 Mostly supportive testimony was heard on Resolution 826. The Florida delegation
41 proffered an amendment to add a second Resolve clause asking the AMA to send this
42 information to Congress. In order to address the concerns raised by the Dermatology
43 Section Council and maintain the spirit of the amendment, the new language ensures
44 that the AMA is not committed to sending results to Congress before the data has been
45 gathered and the graphics have been created. Therefore, we recommend Resolution
46 826 be adopted as amended.

1 RECOMMENDED FOR ADOPTION IN LIEU OF 2

3 (13) RESOLUTION 806 - HEALTHCARE MARKETPLACE
4 PLAN SELECTION

5
6 RECOMMENDATION:
7

8 Alternate Resolution 806 be adopted in lieu of Resolution
9 806:

10 RESOLVED, That our AMA re-evaluate and study the
11 effectiveness of the current plan options in the Healthcare
12 Marketplace to adequately provide choice and competition,
13 especially in communities in close proximity to multiple
14 states (insurance markets) and submit a report to the AMA
15 HOD at A-23. (Directive to Take Action)

16
17 **HOD ACTION: Alternate Resolution 806 adopted in lieu**
18 **of Resolution 806**

19 RESOLVED, That our American Medical Association advocate for patients to have
20 expanded plan options on the Healthcare Marketplace beyond the current options based
21 solely on the zip code of their primary residence or where their physician practices,
22 including the interstate portability of plans. (Directive to Take Action)

23 Testimony on Resolution 806 was mixed. The Council on Medical Service, the Council
24 on Legislation, the California delegation, and the Medical Student Section recommended
25 reaffirmation and the Young Physician Section recommended this item be referred.
26 Several state delegations spoke in support of this resolution. There were questions
27 raised on the unintended logistical consequences the resolution as written may cause.
28 The Georgia delegation proffered an amendment to address these concerns and your
29 Reference Committee found that the alternate language captures the concerns raised in
30 testimony. Therefore, your Reference Committee recommends Alternate Resolution 806
31 be adopted in lieu of Resolution 806.

32
33 (14) RESOLUTION 813 - AMENDING POLICY ON A PUBLIC
34 OPTION TO MAXIMIZE AMA ADVOCACY

35
36 RECOMMENDATION:
37

38 Alternate Resolution 813 be adopted in lieu of Resolution
39 813.

40 RESOLVED, That our American Medical Association
41 amend Policy H-165.823, "Options to Maximize Coverage
42 under the AMA Proposal for Reform," by addition and
43 deletion to read as follows:

Options to Maximize Coverage under the AMA Proposal for Reform H-165.823

1. That our AMA advocate for a pluralistic health care system, which may include a public option, that focuses on increasing equity and access, is cost-conscious, and reduces burden on physicians.

2. 4. Our AMA will advocate that any public option to expand health insurance coverage must meet the following standards:

- a. The primary goals of establishing a public option are to maximize patient choice of health plan and maximize health plan marketplace competition.

b. Eligibility for premium tax credit and cost-sharing assistance to purchase the public option is restricted to individuals without access to affordable employer-sponsored coverage that meets standards for minimum value of benefits

c. Physician payments under the public option are established through meaningful negotiations and contracts. Physician payments under the public option must be higher than prevailing Medicare rates and at rates sufficient to sustain the costs of medical practice.

d. Physicians have the freedom to choose whether to participate in the public option. Public option proposals should not require provider participation and/or tie physician participation in Medicare, Medicaid and/or any commercial product to participation in the public option.

e. The public option is financially self-sustaining and has uniform solvency requirements.

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

g. The public option shall be made available to uninsured individuals who fall into the “coverage gap” in states that do not expand Medicaid – having incomes above Medicaid eligibility limits but below the federal poverty level, which is the lower limit for premium tax credits – at no or nominal cost.

2.3. Our AMA supports states and/or the federal government pursuing auto-enrollment in health insurance coverage that meets the following standards:

- a. Individuals must provide consent to the applicable state and/or federal entities to share their health insurance status and tax data with the entity with the authority to make coverage determinations.

b. Individuals should only be auto-enrolled in health insurance coverage if they are eligible for coverage options

1 that would be of no cost to them after the application of
2 any subsidies. Candidates for auto-enrollment would,
3 therefore, include individuals eligible for
4 Medicaid/Children's Health Insurance Program (CHIP) or
5 zero-premium marketplace coverage.

6 c. Individuals should have the opportunity to opt out from
7 health insurance coverage into which they are auto-
8 enrolled.

9 d. Individuals should not be penalized if they are auto-
10 enrolled into coverage for which they are not eligible or
11 remain uninsured despite believing they were enrolled in
12 health insurance coverage via auto-enrollment.

13 e. Individuals eligible for zero-premium marketplace
14 coverage should be randomly assigned among the zero-
15 premium plans with the highest actuarial values.

16 f. Health plans should be incentivized to offer pre-
17 deductible coverage including physician services in their
18 bronze and silver plans, to maximize the value of zero-
19 premium plans to plan enrollees.

20 g. Individuals enrolled in a zero-premium bronze plan who
21 are eligible for cost-sharing reductions should be notified of
22 the cost-sharing advantages of enrolling in silver plans.

23 h. There should be targeted outreach and streamlined
24 enrollment mechanisms promoting health insurance
25 enrollment, which could include raising awareness of the
26 availability of premium tax credits and cost-sharing
27 reductions, and establishing a special enrollment period.

28
29 3.4. Our AMA: (a) will advocate that any federal approach
30 to cover uninsured individuals who fall into the "coverage
31 gap" in states that do not expand Medicaid--having
32 incomes above Medicaid eligibility limits but below the
33 federal poverty level, which is the lower limit for premium
34 tax credit eligibility--make health insurance coverage
35 available to uninsured individuals who fall into the
36 coverage gap at no or nominal cost, with significant cost-
37 sharing protections; (b) will advocate that any federal
38 approach to cover uninsured individuals who fall into the
39 coverage gap provide states that have already
40 implemented Medicaid expansions with additional
41 incentives to maintain their expansions; (c) supports
42 extending eligibility to purchase Affordable Care Act (ACA)
43 marketplace coverage to undocumented immigrants and
44 Deferred Action for Childhood Arrivals (DACA) recipients,
45 with the guarantee that health plans and ACA
46 marketplaces will not collect and/or report data regarding
47 enrollee immigration status; and (d) recognizes the
48 potential for state and local initiatives to provide coverage
49 to immigrants without regard to immigration status. (Modify
50 Current HOD Policy)

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HOD ACTION: Alternate Resolution 813 adopted in lieu of Resolution 813.

RESOLVED, That our American Medical Association amend Policy H-165.823, "Options to Maximize Coverage under the AMA Proposal for Reform," by addition and deletion to read as follows:

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Options to Maximize Coverage under the AMA Proposal for Reform H-165.823

1. Our AMA will advocate that any for a public option to expand health insurance coverage must that meets the following standards:

a. The primary goals of establishing a public option are to maximize patient choice of health plan and maximize health plan marketplace competition.

b. Eligibility for premium tax credit and cost-sharing assistance to purchase the public option is restricted to individuals without access to affordable employer-sponsored coverage that meets standards for minimum value of benefits.

c. Physician payments under the public option are established through meaningful negotiations and contracts. Physician payments under the public option must be higher than prevailing Medicare rates and at rates sufficient to sustain the costs of medical practice.

d. Physicians have the freedom to choose whether to participate in the public option. Public option proposals should not require provider participation and/or tie physician participation in Medicare, Medicaid and/or any commercial product to participation in the public option.

e. The public option is financially self-sustaining and has uniform solvency requirements.

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

g. The public option shall be made available to uninsured individuals who fall into the "coverage gap" in states that do not expand Medicaid – having incomes above Medicaid eligibility limits but below the federal poverty level, which is the lower limit for premium tax credits – at no or nominal cost.

2. Our AMA supports states and/or the federal government pursuing auto-enrollment in health insurance coverage that meets the following standards:

a. Individuals must provide consent to the applicable state and/or federal entities to share their health insurance status and tax data with the entity with the authority to make coverage determinations.

- b. Individuals should only be auto-enrolled in health insurance coverage if they are eligible for coverage options that would be of no cost to them after the application of any subsidies. Candidates for auto-enrollment would, therefore, include individuals eligible for Medicaid/Children's Health Insurance Program (CHIP) or zero-premium marketplace coverage.
- c. Individuals should have the opportunity to opt out from health insurance coverage into which they are auto-enrolled.
- d. Individuals should not be penalized if they are auto-enrolled into coverage for which they are not eligible or remain uninsured despite believing they were enrolled in health insurance coverage via auto-enrollment.
- e. Individuals eligible for zero-premium marketplace coverage should be randomly assigned among the zero-premium plans with the highest actuarial values.
- f. Health plans should be incentivized to offer pre-deductible coverage including physician services in their bronze and silver plans, to maximize the value of zero-premium plans to plan enrollees.
- g. Individuals enrolled in a zero-premium bronze plan who are eligible for cost-sharing reductions should be notified of the cost-sharing advantages of enrolling in silver plans.
- h. There should be targeted outreach and streamlined enrollment mechanisms promoting health insurance enrollment, which could include raising awareness of the availability of premium tax credits and cost-sharing reductions, and establishing a special enrollment period.

3. Our AMA: (a) will advocate that any federal approach to cover uninsured individuals who fall into the "coverage gap" in states that do not expand Medicaid--having incomes above Medicaid eligibility limits but below the federal poverty level, which is the lower limit for premium tax credit eligibility--make health insurance coverage available to uninsured individuals who fall into the coverage gap at no or nominal cost, with significant cost-sharing protections; (b) will advocate that any federal approach to cover uninsured individuals who fall into the coverage gap provide states that have already implemented Medicaid expansions with additional incentives to maintain their expansions; (c) supports extending eligibility to purchase Affordable Care Act (ACA) marketplace coverage to undocumented immigrants and Deferred Action for Childhood Arrivals (DACA) recipients, with the guarantee that health plans and ACA marketplaces will not collect and/or report data regarding enrollee immigration status; and (d) recognizes the potential for state and local initiatives to provide coverage

1 to immigrants without regard to immigration status. (Modify
2 Current HOD Policy)

3 Your Reference Committee heard extensive testimony on Resolution 813. Testimony
4 was mixed and passionate from both sides. To come to a consensus, it seemed that
5 focusing on the similarities rather than the differences in testimony would be most
6 productive. Your Reference Committee heard testimony on Resolution 813 that
7 guardrails were needed when considering support of a public option, that there are
8 barriers to access in the American health care system, and that we need to address
9 health equity, decrease the cost of care, and decrease burdens placed on physicians.

10
11 Your Reference Committee recommends addressing concerns surrounding the
12 guardrails and potential "poison pill" public option programs that would ask the AMA to
13 advocate for a program if it met all of the guidelines listed in H-165.823, regardless of
14 what else was included in that public option program, by returning the clause to its
15 original language.

16
17 To address a more active stance advocating for a public option, your Reference
18 Committee took a "principles first" approach proffering language for a new clause to be
19 added to the beginning of H-165.823. This clause would ask the AMA to advocate for a
20 pluralistic health care system that includes a public option and addresses concerns of
21 equity, access, cost, and burdens on physicians.

22
23 There was concern raised during testimony that this resolution was a way for the AMA to
24 work towards a single-payer system. AMA Policy H-165.888(1b) clearly states that
25 "Unfair concentration of market power of payors is detrimental to patients and
26 physicians, if patient freedom of choice or physician ability to select mode of practice is
27 limited or denied. Single payor systems clearly fall within such a definition and,
28 consequently, should continue to be opposed by the AMA."

29
30 This alternate resolution addresses the concerns raised and strengthens AMA policy on
31 health system reform. Your Reference Committee recommends Alternate Resolution
32 813 be adopted in lieu of Resolution 813.

33
34 (15) RESOLUTION 814 - SOCIOECONOMICS OF CT
35 CORONARY CALCIUM: IS IT SCORED OR IGNORED?

36
37 RECOMMENDATION:

38
39 Alternate Resolution 814 be adopted in lieu of Resolution
40 814.

41
42 "NATIONAL COVERAGE DETERMINATION OF
43 CORONARY ARTERY CALCIUM SCORING"

44

1 RESOLVED, That our American Medical Association ask
2 the United States Preventive Services Task Force to study
3 the impact of a national coverage determination to include
4 coronary artery calcium scoring for patients who meet the
5 screening criteria. (Directive to Take Action)

6

7 **HOD ACTION: Alternate Resolution 814 adopted in lieu of**
8 **Resolution 814**

9

10 RESOLVED, That our American Medical Association seek national and/or state
11 legislation and/or a national coverage determination (NCD) to include coronary artery
12 calcium scoring (CACS) for patients who meet the screening criteria set forth by the
13 American College of Cardiology/American Heart Association 2019 Primary Prevention
14 Guidelines, as a first-dollar covered preventive service, consistent with the current policy
15 in the state of Texas (Directive to Take Action); and be it further

16

17 RESOLVED, That our AMA collaborate with the appropriate stakeholders to propose
18 that hospitals strongly consider a no cost/nominal cost option for CACS in appropriate
19 patients who are unable to afford this test, as a means to enhance disease detection,
20 disease modification and management. (Directive to Take Action)

21

22 Testimony on Resolution 814 was mixed. The inequity in access to the CACS testing
23 was raised. Testimony outlined the importance of this test, especially in historically
24 underserved and rural communities and populations. Testimony opposing Resolution
25 814 outlined the lack of evidence for CACS and the need for more information to be
26 gathered before the test is recommended via AMA policy. Concern was raised that this
27 is an attempt to legislate around the currently available body of evidence-based
28 literature. Additionally, this concern was raised in the context of inconsistency with
29 existing AMA policy supporting the use of evidence-based practice.

30

31 The USPSTF last studied this issue in 2018 and testimony indicated that there may be
32 new evidence that would be favorable for recommendation for this coverage.

33

34 The Council on Medical Service suggested alternative language that requests that the
35 USPSTF study the impact of a national coverage determination to include CACS for
36 patients who meet the screening criteria. Subsequent testimony was supportive of this
37 language. Therefore, your Reference Committee recommends that Alternate Resolution
38 814 be adopted in lieu of Resolution 814.

39

40 (16) RESOLUTION 815 - OPPOSITION TO DEBT LITIGATION
41 AGAINST PATIENTS

42

43 RECOMMENDATION:

44

45 Resolution 815 not be adopted.

46

47 **HOD ACTION: Alternate Resolution 815 not adopted**

48

49 RESOLVED, That our American Medical Association (AMA) oppose the practice of
50 health care organizations pursuing litigation against patients due to medical debt, and

1 encourages health care organizations to consider the relative financial benefit of
2 collecting medical debt to their revenue, against the detrimental cost to a patient's well-
3 being (New HOD Policy); and be it further

4
5 RESOLVED, That our AMA encourage health care organizations to manage medical
6 debt with patients directly and consider several options, including discounts, payment
7 plans with flexibility and extensions as needed, or forgiveness of debt altogether, before
8 resorting to third-party debt collectors or any punitive actions (New HOD Policy); and be
9 it further

10
11 RESOLVED, That our AMA encourage health care organizations to consider the
12 American Hospital Associate Patient Billing Guidelines when faced with patients
13 struggling to finance their medical bills. (New HOD Policy)

14
15 Testimony for Resolution 815 was mixed. Opposition to Resolution 815 outlined
16 concerns that the removal of debt litigation and forgiveness of debt altogether may result
17 in a "sonic boom" of non-payment as patients may not have the motivation to pay.
18 Additional testimony opposing Resolution 815 was raised the Council on Medical
19 Service, stating that the content of the resolution is adequately covered by existing AMA
20 policy. However, even in testimony opposing Resolution 815 the spirit of health care
21 organizations avoiding litigating against patients was supported.

22
23 Testimony in favor of Resolution 815 outlined the impact of medical debt, especially on
24 historically marginalized communities. The importance of access to health care
25 regardless of socioeconomic status was raised in support of the resolution. In order to
26 maintain the spirit of the original resolution an alternative title and resolution language
27 were recommended. Specifically, the new language outlines a modernized approach to
28 debt litigation, that the AMA consider the relative financial benefit of collecting medical
29 debt against the cost to patient well-being and that physicians work with patients to
30 consider alternative options before initiating litigation or using third-party debt collectors.
31 This revised language captures the spirit of the original resolution, while balancing the
32 concerns that the original language raised. Therefore, your Reference Committee
33 recommends that Alternate Resolution 815 be adopted in lieu of Resolution 815.

34
35 (17) RESOLUTION 817 - PROMOTING ORAL ANTICANCER
36 DRUG PARITY

37
38 RECOMMENDATION:

39
40 Alternate Resolution 817 be adopted in lieu of Resolution
41 817.

42
43 RESOLVED, That our American Medical Association work
44 with interested stakeholders to advocate for cost-sharing
45 parity between injectable/infusible and oral therapy for
46 cancer. (Directive to Take Action)

47
48 HOD ACTION: Alternate Resolution 817 adopted in lieu
49 of Resolution 817

1 RESOLVED, That our American Medical Association amend H-55.986, Home
2 Chemotherapy and Antibiotic Infusions by addition to read as follows:
3

4 H-55.986 - HOME CHEMOTHERAPY AND ANTIBIOTIC INFUSIONS

5 Our AMA: (1) endorses the use of home medications to include those orally-
6 administered, injections and/or infusions of FDA approved drugs and group C drugs
7 (including chemotherapy and/or antibiotic therapy) for appropriate patients under
8 physicians' recommendation and supervision; (2) only considers extension of the use of
9 home infusions for biologic agents, immune modulating therapy, and anti-cancer therapy
10 as allowed under the public health emergency when circumstances are present such
11 that the benefits to the patient outweigh the potential risks; (3) encourages CMS and/or
12 other insurers to provide adequate reimbursement and liability protections for such
13 treatment; (4) supports educating legislators and administrators about the risks and
14 benefits of such home infused antibiotics and supportive care treatments in terms of cost
15 saving, increased quality of life and decreased morbidity, and about the need to ensure
16 patient and provider safety when considering home infusions for such treatment as
17 biologic, immune modulating, and anti-cancer therapy; (5) advocates for appropriate
18 reimbursement policies for home infusions; and (6) opposes any requirement by insurers
19 for home administration of drugs, if in the treating physician's clinical judgment it is not
20 appropriate, or the precautions necessary to protect medical staff, patients and
21 caregivers from adverse events associated with drug infusion and disposal are not in
22 place; this includes withholding of payment or prior authorization requirements for other
23 settings; and (7) advocates for patient cost-sharing parity between office- and home-
24 administered anticancer drugs. (Modify Current HOD Policy)

25
26 Testimony around Resolution 817 was primarily in support with some recommendations
27 for referral. The importance for patients to receive affordable care in the setting and
28 method of their choosing was raised. Additionally, the concerning cost differential
29 between different methods of treatment was stated in support of the resolution. A
30 number of societies and delegations spoke in support of patient ability to receive this
31 treatment in their home if it is determined to be the best course of treatment by the
32 physician and desired by the patient. Testimony opposing Resolution 817 was focused
33 on the need for additional study of this complex issue and suggested that the resolution
34 be referred. However, additional testimony outlined the body of research that exists
35 supporting the use of these types of treatments. Therefore, in order to capture the spirit
36 of proposed amendments, alternative language was suggested that the AMA work with
37 interested stakeholders to advocate for cost-sharing between injectable/infusible and
38 oral therapies for cancer. Therefore, your Reference Committee recommends that
39 Alternate Resolution 817 be adopted in lieu of Resolution 817.

1 (18) RESOLUTION 818 - PEDIATRIC OBESITY TREATMENT
2 INSURANCE COVERAGE

3
4 RECOMMENDATION:

5
6 Alternate Resolution 818 be adopted in lieu of Resolution
7 818:

8
9 RESOLVED, That our American Medical Association
10 amend Policy D-440.954, "Addressing Obesity," by
11 addition and deletion:

12
13 ADDRESSING ADULT AND PEDIATRIC OBESITY D-
14 440.954

15
16 1. Our AMA will: (a) assume a leadership role in
17 collaborating with other interested organizations, including
18 national medical specialty societies, the American Public
19 Health Association, the Center for Science in the Public
20 Interest, and the AMA Alliance, to discuss ways to finance
21 a comprehensive national program for the study,
22 prevention, and treatment of obesity, as well as public
23 health and medical programs that serve vulnerable
24 populations; (b) encourage state medical societies to
25 collaborate with interested state and local organizations to
26 discuss ways to finance a comprehensive program for the
27 study, prevention, and treatment of obesity, as well as
28 public health and medical programs that serve vulnerable
29 populations; and (c) continue to monitor and support state
30 and national policies and regulations that encourage
31 healthy lifestyles and promote obesity prevention.

32
33 2. Our AMA, consistent with H-440.842, Recognition of
34 Obesity as a Disease, will work with national specialty and
35 state medical societies to advocate for patient access to
36 and physician payment for the full continuum of evidence-
37 based obesity treatment modalities (such as behavioral,
38 pharmaceutical, psychosocial, nutritional, and surgical
interventions).

39
40 3. That our AMA work with interested national medical
41 specialty societies and state medical associations to
42 increase public insurance coverage of and payment for the
43 full spectrum of evidence-based adult and pediatric obesity
treatment.

1 3.4. Our AMA will: (a) work with state and specialty
2 societies to identify states in which physicians are
3 restricted from providing the current standard of care with
4 regards to obesity treatment; and (b) work with interested
5 state medical societies and other stakeholders to remove
6 out-of-date restrictions at the state and federal level
7 prohibiting healthcare providers from providing the current
8 standard of care to patients affected by obesity.

9 4.5. Our AMA will leverage existing channels within AMA
10 that could advance the following priorities:

- Promotion of awareness amongst practicing physicians and trainees that obesity is a treatable chronic disease along with evidence-based treatment options.
- Advocacy efforts at the state and federal level to impact the disease obesity.
- Health disparities, stigma and bias affecting people with obesity.
- Lack of insurance coverage for evidence-based treatments including intensive lifestyle intervention, anti-obesity pharmacotherapy and bariatric and metabolic surgery.
- Increasing obesity rates in children, adolescents and adults.
- Drivers of obesity including lack of healthful food choices, over-exposure to obesogenic foods and food marketing practices.

5.6. Our AMA will conduct a landscape assessment that includes national level obesity prevention and treatment initiatives, and medical education at all levels of training to identify gaps and opportunities where AMA could demonstrate increased impact.

6.7. Our AMA will convene an expert advisory panel once, and again if needed, to counsel AMA on how best to leverage its voice, influence and current resources to address the priorities listed in item 4.5. above. (Modify Current AMA Policy)

**38 HOD ACTION: Alternate Resolution 818 adopted in lieu
39 of Resolution 818**

41 RESOLVED, That our American Medical Association immediately call for full public
42 health insurance coverage of pediatric evidence-based anti-obesity treatment, including
43 comprehensive life-style therapy, anti-obesity medications and metabolic and bariatric
44 surgery (Directive to Take Action); and be it further

46 RESOLVED, That our AMA work with all interested parties to lobby the legislative and
47 executive branches of government to affect public health insurance coverage and
48 payment for the full spectrum of evidence-based pediatric anti-obesity therapy. (Directive
49 to Take Action)

1 Testimony on Resolution 818 was mixed. There were amendments proffered by the
2 Council on Medical Service, Young Physician Section, and the American Society of
3 Clinical Oncologists. Testimony generally supported the spirit of this resolution.
4 Addressing childhood obesity is of the utmost importance. The amendment proffered by
5 the Council on Medical Service was compelling and broadens Policy D-440.954 to
6 include pediatric obesity streamlines AMA policy and accomplishes the goal of
7 Resolution 818. The amended language captures the sponsors' ask and calls for
8 increased public health insurance coverage of the full spectrum of evidence-based adult
9 and pediatric obesity treatment, which could include comprehensive lifestyle therapy,
10 anti-obesity medications, and metabolic and bariatric surgery. Your Reference
11 Committee recommends that Alternate Resolution 818 be adopted in lieu of Resolution
12 818.

13
14 (19) RESOLUTION 819 - ADVOCATING FOR THE
15 IMPLEMENTATION OF UPDATED U.S. PREVENTIVE
16 SERVICES TASK FORCE RECOMMENDATIONS FOR
17 COLORECTAL CANCER SCREENING AMONG
18 PRIMARY CARE PHYSICIANS AND MAJOR PAYORS BY
19 THE AMA

20
21 RECOMMENDATION:

22
23 Alternate Resolution 819 be adopted in lieu of Resolution
24 819:

25
26 RESOLVED, That our American Medical Association
27 coordinate with interested national medical specialty
28 societies and state medical associations to enhance
29 physician education and awareness of the US Preventive
30 Services Task Force (USPSTF) guidelines to initiate
31 preventive screening for colorectal cancer at age 45.
32 (Directive to Take Action)

33
34 **HOD ACTION: Alternate Resolution 819 adopted in lieu of**
35 **Resolution 819**

36
37 RESOLVED, That our American Medical Association advocate that payors, health
38 systems, and clinicians adopt the updated U.S. Preventive Task Force Recommendation
39 to initiate routine preventive screening for colorectal cancer at age 45; and to coordinate
40 with like-minded professional organizations to enhance physician education and
41 awareness of this essential recommendation. (Directive to Take Action)

42
43 Testimony was supportive of Resolution 819 outlining the importance of preventative
44 colorectal cancer screening at age 45. A number of medical specialty societies and state
45 medical associations spoke to the importance of ensuring physicians and the public are
46 sufficiently educated and aware of the importance of preventative colorectal cancer
47 screening. The Council on Medical Service spoke in support of the sentiment of
48 Resolution 819, but stated that current AMA policy and advocacy efforts meet the
49 submitted language of the resolution. Alternative language was suggested by the
50 Council on Medical Service that focuses on the need for awareness and education of

1 preventative colorectal cancer screening at age 45. Testimony indicated that coverage
2 included in sections 2713, 4105, and 4106 of the ACA requires adherence to the
3 USPSTF guidelines. Additional testimony supported the new language submitted by the
4 Council on Medical Service. Therefore, your Reference Committee recommends that
5 Alternate Resolution 819 be adopted in lieu of Resolution 819.

6

1 RECOMMENDED FOR REFERRAL 2

3 (20) RESOLUTION 823 - HEALTH INSURERS AND
4 COLLECTION OF CO-PAYS AND DEDUCTIBLES
5

6 RECOMMENDATION:
7

8 Resolution 823 be referred.
9

10 **HOD ACTION: Resolution 823 referred**
11

12 RESOLVED, That our American Medical Association advocate for legislation and/or
13 regulations to require insurers to collect co-pays and deductibles in fee-for-service
14 arrangements directly from patients with whom the insurers are contractually engaged
15 and pay physicians the full contracted rate unless physicians opt out to collect on their
16 own. (Directive to Take Action)
17

18 Testimony on Resolution 823 was limited, but universally supportive. The collection of
19 co-pays and deductibles poses a significant burden on physicians and their practices.
20 However, due to the limited testimony, concern was raised surrounding the unintended
21 consequences of the resolution and its changes to the collection of co-pays and
22 deductibles. AMA policy is very similar to the spirit of Resolution 823, but it remains
23 broader than the submitted resolution. For these reasons and the need for additional
24 research to understand the impact of the spirit of this resolution in a variety of practice
25 settings, your Reference Committee recommends that Resolution 823 be referred.
26

27 (21) RESOLUTION 824 - ENABLING AND ENHANCING THE
28 DELIVERY OF CONTINUITY OF CARE WHEN
29 PHYSICIANS DELIVER CARE ACROSS DIVERSE
30 PROBLEM SETS
31

32 RECOMMENDATION:
33

34 Resolution 824 be referred.
35

36 **HOD ACTION: Resolution 824 referred**
37

38 RESOLVED, That our American Medical Association recognize that there is greater
39 value to the patient, improved access to care, greater patient satisfaction, and improved
40 overall patient care by advocating for appropriate payment for multiple services (two or
41 more) to be performed during a single patient encounter. (Directive to Take Action)
42

43 Testimony on Resolution 824 was mixed. Speakers offered anecdotal evidence as to the
44 issues with existing payment practices and raised that mechanisms for collection of
45 surgery codes are in place but are lacking in E/M codes. Testimony went on to say that
46 the intentionally vague wording of the resolution allowed physicians to provide care in
47 fewer office visits through the combination of care in a single visit. The Council on
48 Medical Service testified that this resolution is adequately covered by AMA policy.
49 Testimony in opposition to Resolution 824 centered around concerns that this policy

1 should be an issue addressed by the RUC and that the AMA should advocate for
2 appropriate evaluation of codes and add on complexity. In order to address given
3 testimony, investigate the complexity of the issue, and better understand how this issue
4 will change with the move to time-based reimbursement in 2023, your Reference
5 Committee recommends Resolution 824 be referred.

6

1 RECOMMENDED FOR REAFFIRMATION IN LIEU OF 2

3 (22) RESOLUTION 804 - CENTERS FOR MEDICARE &
4 MEDICAID INNOVATION PROJECTS

5
6 RECOMMENDATION:

7 Resolution 814 be referred for decision.

8
9 **HOD ACTION: Resolution 804 referred for decision**

10
11 RESOLVED, That our American Medical Association advocate against mandatory
12 participation in Centers for Medicare and Medicaid Innovation (CMMI) demonstration
13 projects, and advocate for CMMI instead to focus on the development of voluntary pilot
14 projects (Directive to Take Action); and be it further

15
16 RESOLVED, That our AMA advocate to ensure that any CMMI project that requires
17 physician and/or patient participation be required to be approved by Congress. (Directive
18 to Take Action)

19
20 Testimony on Resolution 804 was mixed. There was testimony in opposition to the
21 second Resolve clause, stating that asking for Congressional approval for CMMI
22 demonstration projects would create unnecessary roadblocks for physicians participating
23 in these programs. Additionally, testimony from the U.S. Public Health Service confirmed
24 that there is already a system in place to take feedback into consideration, noting that
25 most CMMI demonstration projects are voluntary, and only those programs where
26 meaningful improvement data cannot be discerned are reserved for mandatory
27 participation. Without the second Resolve clause, we are left with the first Resolve
28 clause asking for the AMA to advocate against mandatory participation in CMMI
29 demonstration projects. The AMA already has policy supporting this stance. Therefore,
30 your Reference Committee recommends that Policies D-185.950 and H-330.894 be
31 reaffirmed in lieu of Resolution 804.

32
33 CMMI PAYMENT REFORM MODELS

34 Our AMA will: (1) continue to advocate against mandatory Center for Medicare
35 and Medicaid Innovation (CMMI) demonstration projects; (2) advocate that the
36 Centers for Medicare and Medicaid Services seek innovative payment and care
37 delivery model ideas from physicians and groups such as medical specialty
38 societies to guide recommendation of the Physician-Focused Payment Model
39 Technical Advisory Committee (PTAC) and work of the CMMI to propose
40 demonstration projects that are voluntary and can be appropriately tested; and
41 (3) advocate that CMMI focus on the development of multiple pilot projects in
42 many specialties, which are voluntary and tailored to the needs of local
43 communities and the needs of different specialties. (Res. 231, A-21)

44
45 DEMONSTRATION PROJECT REGARDING MEDICARE PART D H-330.894

46 1. Our AMA will continue its policy of promoting beneficiary choice and market
47 based options in the context of the Medicare prescription drug benefit program
48 (Part D).

1 2. Our AMA encourages the development of voluntary models under the
2 auspices of the CMS Innovation Center (CMMI) to test the impact of offering
3 Medicare beneficiaries additional enhanced alternative health plan choices that
4 offer lower, consistent, and predictable out-of-pocket costs for select prescription
5 drugs. (BOT Action in response to referred for decision Res. 142, A-07;
6 Reaffirmed: CMS Rep. 01, A-17; Appended: CMS Rep. 4, A-22)

7
8 (23) RESOLUTION 808 - REINSTATEMENT OF
9 CONSULTATION CODES

10 RECOMMENDATION:

11 Policy D-385.955 be reaffirmed in lieu of Resolution 808.

12
13 **HOD ACTION: Policy D-385.955 reaffirmed in lieu of**
14 **Resolution 808**

15 RESOLVED, That our American Medical Association proactively engage and advocate
16 with any commercial insurance company that discontinues payment for consultation
17 codes or that is proposing to or considering eliminating payment for such codes,
18 requesting that the company reconsider the policy change. (Directive to Take Action)

19 Testimony was mixed for Resolution 808. Testimony supporting Resolution 808 was
20 primarily centered around the need for physicians to be adequately reimbursed.
21 Opposition to Resolution 808 focused entirely on fact that the language of this resolution
22 is verbatim from AMA policy, specifically the first Resolve of AMA Policy D-385.955.
23 Therefore, your Reference Committee recommends that Policy D-385.955 be reaffirmed
24 in lieu of Resolution 808.

25 CONSULTATION CODES AND PRIVATE PAYERS D-385.955

26 1. Our AMA will proactively engage and advocate with any commercial insurance
27 company that discontinues payment for consultation codes or that is proposing to
28 or considering eliminating payment for such codes, requesting that the company
29 reconsider the policy change.

30 2. Where a reason given by an insurance company for policy change to
31 discontinue payment of consultation codes includes purported coding errors or
32 abuses, our AMA will request the company carry out coding education and
33 outreach to physicians on consultation codes rather than discontinue payment for
34 the codes, and call for release of de-identified data from the company related to
35 purported coding issues in order to help facilitate potential education by physician
36 societies.

37
38 (24) RESOLUTION 810 - MEDICARE DRUG PRICING AND
39 PHARMACY COSTS

40 RECOMMENDATION:

41 Policies D-330.954, H-110.987, D-110.994, H-125.978,
42 and H-105.988 be reaffirmed in lieu of Resolution 810.

1 **HOD ACTION: Policies D-330.954, H-110.987, D-110.994, H-**
2 **125.978, and H-105.988 reaffirmed in lieu of Resolution 810**

3
4 RESOLVED, That our American Medical Association advocate for immediate, timely and
5 transparent negotiations for how Medicare drug prices are set to be incorporated into law
6 (Directive to Take Action); and be it further

7
8 RESOLVED, That our AMA advocate to eliminate loopholes such as new usage for
9 current medications (commonly known as patent evergreening) (Directive to Take
10 Action); and be it further

11
12 RESOLVED, That our AMA advocate for a ban on direct-to-consumer advertising for
13 prescription drugs by no later than five years, in 2027. (Directive to Take Action)

14
15 Testimony for Resolution 810 was mixed. The importance of eliminating patent
16 loopholes and the associated “patent evergreening” practice was emphasized as
17 especially important. Testimony also supported the need for affordable prescription
18 drugs through negotiated Medicare drug prices. Opposition to Resolution 810 was
19 centered around the fact that this resolution is adequately covered by existing AMA
20 policies. The Council on Medical Service and the Council on Legislation testified to the
21 coverage of this resolution in AMA Policies D-330.954, H-110.987, D-110.994, H-
22 125.978, and H-105.988, as well as a history of AMA advocacy and recently passed
23 federal legislation supporting the goals of this resolution. Therefore, your Reference
24 Committee recommends that Policies D-330.954, H-110.987, D-110.994, H-125.978,
25 and H-105.988 be reaffirmed in lieu of Resolution 810.

26
27 PRESCRIPTION DRUG PRICES AND MEDICARE D-330.954

28 1. Our AMA will support federal legislation which gives the Secretary of the
29 Department of Health and Human Services the authority to negotiate contracts
30 with manufacturers of covered Part D drugs.

31 2. Our AMA will work toward eliminating Medicare prohibition on drug price
32 negotiation.

33 3. Our AMA will prioritize its support for the Centers for Medicare & Medicaid
34 Services to negotiate pharmaceutical pricing for all applicable medications
35 covered by CMS. (Res. 211, A-04; Reaffirmation I-04; Reaffirmed in lieu of Res.
36 201, I-11; Appended: Res. 206, I-14; Reaffirmed: CMS Rep. 2, I-15; Appended:
37 Res. 203, A-17; Reaffirmed: CMS Rep. 4, I-19; Reaffirmed: CMS Rep. 3, I-20;
38 Reaffirmed: Res. 113, I-21; Reaffirmed: CMS Rep. 4, A-22)

39
40 PHARMACEUTICAL COSTS H-110.987

41 1. Our AMA encourages Federal Trade Commission (FTC) actions to limit
42 anticompetitive behavior by pharmaceutical companies attempting to reduce
43 competition from generic manufacturers through manipulation of patent
44 protections and abuse of regulatory exclusivity incentives.

45 2. Our AMA encourages Congress, the FTC and the Department of Health and
46 Human Services to monitor and evaluate the utilization and impact of controlled
47 distribution channels for prescription pharmaceuticals on patient access and
48 market competition.

49 3. Our AMA will monitor the impact of mergers and acquisitions in the
50 pharmaceutical industry.

1 4. Our AMA will continue to monitor and support an appropriate balance between
2 incentives based on appropriate safeguards for innovation on the one hand and
3 efforts to reduce regulatory and statutory barriers to competition as part of the
4 patent system.

5 5. Our AMA encourages prescription drug price and cost transparency among
6 pharmaceutical companies, pharmacy benefit managers and health insurance
7 companies.

8 6. Our AMA supports legislation to require generic drug manufacturers to pay an
9 additional rebate to state Medicaid programs if the price of a generic drug rises
10 faster than inflation.

11 7. Our AMA supports legislation to shorten the exclusivity period for biologics.

12 8. Our AMA will convene a task force of appropriate AMA Councils, state medical
13 societies and national medical specialty societies to develop principles to guide
14 advocacy and grassroots efforts aimed at addressing pharmaceutical costs and
15 improving patient access and adherence to medically necessary prescription
16 drug regimens.

17 9. Our AMA will generate an advocacy campaign to engage physicians and
18 patients in local and national advocacy initiatives that bring attention to the rising
19 price of prescription drugs and help to put forward solutions to make prescription
20 drugs more affordable for all patients.

21 10. Our AMA supports: (a) drug price transparency legislation that requires
22 pharmaceutical manufacturers to provide public notice before increasing the
23 price of any drug (generic, brand, or specialty) by 10% or more each year or per
24 course of treatment and provide justification for the price increase; (b) legislation
25 that authorizes the Attorney General and/or the Federal Trade Commission to
26 take legal action to address price gouging by pharmaceutical manufacturers and
27 increase access to affordable drugs for patients; and (c) the expedited review of
28 generic drug applications and prioritizing review of such applications when there
29 is a drug shortage, no available comparable generic drug, or a price increase of
30 10% or more each year or per course of treatment.

31 11. Our AMA advocates for policies that prohibit price gouging on prescription
32 medications when there are no justifiable factors or data to support the price
33 increase.

34 12. Our AMA will provide assistance upon request to state medical associations
35 in support of state legislative and regulatory efforts addressing drug price and
36 cost transparency.

37 13. Our AMA supports legislation to shorten the exclusivity period for FDA
38 pharmaceutical products where manufacturers engage in anti-competitive
39 behaviors or unwarranted price escalations.

40 14. Our AMA supports legislation that limits Medicare annual drug price
41 increases to the rate of inflation. (CMS Rep. 2, I-15Reaffirmed in lieu of: Res.
42 817, I-16Appended: Res. 201, A-17Reaffirmed in lieu of: Res. 207, A-17Modified:
43 Speakers Rep. 01, A-17Appended: Alt. Res. 806, I-17Reaffirmed: BOT Rep. 14,
44 A-18Appended: CMS Rep. 07, A-18Appended: BOT Rep. 14, A-19Reaffirmed:
45 Res. 105, A-19Appended: Res. 113, I-21)

46
47 INAPPROPRIATE EXTENSION OF PATENT LIFE OF PHARMACEUTICALS D-
48 110.994

49 Our AMA will continue to monitor the implementation of the newly-enacted
50 reforms to the Hatch-Waxman law to see if further refinements are needed that

would prevent inappropriate extension of patent life of pharmaceuticals, and work accordingly with Congress and the Administration to ensure that AMA policy concerns are addressed. (BOT Rep. 21, A-04; Reaffirmed: BOT Rep. 19, A-14)

PATIENT PROTECTION FROM FORCED SWITCHING OF PATENT-PROTECTED DRUGS H-125.978

Our AMA will: (1) raise awareness among physicians of the strategy that could be used to limit the value to manufacturers of forced switching of brand formulations of prescription drugs; and (2) advocate that the U.S. Food and Drug Administration (FDA) and Congress ascertain the pervasiveness of this practice and advance solutions that strike an appropriate balance between innovation incentives and competition in order to support patient access to the newest treatments as well as those that are cost-effective. (BOT action in response to referred for decision Res. 219, A-14)

DIRECT-TO-CONSUMER ADVERTISING (DTCA) OF PRESCRIPTION DRUGS AND IMPLANTABLE DEVICES H-105.988

1. To support a ban on direct-to-consumer advertising for prescription drugs and implantable medical devices.

2. That until such a ban is in place, our AMA opposes product-claim DTCA that does not satisfy the following guidelines:

(a) The advertisement should be indication-specific and enhance consumer education about the drug or implantable medical device, and the disease, disorder, or condition for which the drug or device is used.

(b) In addition to creating awareness about a drug or implantable medical device for the treatment or prevention of a disease, disorder, or condition, the advertisement should convey a clear, accurate and responsible health education message by providing objective information about the benefits and risks of the drug or implantable medical device for a given indication. Information about benefits should reflect the true efficacy of the drug or implantable medical device as determined by clinical trials that resulted in the drug's or device's approval for marketing.

(c) The advertisement should clearly indicate that the product is a prescription drug or implantable medical device to distinguish such advertising from other advertising for non-prescription products.

(d) The advertisement should not encourage self-diagnosis and self-treatment, but should refer patients to their physicians for more information. A statement, such as "Your physician may recommend other appropriate treatments," is recommended.

(e) The advertisement should exhibit fair balance between benefit and risk information when discussing the use of the drug or implantable medical device product for the disease, disorder, or condition. The amount of time or space devoted to benefit and risk information, as well as its cognitive accessibility, should be comparable.

(f) The advertisement should present information about warnings, precautions, and potential adverse reactions associated with the drug or implantable medical device product in a manner (e.g., at a reading grade level) such that it will be understood by a majority of consumers, without distraction of content, and will help facilitate communication between physician and patient.

(g) The advertisement should not make comparative claims for the product versus other prescription drug or implantable medical device products; however,

1 the advertisement should include information about the availability of alternative
2 non-drug or non-operative management options such as diet and lifestyle
3 changes, where appropriate, for the disease, disorder, or condition.

4 (h) In general, product-claim DTCA should not use an actor to portray a health
5 care professional who promotes the drug or implantable medical device product,
6 because this portrayal may be misleading and deceptive. If actors portray health
7 care professionals in DTCA, a disclaimer should be prominently displayed.

8 (i) The use of actual health care professionals, either practicing or retired, in
9 DTCA to endorse a specific drug or implantable medical device product is
10 discouraged but if utilized, the advertisement must include a clearly visible
11 disclaimer that the health care professional is compensated for the endorsement.

12 (j) The advertisement should be targeted for placement in print, broadcast, or
13 other electronic media so as to avoid audiences that are not age appropriate for
14 the messages involved.

15 (k) In addition to the above, the advertisement must comply with all other
16 applicable Food and Drug Administration (FDA) regulations, policies and
17 guidelines.

18 3. That the FDA review and pre-approve all DTCA for prescription drugs or
19 implantable medical device products before pharmaceutical and medical device
20 manufacturers (sponsors) run the ads, both to ensure compliance with federal
21 regulations and consistency with FDA-approved labeling for the drug or
22 implantable medical device product.

23 4. That the Congress provide sufficient funding to the FDA, either through direct
24 appropriations or through prescription drug or implantable medical device user
25 fees, to ensure effective regulation of DTCA.

26 5. That DTCA for newly approved prescription drug or implantable medical
27 device products not be run until sufficient post-marketing experience has been
28 obtained to determine product risks in the general population and until physicians
29 have been appropriately educated about the drug or implantable medical device.
30 The time interval for this moratorium on DTCA for newly approved drugs or
31 implantable medical devices should be determined by the FDA, in negotiations
32 with the drug or medical device product's sponsor, at the time of drug or
33 implantable medical device approval. The length of the moratorium may vary
34 from drug to drug and device to device depending on various factors, such as:
35 the innovative nature of the drug or implantable medical device; the severity of
36 the disease that the drug or implantable medical device is intended to treat; the
37 availability of alternative therapies; and the intensity and timeliness of the
38 education about the drug or implantable medical device for physicians who are
39 most likely to prescribe it.

40 6. That our AMA opposes any manufacturer (drug or device sponsor) incentive
41 programs for physician prescribing and pharmacist dispensing that are run
42 concurrently with DTCA.

43 7. That our AMA encourages the FDA, other appropriate federal agencies, and
44 the pharmaceutical and medical device industries to conduct or fund research on
45 the effect of DTCA, focusing on its impact on the patient-physician relationship as
46 well as overall health outcomes and cost benefit analyses; research results
47 should be available to the public.

48 8. That our AMA supports the concept that when companies engage in DTCA,
49 they assume an increased responsibility for the informational content and an

1 increased duty to warn consumers, and they may lose an element of protection
2 normally accorded under the learned intermediary doctrine.

3 9. That our AMA encourages physicians to be familiar with the above AMA
4 guidelines for product-claim DTCA and with the Council on Ethical and Judicial
5 Affairs Ethical Opinion E-9.6.7 and to adhere to the ethical guidance provided in
6 that Opinion.

7 10. That the Congress should request the Agency for Healthcare Research and
8 Quality or other appropriate entity to perform periodic evidence-based reviews of
9 DTCA in the United States to determine the impact of DTCA on health outcomes
10 and the public health. If DTCA is found to have a negative impact on health
11 outcomes and is detrimental to the public health, the Congress should consider
12 enacting legislation to increase DTCA regulation or, if necessary, to prohibit
13 DTCA in some or all media. In such legislation, every effort should be made to
14 not violate protections on commercial speech, as provided by the First
15 Amendment to the U.S. Constitution.

16 11. That our AMA supports eliminating the costs for DTCA of prescription drugs
17 as a deductible business expense for tax purposes.

18 12. That our AMA continues to monitor DTCA, including new research findings,
19 and work with the FDA and the pharmaceutical and medical device industries to
20 make policy changes regarding DTCA, as necessary.

21 13. That our AMA supports "help-seeking" or "disease awareness"□
22 advertisements (i.e., advertisements that discuss a disease, disorder, or
23 condition and advise consumers to see their physicians, but do not mention a
24 drug or implantable medical device or other medical product and are not
25 regulated by the FDA).

26 14. Our AMA will advocate to the applicable Federal agencies (including the
27 Food and Drug Administration, the Federal Trade Commission, and the Federal
28 Communications Commission) which regulate or influence direct-to-consumer
29 advertising of prescription drugs that such advertising should be required to state
30 the manufacturer's suggested retail price of those drugs. (BOT Rep. 38 and Sub.
31 Res. 513, A-99Reaffirmed: CMS Rep. 9, Amended: Res. 509, and Reaffirmation
32 I-99Appended & Reaffirmed: Sub. Res. 503, A-01Reaffirmed: Res. 522, A-
33 02Reaffirmed: Res. 914, I-02Reaffirmed: Sub. Res. 504, A-03Reaffirmation A-
34 04Reaffirmation A-05Modified: BOT Rep. 9, A-06Reaffirmed in lieu of Res. 514,
35 A-07BOT Action in response to referred for decision: Res. 927, I-15Modified:
36 BOT Rep. 09, I-16Appended: Res. 236, A-17Reaffirmed in lieu of: Res. 223, A-
37 17Reaffirmed in lieu of: Res. 112, A-19)

38
39 (25) RESOLUTION 822 - MONITORING OF ALTERNATIVE
40 PAYMENT MODELS WITHIN TRADITIONAL MEDICARE

41 RECOMMENDATION:

42 Resolution 822 be referred.

43
44 **HOD ACTION: Resolution 822 be referred**

45
46 RESOLVED, That our AMA monitor the Accountable Care Organization Realizing
47 Equity, Access, and Community Health (ACO-REACH) program for its impacts on
48 patients and physicians in Traditional Medicare, including the quality and cost of
49
50

1 healthcare and patient/provider choice, and report back to the House of Delegates on
2 the impact of the ACO-REACH demonstration program annually until its conclusion
3 (Directive to Take Action); and be it further
4

5 RESOLVED, That our AMA advocate against any Medicare demonstration project that
6 denies or limits coverage or benefits that beneficiaries would otherwise receive in
7 Traditional Medicare (Directive to Take Action); and be it further
8

9 RESOLVED, That our AMA develop educational materials for physicians regarding the
10 Accountable Care Organization Realizing Equity, Access, and Community Health (ACO-
11 REACH) program to help physicians understand the implications of their or their
12 employer's participation in this program and to help physicians determine whether
13 participation in the program is in the best interests of themselves and their patients.
14 (Directive to Take Action)
15

16 Limited testimony was heard on Resolution 822. The Medical Student Section testified
17 as authors of this resolution stating that ACO-REACH programs need to be monitored
18 and studied. While your Reference Committee appreciated the author's testimony, it
19 does not justify new AMA policy. Your Reference Committee notes that the AMA has
20 strict policy about Medicare Advantage plans being explicit and transparent with
21 patients. We agree that it is important to educate patients on participation in these
22 programs. This notification is already happening and is subject to stringent oversight.
23 Specifically, the second Resolve clause is addressed by H-373.998(5). This policy
24 specifically calls out and addresses patient choice. For these reasons, your Reference
25 Committee recommends that Policies D-160.915, D-385.953, H-373.998, and D-160.923
26 be reaffirmed in lieu of Resolution 822.
27

28 OPPOSITION TO ELIMINATION OF "INCIDENT-TO" BILLING FOR NON-
29 PHYSICIAN PRACTITIONERS D-160.915

30 Our AMA will advocate against efforts to eliminate "incident-to" billing for non-
31 physician practitioners among private and public payors. (Res. 711, A-21)
32

33 DUE DILIGENCE FOR PHYSICIANS AND PRACTICES JOINING AN ACO
34 WITH RISK BASED MODELS (UP SIDE AND DOWN SIDE RISK) D-385.953

35 1. Our AMA will advocate for the continuation of up side only risk Medicare
36 Shared Savings ACO (MSSP ACO) program as an option from the Centers for
37 Medicare and Medicaid Services, particularly for physician owned groups.

38 2. Our AMA will develop educational resources and business tools to help
39 physicians complete due diligence in evaluating the performance of physician-led
40 and hospital integrated systems before considering consolidation. Specific
41 attention should be given to the evaluation of transparency on past savings
42 results, system finances, quality metrics, physician workforce stability and
43 physician job satisfaction, and the cost of clinical documentation software.

44 3. Our AMA will evaluate the characteristics of successful physician owned
45 MSSP ACOs and participation in alternative payment models (APMs) to create a
46 framework of the resources and organizational tools needed to allow practices to
47 form virtual ACOs that would facilitate participation in MSSP ACOs and APMs.
48 (Res. 802, I-18)

49 PATIENT INFORMATION AND CHOICE H-373.998
50

1 Our AMA supports the following principles:
2

- 3 1. Greater reliance on market forces, with patients empowered with
4 understandable fee/price information and incentives to make prudent choices,
5 and with the medical profession empowered to enforce ethical and clinical
6 standards which continue to place patients' interests first, is clearly a more
7 effective and preferable approach to cost containment than is a government-run,
8 budget-driven, centrally controlled health care system.
- 9 2. Individuals should have freedom of choice of physician and/or system of health
10 care delivery. Where the system of care places restrictions on patient choice,
11 such restrictions must be clearly identified to the individual prior to their selection
12 of that system.
- 13 3. In order to facilitate cost-conscious, informed market-based decision-making in
14 health care, physicians, hospitals, pharmacies, durable medical equipment
15 suppliers, and other health care providers should be required to make
16 information readily available to consumers on fees/prices charged for frequently
17 provided services, procedures, and products, prior to the provision of such
18 services, procedures, and products. There should be a similar requirement that
19 insurers make available in a standard format to enrollees and prospective
20 enrollees information on the amount of payment provided toward each type of
21 service identified as a covered benefit.
- 22 4. Federal and/or state legislation should authorize medical societies to operate
23 programs for the review of patient complaints about fees, services, etc. Such
24 programs would be specifically authorized to arbitrate a fee or portion thereof as
25 appropriate and to mediate voluntary agreements, and could include the input of
26 the state medical society and the AMA Council on Ethical and Judicial Affairs.
- 27 5. Physicians are the patient advocates in the current health system reform
28 debate. Efforts should continue to seek development of a plan that will effectively
29 provide universal access to an affordable and adequate spectrum of health care
30 services, maintain the quality of such services, and preserve patients' freedom to
31 select physicians and/or health plans of their choice.
- 32 6. Efforts should continue to vigorously pursue with Congress and the
33 Administration the strengthening of our health care system for the benefit of all
34 patients and physicians by advocating policies that put patients, and the
35 patient/physician relationships, at the forefront. (BOT Rep. QQ, I-91; Reaffirmed:
36 BOT Rep. TT, I-92; Reaffirmed: Ref. Cmte. A, A-93; Reaffirmed: BOT Rep. UU,
37 A-93; Reaffirmed: CMS Rep. E, A-93; Reaffirmed: CMS Rep. G, A-93;
38 Reaffirmed: Sub. Res. 701, A-93; Sub. Res. 125, A-93; Reaffirmation A-93;
39 Reaffirmed: BOT Rep. 25, I-93; Reaffirmed: BOT Rep. 40, I-93; Reaffirmed: CMS
40 Rep. 5, I-93; Reaffirmed: CMS Rep. 10, I-93; Reaffirmed: Sub. Res. 107, I-93;
41 Reaffirmed: BOT Rep. 46, A-94; Reaffirmed: Sub. Res. 127, A-94; Reaffirmed:
42 Sub. Res. 132, A-94; Reaffirmed: BOT Rep. 16, I-94; BOT Rep. 36 - I-94;
43 Reaffirmed: CMS Rep. 8, A-95; Reaffirmed: Sub. Res. 109, A-95; Reaffirmed:
44 Sub. Res. 125, A-95; Reaffirmed by Sub. Res. 107, I-95; Reaffirmed: Sub. Res.
45 109, I-95; Reaffirmed by Rules & Credentials Cmt., A-96; Reaffirmation A-96;
46 Reaffirmation I-96; Reaffirmation A-97; Reaffirmed: Rules and Cred. Cmt., I-97;
47 Reaffirmed: CMS Rep. 3, I-97; Reaffirmation I-98; Reaffirmed: CMS Rep. 9, A-
48 98; Reaffirmation A-99; Reaffirmation A-00; Reaffirmation I-00; Reaffirmation A-
49 04; Consolidated and Renumbered: CMS Rep. 7, I-05; Reaffirmation A-07;
50 Reaffirmation A-08; Reaffirmed: CMS Rep. 4, A-09; Reaffirmed: CMS Rep. 3, I-
09; Reaffirmation I-14; Reaffirmed: CMS Rep. 4, A-15; Reaffirmation: A-17;

1 Reaffirmed: Res. 108, A-17; Reaffirmation: A-19; Reaffirmed in lieu of: Res. 112,
2 A-19)

3
4 URGE AMA TO RELEASE A WHITE PAPER ON ACOs D-160.923
5 Our AMA will seek objective, independent data on Accountable Care
6 Organizations and release a whitepaper regarding their effect on cost savings
7 and quality of care. (Res. 713, A-17; Reaffirmation: I-17)

8

1 Mister Speaker, this concludes the report of Reference Committee J. I would like to
2 thank Sarah Candler, MD, M. Laurin Council, MD, Amar Kelkar, MD, Anne Mongiu, MD,
3 Jason Schwalb, MD, Natalia Solenkova, MD, and all those who testified before the
4 Committee.

5

6

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