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

Your Reference Committee recommends the following consent calendar for acceptance:

1. CMS Report 01 – Incentives to Encourage the Efficient Use of Emergency Departments
2. Resolution 805 – COVID Vaccine Administration Fee

RECOMMENDED FOR ADOPTION AS AMENDED

4. CMS Report 02 – Corporate Practice of Medicine
5. Resolution 801 – Parity in Military Reproductive Health Insurance Coverage for All Service Members and Veterans
6. Resolution 802 – FAIR Health Database
7. Resolution 809 – Uniformity and Enforcement of Medicare Advantage Plans and Regulations
8. Resolution 811 – Covering Vaccinations for Seniors through Medicare Part B
9. Resolution 812 – Implant-Associated Anaplastic Large Cell Lymphoma
10. Resolution 816 – Medicaid and CHIP Coverage for Glucose Monitoring Devices for Patients with Diabetes
11. Resolution 821 – PrEP is an Essential Health Benefit
12. Resolution 826 – Leveling the Playing Field

RECOMMENDED FOR ADOPTION IN LIEU OF

14. Resolution 813 – Amending Policy on a Public Option toMaximize AMA Advocacy
15. Resolution 814 – Socioeconomics of CT Coronary Calcium: Is it Scored or Ignored?
16. Resolution 815 – Opposition to Debt Litigation Against Patients
17. Resolution 817 – Promoting Oral Anticancer Drug Parity
18. Resolution 818 – Pediatric Obesity Treatment Insurance Coverage
19. Resolution 819 – Advocating for the Implementation of Updated U.S. Preventive Services Task Force Recommendations for Colorectal Cancer Screening Among Primary Care Physicians and Major Payors by the AMA

RECOMMENDED FOR REFERRAL

20. Resolution 823 – Health Insurers and Collection of Co-Pays and Deductibles

21. Resolution 824 – Enabling and Enhancing the Delivery of Continuity of Care When Physicians Deliver Care Across Diverse Problem Sets

RECOMMENDED FOR REAFFIRMATION IN LIEU OF

22. Resolution 804 – Centers for Medicare & Medicaid Innovation Projects

23. Resolution 808 – Reinstatement of Consultation Codes

24. Resolution 810 – Medicare Drug Pricing and Pharmacy Costs

25. Resolution 822 – Monitoring of Alternative Payment Models within Traditional Medicare
RECOMMENDED FOR ADOPTION

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

RECOMMENDATION:

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

HOD ACTION: CMS Report 1 adopted and the remainder of the report filed

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

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

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

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

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

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

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

Testimony was overwhelmingly supportive of CMS Report 01. There was an amendment proposed by the Medical Student Section (MSS) to address co-pays and other cost-sharing measures for Medicaid patients receiving care in the Emergency Department. The Council on Medical Service commented that the MSS amendment goes beyond the
purview of this report. Your Reference Committee agrees. Therefore, your Reference Committee thanks the Council on Medical Service for a well-written report and recommends the report be adopted the remainder of the report be filed.

(2) RESOLUTION 805 - COVID VACCINE ADMINISTRATION

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RECOMMENDATION:

Resolution 805 be adopted.

HOD ACTION: Resolution 805 adopted

RESOLVED, That American Medical Association Policy D-440.981, “Appropriate Reimbursements and Carve-outs for Vaccines,” be amended by addition to read as follows:

Appropriate Reimbursements and Carve-outs for Vaccines D-440.981

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

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

(3) RESOLUTION 820 - THIRD-PARTY PHARMACY BENEFIT ADMINISTRATORS

RECOMMENDATION:

Resolution 820 be adopted.

HOD ACTION: Resolution 820 adopted
RESOLVED, That our American Medical Association recommend that third-party pharmacy benefit administrators that contract to manage the specialty pharmacy portion of drug formularies be included in existing pharmacy benefit manager (PBM) regulatory frameworks and statutes, and be subject to the same licensing, registration, and transparency reporting requirements (New HOD Policy); and be it further RESOLVED, That our AMA advocate that third-party pharmacy benefit administrators be included in future PBM oversight efforts at the state and federal levels. (Directive to Take Action)

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

CMS REPORT 02 - CORPORATE PRACTICE OF MEDICINE

RECOMMENDATION A:

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

3. That our AMA amend Policy H-160.891 by addition of two new clauses, as follows: 
j. Each individual physician should have the ultimate decision for medical judgment in 
patient care and medical care processes, including the use of mandated patient care algorithms or supervision of non-physician practitioners. 
k. Physicians should retain primary and final responsibility for structured medical education inclusive of 
undergraduate medical education including the structure of the program, program curriculum, selection of faculty and 
trainees, as well as education and disciplinary issues related to these programs. (Modify Current HOD Policy)

RECOMMENDATION B:

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

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

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

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

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

3. That our AMA amend Policy H-160.891 by addition of two new clauses, as follows: 
j. Each individual physician should have the ultimate decision for medical judgment in 
patient care and medical care processes, including the use of mandated patient care algorithms or supervision of non-physician practitioners. 
k. Physicians should retain primary and final responsibility for structured medical education inclusive of undergraduate medical education including the structure of the
program, program curriculum, selection of faculty and trainees, as well as education and disciplinary issues related to these programs. (Modify Current HOD Policy)

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

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

RECOMMENDATION A:

Resolution 801 be amended by addition to read as follows:

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

RECOMMENDATION B:

Resolution 801 be adopted as amended.

HOD ACTION: Resolution 801 adopted as amended

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

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

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

RESOLVED, That our American Medical Association advocate to FAIR Health to ensure the continued identification of provider type and the frequency by which a particular CPT® codes are used. (New HOD Policy)

RECOMMENDATION B:

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

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

RECOMMENDATION C:

Resolution 802 be adopted as amended.

RECOMMENDATION D:

The title of Resolution 802 be changed:

“INDEPENDENT MEDICAL CHARGE DATABASES OF ALLOWED AMOUNTS AND CHARGES”

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

“INDEPENDENT MEDICAL CHARGE DATABASES OF ALLOWED AMOUNTS AND CHARGES”

RESOLVED, That our American Medical Association advocate to FAIR Health to ensure the continued identification of the frequency by which a particular CPT code is used. (New HOD Policy)
Testimony on Resolution 802 was primarily in support. The importance of independent medical charge databases making available frequency codes to identify and assess low volume data cells, as well as the need for transparency of data sources and the provider type of each CPT code were raised by the Dermatology Section Council. The Council on Medical Service testified that to remain consistent across policy, the proprietary language of the original resolution should be replaced with “independent medical charge databases.” This amendment was supported by testimony. Testimony further supported the addition of a second resolve that the AMA advocate for transparency as to the source and validation of data from payors. Your Reference Committee recommends that Resolution 802 be adopted as amended.

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

RECOMMENDATION A:

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

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

RECOMMENDATION B:

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

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

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

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

RECOMMENDATION D:

Resolution 809 be adopted as amended.

HOD ACTION: Resolution 809 adopted as amended

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

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

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

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

Testimony expressed concern for the feasibility of Resolve three as written and the Council on Medical Service suggested alternative language that was supported by further testimony. This language states that the AMA will advocate for CMS to maintain a database of providers and the status of providers accepting new patients in a manner that is least burdensome to physicians. Additional concern was expressed about the
original language limiting the database to “senior” physicians and testimony supported the removal of this language. Therefore, your Reference Committee recommends Resolution 809 be adopted as amended.

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

RECOMMENDATION A:

Resolution 811 be amended by deletion to read as follows:

RESOLVED, That our American Medical Association advocate that Medicare Part B cover the full cost of all vaccinations administered to Medicare patients that are recommended by the Advisory Committee on Immunization Practices (ACIP), the US Preventive Services Task Force (USPSTF), or based on prevailing preventive clinical health guidelines at the point of care and outside of budget neutrality requirements. (Directive to Take Action)

RECOMMENDATION B:

Resolution 811 be adopted as amended.

RECOMMENDATION C:

The title of Resolution 811 be changed:

“COVERING VACCINATIONS THROUGH MEDICARE PART B”

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

“COVERING VACCINATIONS THROUGH MEDICARE PART B”

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

Testimony on Resolution 811 was mostly supportive. Several delegations supported the spirit of the resolution, but there was concern raised about budget neutrality. There was compelling testimony heard from the U.S. Public Health Service that called for striking “or based on prevailing preventive clinical health guidelines” as this language was ambiguous and unclear. There were amendments proposed to address budget neutrality by a few delegations, including the Council on Medical Service; however, your
Reference Committee heard testimony that AMA policy adequately covers our stance on budget neutrality and repeating that here would be redundant. There was testimony from a representative from the RUC also suggesting that this is not the place to address budget neutrality. Your Reference Committee recommends that Resolution 811 be adopted as amended.

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

RECOMMENDATION A:

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

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

RECOMMENDATION B:

Resolution 812 be adopted as amended.

RECOMMENDATION C:

The title of Resolution 812 be changed:

"COVERAGE FOR IMPLANT ASSOCIATED MALIGNANCIES"

HOD ACTION: Resolution 812 adopted as amended

"COVERAGE FOR IMPLANT ASSOCIATED MALIGNANCIES"

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

Testimony on Resolution 812 was supportive of the spirit of the resolution, however there were amendments proffered from the American Society of Breast Surgeons and the American Society of Plastic Surgeons to broaden and clarify this language. Your Reference Committee felt that both proffered amendments had merit and we incorporated the language. We recommend that Resolution 812 be adopted as amended.
(10) RESOLUTION 816 - MEDICAID AND CHIP COVERAGE
FOR GLUCOSE MONITORING DEVICES FOR
PATIENTS WITH DIABETES

RECOMMENDATION A:

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

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

RECOMMENDATION B:

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

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

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

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

RECOMMENDATION C:

Resolution 816 be adopted as amended.

RECOMMENDATION D:

The title of Resolution 816 be changed:

“COVERAGE FOR CONTINUOUS OR FLASH GLUCOSE
MONITORING DEVICES”

HOD ACTION: Resolution 816 adopted as amended with a
change in title to read as follows
RESOLVED, That our American Medical Association (AMA) advocate for broadening the classification criteria of Durable Medical Equipment to include all clinically effective and cost-saving diabetic glucose monitors (Directive to Take Action); and be it further

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

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

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

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

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

RECOMMENDATION A:

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

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

RECOMMENDATION B:

Resolution 821 be adopted as amended.

HOD ACTION: Resolution 821 adopted as amended
RESOLVED, That our American Medical Association supports the continued inclusion of Pre-Exposure Prophylaxis (PrEP) for Human Immunodeficiency Virus (HIV) as an Essential Health Benefit under the Patient Protection and Affordable Care Act (Directive to Take Action); and be it further

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

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

(12) RESOLUTION 826 - LEVELING THE PLAYING FIELD

RECOMMENDATION A:

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

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

RECOMMENDATION B:

Resolution 826 be adopted as amended.

HOD ACTION: Resolution 826 adopted as amended

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

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

(13) RESOLUTION 806 - HEALTHCARE MARKETPLACE PLAN SELECTION

RECOMMENDATION:

Alternate Resolution 806 be adopted in lieu of Resolution 806:

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

HOD ACTION: Alternate Resolution 806 adopted in lieu of Resolution 806

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

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

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

RECOMMENDATION:

Alternate Resolution 813 be 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:
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. 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
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.

3.4. 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 to immigrants without regard to immigration status. (Modify Current HOD Policy)
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:

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

1. 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. 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...
Your Reference Committee heard extensive testimony on Resolution 813. Testimony was mixed and passionate from both sides. To come to a consensus, it seemed that focusing on the similarities rather than the differences in testimony would be most productive. Your Reference Committee heard testimony on Resolution 813 that guardrails were needed when considering support of a public option, that there are barriers to access in the American health care system, and that we need to address health equity, decrease the cost of care, and decrease burdens placed on physicians.

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

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

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

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

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

RECOMMENDATION:

Alternate Resolution 814 be adopted in lieu of Resolution 814.

“NATIONAL COVERAGE DETERMINATION OF CORONARY ARTERY CALCIUM SCORING”
RESOLVED, That our American Medical Association ask the United States Preventive Services Task Force to study the impact of a national coverage determination to include coronary artery calcium scoring for patients who meet the screening criteria. (Directive to Take Action)

HOD ACTION: Alternate Resolution 814 adopted in lieu of Resolution 814

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

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

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

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

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

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

RECOMMENDATION:

Resolution 815 not be adopted.

HOD ACTION: Alternate Resolution 815 not adopted

RESOLVED, That our American Medical Association (AMA) oppose the practice of health care organizations pursuing litigation against patients due to medical debt, and
encourages health care organizations to consider the relative financial benefit of collecting medical debt to their revenue, against the detrimental cost to a patient’s well-being (New HOD Policy); and be it further

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

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

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

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

(17) RESOLUTION 817 - PROMOTING ORAL ANTICANCER DRUG PARITY

RECOMMENDATION:

Alternate Resolution 817 be adopted in lieu of Resolution 817.

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

HOD ACTION: Alternate Resolution 817 adopted in lieu of Resolution 817
RESOLVED, That our American Medical Association amend H-55.986, Home Chemotherapy and Antibiotic Infusions by addition to read as follows:

H-55.986 - HOME CHEMOTHERAPY AND ANTIBIOTIC INFUSIONS
Our AMA: (1) endorses the use of home medications to include those orally-administered, injections and/or infusions of FDA approved drugs and group C drugs (including chemotherapy and/or antibiotic therapy) for appropriate patients under physicians’ recommendation and supervision; (2) only considers extension of the use of home infusions for biologic agents, immune modulating therapy, and anti-cancer therapy as allowed under the public health emergency when circumstances are present such that the benefits to the patient outweigh the potential risks; (3) encourages CMS and/or other insurers to provide adequate reimbursement and liability protections for such treatment; (4) supports educating legislators and administrators about the risks and benefits of such home infused antibiotics and supportive care treatments in terms of cost saving, increased quality of life and decreased morbidity, and about the need to ensure patient and provider safety when considering home infusions for such treatment as biologic, immune modulating, and anti-cancer therapy; (5) advocates for appropriate reimbursement policies for home infusions; and (6) opposes any requirement by insurers for home administration of drugs, if in the treating physician’s clinical judgment it is not appropriate, or the precautions necessary to protect medical staff, patients and caregivers from adverse events associated with drug infusion and disposal are not in place; this includes withholding of payment or prior authorization requirements for other settings; and (7) advocates for patient cost-sharing parity between office- and home-administered anticancer drugs. (Modify Current HOD Policy)

Testimony around Resolution 817 was primarily in support with some recommendations for referral. The importance for patients to receive affordable care in the setting and method of their choosing was raised. Additionally, the concerning cost differential between different methods of treatment was stated in support of the resolution. A number of societies and delegations spoke in support of patient ability to receive this treatment in their home if it is determined to be the best course of treatment by the physician and desired by the patient. Testimony opposing Resolution 817 was focused on the need for additional study of this complex issue and suggested that the resolution be referred. However, additional testimony outlined the body of research that exists supporting the use of these types of treatments. Therefore, in order to capture the spirit of proposed amendments, alternative language was suggested that the AMA work with interested stakeholders to advocate for cost-sharing between injectable/infusible and oral therapies for cancer. Therefore, your Reference Committee recommends that Alternate Resolution 817 be adopted in lieu of Resolution 817.
RESOLUTION 818 - PEDIATRIC OBESITY TREATMENT INSURANCE COVERAGE

RECOMMENDATION:

Alternate Resolution 818 be adopted in lieu of Resolution 818:

RESOLVED, That our American Medical Association amend Policy D-440.954, “Addressing Obesity,” by addition and deletion:

ADDRESSING ADULT AND PEDIATRIC OBESITY D-440.954

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

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

3. That our AMA work with interested national medical specialty societies and state medical associations to increase public insurance coverage of and payment for the full spectrum of evidence-based adult and pediatric obesity treatment.
3.4. Our AMA will: (a) work with state and specialty societies to identify states in which physicians are restricted from providing the current standard of care with regards to obesity treatment; and (b) work with interested state medical societies and other stakeholders to remove out-of-date restrictions at the state and federal level prohibiting healthcare providers from providing the current standard of care to patients affected by obesity.

4-5. Our AMA will leverage existing channels within AMA 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)

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

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

RESOLVED, That our AMA work with all interested parties to lobby the legislative and executive branches of government to affect public health insurance coverage and payment for the full spectrum of evidence-based pediatric anti-obesity therapy. (Directive to Take Action)
Testimony on Resolution 818 was mixed. There were amendments proffered by the Council on Medical Service, Young Physician Section, and the American Society of Clinical Oncologists. Testimony generally supported the spirit of this resolution. Addressing childhood obesity is of the utmost importance. The amendment proffered by the Council on Medical Service was compelling and broadens Policy D-440.954 to include pediatric obesity streamlines AMA policy and accomplishes the goal of Resolution 818. The amended language captures the sponsors’ ask and calls for increased public health insurance coverage of the full spectrum of evidence-based adult and pediatric obesity treatment, which could include comprehensive lifestyle therapy, anti-obesity medications, and metabolic and bariatric surgery. Your Reference Committee recommends that Alternate Resolution 818 be adopted in lieu of Resolution 818.

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

RECOMMENDATION:

Alternate Resolution 819 be adopted in lieu of Resolution 819:

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

HOD ACTION: Alternate Resolution 819 adopted in lieu of Resolution 819

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

Testimony was supportive of Resolution 819 outlining the importance of preventative colorectal cancer screening at age 45. A number of medical specialty societies and state medical associations spoke to the importance of ensuring physicians and the public are sufficiently educated and aware of the importance of preventative colorectal cancer screening. The Council on Medical Service spoke in support of the sentiment of Resolution 819, but stated that current AMA policy and advocacy efforts meet the submitted language of the resolution. Alternative language was suggested by the Council on Medical Service that focuses on the need for awareness and education of
preventative colorectal cancer screening at age 45. Testimony indicated that coverage included in sections 2713, 4105, and 4106 of the ACA requires adherence to the USPSTF guidelines. Additional testimony supported the new language submitted by the Council on Medical Service. Therefore, your Reference Committee recommends that Alternate Resolution 819 be adopted in lieu of Resolution 819.
RECOMMENDED FOR REFERRAL

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

RECOMMENDATION:

Resolution 823 be referred.

HOD ACTION: Resolution 823 referred

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

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

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

RECOMMENDATION:

Resolution 824 be referred.

HOD ACTION: Resolution 824 referred

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

Testimony on Resolution 824 was mixed. Speakers offered anecdotal evidence as to the issues with existing payment practices and raised that mechanisms for collection of surgery codes are in place but are lacking in E/M codes. Testimony went on to say that the intentionally vague wording of the resolution allowed physicians to provide care in fewer office visits through the combination of care in a single visit. The Council on Medical Service testified that this resolution is adequately covered by AMA policy. Testimony in opposition to Resolution 824 centered around concerns that this policy
should be an issue addressed by the RUC and that the AMA should advocate for appropriate evaluation of codes and add on complexity. In order to address given testimony, investigate the complexity of the issue, and better understand how this issue will change with the move to time-based reimbursement in 2023, your Reference Committee recommends Resolution 824 be referred.
RECOMMENDED FOR REAFFIRMATION IN LIEU OF

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

RECOMMENDATION:

Resolution 814 be referred for decision.

HOD ACTION: Resolution 804 referred for decision

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

RESOLVED, That our AMA advocate to ensure that any CMMI project that requires physician and/or patient participation be required to be approved by Congress. (Directive to Take Action)
2. Our AMA encourages the development of voluntary models under the auspices of the CMS Innovation Center (CMMI) to test the impact of offering Medicare beneficiaries additional enhanced alternative health plan choices that offer lower, consistent, and predictable out-of-pocket costs for select prescription drugs. (BOT Action in response to referred for decision Res. 142, A-07; Reaffirmed: CMS Rep. 01, A-17; Appended: CMS Rep. 4, A-22)

(23) RESOLUTION 808 - REINSTATEMENT OF
CONSULTATION CODES

RECOMMENDATION:

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

HOD ACTION: Policy D-385.955 reaffirmed in lieu of Resolution 808

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

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

CONSULTATION CODES AND PRIVATE PAYERS D-385.955
1. Our AMA will proactively engage and advocate with any commercial insurance company that discontinues payment for consultation codes or that is proposing to or considering eliminating payment for such codes, requesting that the company reconsider the policy change.
2. Where a reason given by an insurance company for policy change to discontinue payment of consultation codes includes purported coding errors or abuses, our AMA will request the company carry out coding education and outreach to physicians on consultation codes rather than discontinue payment for the codes, and call for release of de-identified data from the company related to purported coding issues in order to help facilitate potential education by physician societies.

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

RECOMMENDATION:


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

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

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

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

PRESCRIPTION DRUG PRICES AND MEDICARE D-330.954
1. Our AMA will support federal legislation which gives the Secretary of the Department of Health and Human Services the authority to negotiate contracts with manufacturers of covered Part D drugs.
2. Our AMA will work toward eliminating Medicare prohibition on drug price negotiation.

PHARMACEUTICAL COSTS H-110.987
1. Our AMA encourages Federal Trade Commission (FTC) actions to limit anticompetitive behavior by pharmaceutical companies attempting to reduce competition from generic manufacturers through manipulation of patent protections and abuse of regulatory exclusivity incentives.
2. Our AMA encourages Congress, the FTC and the Department of Health and Human Services to monitor and evaluate the utilization and impact of controlled distribution channels for prescription pharmaceuticals on patient access and market competition.
3. Our AMA will monitor the impact of mergers and acquisitions in the pharmaceutical industry.
4. Our AMA will continue to monitor and support an appropriate balance between incentives based on appropriate safeguards for innovation on the one hand and efforts to reduce regulatory and statutory barriers to competition as part of the patent system.

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

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

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

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

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

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

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

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

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


INAPPROPRIATE EXTENSION OF PATENT LIFE OF PHARMACEUTICALS D-110.994

Our AMA will continue to monitor the implementation of the newly-enacted 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,
the advertisement should include information about the availability of alternative non-drug or non-operative management options such as diet and lifestyle changes, where appropriate, for the disease, disorder, or condition.

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

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

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

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

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

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

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

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

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

8. That our AMA supports the concept that when companies engage in DTCA, they assume an increased responsibility for the informational content and an
increased duty to warn consumers, and they may lose an element of protection
normally accorded under the learned intermediary doctrine.

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

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

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

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

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

14. Our AMA will advocate to the applicable Federal agencies (including the
Food and Drug Administration, the Federal Trade Commission, and the Federal
Communications Commission) which regulate or influence direct-to-consumer
advertising of prescription drugs that such advertising should be required to state
the manufacturer’s suggested retail price of those drugs. (BOT Rep. 38 and Sub.
02Reaffirmed: Res. 914, I-02Reaffirmed: Sub. Res. 504, A-03Reaffirmation A-
04Reaffirmation A-05Modified: BOT Rep. 9, A-06Reaffirmed in lieu of Res. 514,
A-07BOT Action in response to referred for decision: Res. 927, I-15Modified:
BOT Rep. 09, I-16Appended: Res. 236, A-17Reaffirmed in lieu of: Res. 223, A-
17Reaffirmed in lieu of: Res. 112, A-19)

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

RECOMMENDATION:
Resolution 822 be referred.

HOD ACTION: Resolution 822 be referred

RESOLVED, That our AMA monitor the Accountable Care Organization Realizing
Equity, Access, and Community Health (ACO-REACH) program for its impacts on
patients and physicians in Traditional Medicare, including the quality and cost of
healthcare and patient/provider choice, and report back to the House of Delegates on the impact of the ACO-REACH demonstration program annually until its conclusion (Directive to Take Action); and be it further

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

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

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

OPPOSITION TO ELIMINATION OF “INCIDENT-TO” BILLING FOR NON-PHYSICIAN PRACTITIONERS D-160.915
Our AMA will advocate against efforts to eliminate “incident-to” billing for non-physician practitioners among private and public payors. (Res. 711, A-21)

DUE DILIGENCE FOR PHYSICIANS AND PRACTICES JOINING AN ACO WITH RISK BASED MODELS (UP SIDE AND DOWN SIDE RISK) D-385.953
1. Our AMA will advocate for the continuation of up side only risk Medicare Shared Savings ACO (MSSP ACO) program as an option from the Centers for Medicare and Medicaid Services, particularly for physician owned groups.
2. Our AMA will develop educational resources and business tools to help physicians complete due diligence in evaluating the performance of physician-led and hospital integrated systems before considering consolidation. Specific attention should be given to the evaluation of transparency on past savings results, system finances, quality metrics, physician workforce stability and physician job satisfaction, and the cost of clinical documentation software.
3. Our AMA will evaluate the characteristics of successful physician owned MSSP ACOs and participation in alternative payment models (APMs) to create a framework of the resources and organizational tools needed to allow practices to form virtual ACOs that would facilitate participation in MSSP ACOs and APMs. (Res. 802, I-18)

PATIENT INFORMATION AND CHOICE H-373.998
Our AMA supports the following principles:

1. Greater reliance on market forces, with patients empowered with understandable fee/price information and incentives to make prudent choices, and with the medical profession empowered to enforce ethical and clinical standards which continue to place patients' interests first, is clearly a more effective and preferable approach to cost containment than is a government-run, budget-driven, centrally controlled health care system.

2. Individuals should have freedom of choice of physician and/or system of health care delivery. Where the system of care places restrictions on patient choice, such restrictions must be clearly identified to the individual prior to their selection of that system.

3. In order to facilitate cost-conscious, informed market-based decision-making in health care, physicians, hospitals, pharmacies, durable medical equipment suppliers, and other health care providers should be required to make information readily available to consumers on fees/prices charged for frequently provided services, procedures, and products, prior to the provision of such services, procedures, and products. There should be a similar requirement that insurers make available in a standard format to enrollees and prospective enrollees information on the amount of payment provided toward each type of service identified as a covered benefit.

4. Federal and/or state legislation should authorize medical societies to operate programs for the review of patient complaints about fees, services, etc. Such programs would be specifically authorized to arbitrate a fee or portion thereof as appropriate and to mediate voluntary agreements, and could include the input of the state medical society and the AMA Council on Ethical and Judicial Affairs.

5. Physicians are the patient advocates in the current health system reform debate. Efforts should continue to seek development of a plan that will effectively provide universal access to an affordable and adequate spectrum of health care services, maintain the quality of such services, and preserve patients' freedom to select physicians and/or health plans of their choice.

URGE AMA TO RELEASE A WHITE PAPER ON ACOs D-160.923

Our AMA will seek objective, independent data on Accountable Care Organizations and release a whitepaper regarding their effect on cost savings and quality of care. (Res. 713, A-17; Reaffirmation: I-17)
Mister Speaker, this concludes the report of Reference Committee J. I would like to thank Sarah Candler, MD, M. Laurin Council, MD, Amar Kelkar, MD, Anne Mongiu, MD, Jason Schwalb, MD, Natalia Solenkova, MD, and all those who testified before the Committee.

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