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REPORT OF THE BOARD OF TRUSTEES

B of T Report 6-I-22

Subject: Informal Inter-Member Mentoring

Presented by: Sandra Adamson Fryhofer, MD, Chair

At the November 2021 Special Meeting of the House of Delegates (HOD), Policy D-635.980, "Informal Inter-Member Mentoring," was adopted.

To implement the policy, our AMA has convened a Mentorship Steering Committee consisting of representatives from each of the AMA sections (see appendix). Given the sections' role as the place for members to become more actively involved in the AMA and their focus on leadership development, the sections are a natural home for this initiative. As the work of the Steering Committee and organization continues, we will continue to be broadly inclusive of the diversity of experiences and needs across our membership.

The Mentorship Steering Committee has been charged with identifying mentorship opportunities and best practices within individual sections and more broadly across the organization. The Committee has discussed the importance of creating informal, organic opportunities for mentors and mentees to identify one another and connect, as opposed to establishing more formal programs with assigned mentors/mentees.

Discussions about the most appropriate format for such interaction continue and will guide management in its exploration of scalable mechanisms to achieve the aim of the policy. Your Board will provide a progress report at the 2023 Annual Meeting.

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

Appendix: Inaugural Membership of the Mentorship Steering Committee

Neel Shah, MD, Academic Physicians Section
Kamalika Roy, MD, International Medical Graduates Section
Donna Smith, MD, Integrated Physician Practice Section
Carl Streed, MD, Advisory Committee on LGBTQ Issues
Samantha Lopez, MD, Minority Affairs Section
Danielle Rivera, Medical Student Section
Nancy Mueller, MD, Organized Medical Staff Section
Carolyn Francavilla, MD, Private Practice Physicians Section
Breyen Coffin, MD, Resident and Fellow Section
Louise Andrew, MD, Senior Physicians Section
Aleesha Shaik, MD, Women Physicians Section
Laura Gephart, MD, Young Physicians Section

REPORT OF THE BOARD OF TRUSTEES

B of T Report 10-I-22

Subject: Redefining AMA's Position on ACA and Healthcare Reform

Presented by: Sandra Adamson Fryhofer, MD, Chair

At the 2013 Annual Meeting of the House of Delegates (HOD), the HOD adopted Policy D-165.938, "Redefining AMA's Position on ACA and Healthcare Reform," which calls on our American Medical Association (AMA) to "develop a policy statement clearly outlining this organization's policies" on several specific issues related to the Affordable Care Act (ACA) as well as repealing the SGR and the Independent Payment Advisory Board (IPAB). The adopted policy also calls for our AMA to report back at each meeting of the HOD. Board of Trustees Report 6-I-13, "Redefining AMA's Position on ACA and Healthcare Reform," accomplished the original intent of the policy. This report serves as an update on the issues and related developments occurring since the most recent meeting of the HOD.

IMPROVING THE AFFORDABLE CARE ACT

Our AMA continues to engage policymakers and advocate for meaningful, affordable health care for all Americans to improve the health of our nation. Our AMA remains committed to the goal of universal coverage, which includes protecting coverage for the 20 million Americans who acquired it through the ACA. Our AMA has been working to fix the current system by advancing solutions that make coverage more affordable and expanding the system's reach to Americans who fall within its gaps. Our AMA also remains committed to improving health care access so that patients receive timely, high-quality care, preventive services, medications, and other necessary treatments.

Our AMA continues to advocate for policies that would allow patients and physicians to be able to choose from a range of public and private coverage options with the goal of providing coverage to all Americans. Specifically, our AMA has been working with Congress, the Administration, and states to advance our plan to cover the uninsured and improve affordability as included in the "2022 and Beyond: AMA's Plan to Cover the Uninsured." The COVID-19 pandemic initially led to many people losing their employer-based health insurance. This only increased the need for significant improvements to the Affordable Care Act. Recent data indicate that the uninsured rate has decreased during the COVID-19 pandemic, due to the temporary ACA improvements included in the American Rescue Plan Act, continuous Medicaid enrollment, state Medicaid expansions, and the 2021 special enrollment period for ACA marketplaces.

We also continue to examine the pros and cons of a broad array of approaches to achieve universal coverage as the policy debate evolves.

Our AMA has been advocating for the following policy provisions:

Cover Uninsured Eligible for ACA's Premium Tax Credits

- Our AMA advocates for increasing the generosity of premium tax credits to improve premium affordability and incentivize tax credit eligible individuals to get covered. Currently, eligible

individuals and families with incomes between 100 and 400 percent federal poverty level (FPL) (133 and 400 percent in Medicaid expansion states) are being provided with refundable and advanceable premium tax credits to purchase coverage on health insurance exchanges.

- Our AMA has been advocating for enhanced premium tax credits to young adults. In order to improve insurance take-up rates among young adults and help balance the individual health insurance market risk pool, young adults ages 19 to 30 who are eligible for advance premium tax credits could be provided with "enhanced" premium tax credits—such as an additional $50 per month—while maintaining the current premium tax credit structure which is inversely related to income, as well as the current 3:1 age rating ratio.
- Our AMA also is advocating for an expansion of the eligibility for and increasing the size of cost-sharing reductions. Currently, individuals and families with incomes between 100 and 250 percent FPL (between 133 and 250 percent FPL in Medicaid expansion states) also qualify for cost-sharing subsidies if they select a silver plan, which leads to lower deductibles, out-of-pocket maximums, copayments, and other cost-sharing amounts. Extending eligibility for cost-sharing reductions beyond 250 percent FPL, and increasing the size of cost-sharing reductions, would lessen the cost-sharing burdens many individuals face, which impact their ability to access and afford the care they need.

<u>Cover Uninsured Eligible for Medicaid or Children's Health Insurance Program</u>

Before the COVID-19 pandemic, in 2018, 6.7 million of the nonelderly uninsured were eligible for Medicaid or the Children's Health Insurance Program (CHIP). Reasons for this population remaining uninsured include lack of awareness of eligibility or assistance in enrollment.

- Our AMA has been advocating for increasing and improving Medicaid/CHIP outreach and enrollment, including auto enrollment.
- Our AMA has been opposing efforts to establish Medicaid work requirements. The AMA believes that Medicaid work requirements would negatively affect access to care and lead to significant negative consequences for individuals' health and well-being.

<u>Make Coverage More Affordable for People Not Eligible for ACA's Premium Tax Credits</u>

Before the COVID-19 pandemic, in 2018, 5.7 million of the nonelderly uninsured were ineligible for financial assistance under the ACA, either due to their income, or because they have an offer of "affordable" employer-sponsored health insurance coverage. Without the assistance provided by ACA's premium tax credits, this population can continue to face unaffordable premiums and remain uninsured.

- Our AMA advocates for eliminating the subsidy "cliff," thereby expanding eligibility for premium tax credits beyond 400 percent FPL.
- Our AMA has been advocating for the establishment of a permanent federal reinsurance program, and the use of Section 1332 waivers for state reinsurance programs. Reinsurance plays a role in stabilizing premiums by reducing the incentive for insurers to charge higher premiums across the board in anticipation of higher-risk people enrolling in coverage. Section 1332 waivers have also been approved to provide funding for state reinsurance programs.
- Our AMA also is advocating for lowering the threshold that determines whether an employee's premium contribution is "affordable," allowing more employees to become eligible for premium tax credits to purchase marketplace coverage.
- Our AMA has been strongly advocating for the Internal Revenue Service (IRS) proposed regulation on April 7, 2022 that would fix the so-called "family glitch" under the ACA,

whereby families of workers remain ineligible for subsidized ACA marketplace coverage even though they face unaffordable premiums for health insurance coverage offered through employers. The proposed regulation would fix the family glitch by extending eligibility for ACA financial assistance to only the family members of workers who are not offered affordable job-based family coverage. Our AMA is urging the Biden Administration to finalize the proposed rule as soon as possible.

EXPAND MEDICAID TO COVER MORE PEOPLE

Before the COVID-19 pandemic, in 2018, 2.3 million of the nonelderly uninsured found themselves in the coverage gap—not eligible for Medicaid, and not eligible for tax credits because they reside in states that did not expand Medicaid. Without access to Medicaid, these individuals do not have a pathway to affordable coverage.

- Our AMA has been encouraging all states to expand Medicaid eligibility to 133 percent FPL.

New policy adopted by the AMA HOD during the November 2021 Special Meeting seeks to assist more than 2 million nonelderly uninsured individuals who fall into the "coverage gap" in states that have not expanded Medicaid—those with incomes above Medicaid eligibility limits but below the FPL, which is the lower limit for premium tax credit eligibility. The new AMA policy maintains that coverage should be extended to these individuals at little or no cost, and further specifies that states that have already expanded Medicaid coverage should receive additional incentives to maintain that status going forward.

AMERICAN RESCUE PLAN OF 2021

On March 11, 2021, President Biden signed into law the American Rescue Plan (ARPA) of 2021. This legislation included the following ACA-related provisions that will:

- Provide a temporary (two-year) 5 percent increase in the Federal Medical Assistance Percentage (FMAP) for Medicaid to states that enact the Affordable Care Act's Medicaid expansion and covers the new enrollment period per requirements of the ACA.
- Invest nearly $35 billion in premium subsidy increases for those who buy coverage on the ACA marketplace.
- Expand the availability of ACA advanced premium tax credits (APTCs) to individuals whose income is above 400 percent of the FPL for 2021 and 2022.
- Give an option for states to provide 12-month postpartum coverage under State Medicaid and CHIP.

ARPA represents the largest coverage expansion since the Affordable Care Act. Under the ACA, eligible individuals, and families with incomes between 100 and 400 percent of the FPL (between 133 and 400 percent FPL in Medicaid expansion states) have been provided with refundable and advanceable premium credits that are inversely related to income to purchase coverage on health insurance exchanges. However, consistent with Policy H-165.824, "Improving Affordability in the Health Insurance Exchanges," ARPA eliminated ACA's subsidy "cliff" for 2021 and 2022. As a result, individuals and families with incomes above 400 percent FPL ($51,520 for an individual and $106,000 for a family of four based on 2021 federal poverty guidelines) are eligible for premium tax credit assistance. Individuals eligible for premium tax credits include individuals who are offered an employer plan that does not have an actuarial value of at least 60 percent or if the employee share of the premium exceeds 9.83 percent of income in 2021.

Consistent with Policy H-165.824, ARPA also increased the generosity of premium tax credits for two years, lowering the cap on the percentage of income individuals are required to pay for premiums of the benchmark (second lowest-cost silver) plan. Premiums of the second lowest-cost silver plan for individuals with incomes at and above 400 percent FPL are capped at 8.5 percent of their income. Notably, resulting from the changes, eligible individuals and families with incomes between 100 and 150 percent of the FPL (133 percent and 150 percent FPL in Medicaid expansion states) now qualify for zero-premium silver plans, effective until the end of 2022.

In addition, individuals and families with incomes between 100 and 250 percent FPL (between 133 and 250 percent FPL in Medicaid expansion states) also qualify for cost-sharing subsidies if they select a silver plan, which reduces their deductibles, out-of-pocket maximums, copayments, and other cost-sharing amounts.

LEGISLATIVE EXTENSION OF ARPA PROVISIONS

On August 16, President Biden signed into law the Inflation Reduction Act of 2022 through the highly partisan budget reconciliation process, which allows both the House and Senate to pass the bill with limits on procedural delays. Most significantly, reconciliation allows the Senate to bypass the filibuster and pass legislation with a 50-vote threshold so long as it meets a series of budgetary requirements. The Inflation Reduction Act includes provisions that would extend for three years to 2025 the aforementioned ACA premium subsidies authorized in ARPA.

The Inflation Reduction Act does not include provisions to close the Medicaid "coverage gap" in the states that have not chosen to expand.

ACA ENROLLMENT

According to the U.S. Department of Health and Human Services (HHS), 14.5 million Americans have signed up for or were automatically re-enrolled in the 2022 individual market health insurance coverage through the marketplaces since the start of the 2022 Marketplace Open Enrollment Period (OEP) on November 1, 2021, through January 15, 2022. That record-high figure includes nearly 2 million new enrollees, many of whom qualified for reduced premiums granted under ARPA. In August, the Department of Health and Human Services issued a report noting that the uninsured rate in the U.S. had dropped to an all-time low of 8 percent.

TEXAS VS. AZAR SUPREME COURT CASE

The Supreme Court agreed on March 2, 2020, to address the constitutionality of the ACA for the third time, granting the petitions for certiorari from Democratic Attorneys General and the House of Representatives. Oral arguments were presented on November 10, 2020, and a decision was expected before June 2021. The AMA filed an amicus brief in support of the Act and the petitioners in this case.

On February 10, 2021, the U.S. Department of Justice under the new Biden Administration submitted a letter to the Supreme Court arguing that the ACA's individual mandate remains valid, and, even if the court determines it is not, the rest of the law can remain intact.

This action reversed the Trump Administration's brief it filed with the Court asking the justices to overturn the ACA in its entirety. The Trump Administration had clarified that the Court could choose to leave some ACA provisions in place if they do not harm the plaintiffs, but as legal experts pointed out, the entire ACA would be struck down if the Court rules that the law is

inseparable from the individual mandate—meaning that there would be no provisions left to selectively enforce.

On June 17, 2021, the Supreme Court in a 7-2 decision ruled that neither the states nor the individuals challenging the law have a legal standing to sue. The Court did not touch the larger issue in the case: whether the entirety of the ACA was rendered unconstitutional when Congress eliminated the penalty for failing to obtain health insurance.

With its legal status now affirmed by three Supreme Court decisions, and provisions such as coverage for preventive services and pre-existing conditions woven into the fabric of U.S. health care, the risk of future lawsuits succeeding in overturning the ACA is significantly diminished.

KELLEY VS. BECERRA FEDERAL COURT CASE

A case before a federal district court judge in the Northern District of Texas, *Kelley v. Becerra*, would eliminate the ACA requirement that most health insurance plans cover preventive services without copayments. Those filing the case object to paying for coverage that they do not want or need, particularly for those items or services that violate their religious beliefs, such as contraception or PrEP drugs. If the case is successful, health plan enrollees will also lose access to full coverage for more than 100 preventive health services, including vaccinations and screenings for breast cancer, colorectal cancer, cervical cancer, heart disease, and other diseases and medical conditions.

The AMA and 61 national physician specialty organizations issued a joint statement on July 25, sounding the alarm about the millions of privately insured patients who would be affected by an adverse ruling.

SGR REPEAL

The Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 repealing and replacing the SGR was signed into law by President Obama on April 16, 2015.

The AMA is now working on unrelated new Medicare payment reduction threats and is currently advocating for a sustainable, inflation-based, automatic positive update system for physicians.

INDEPENDENT PAYMENT ADVISORY BOARD REPEAL

The Bipartisan Budget Act of 2018 signed into law by President Trump on February 9, 2018, included provisions repealing IPAB. Currently, there are not any legislative efforts in Congress to replace the IPAB.

CONCLUSION

Our American Medical Association will remain engaged in efforts to improve the health care system through policies outlined in Policy D-165. 938 and other directives of the House of Delegates.

REPORT 11 OF THE BOARD OF TRUSTEES (I-22)
2022 AMA Advocacy Efforts
(Informational)

EXECUTIVE SUMMARY

Numerous advocacy challenges emerged in 2022, but once again, our AMA rose to the moment and achieved significant progress on the issues most important to America's physicians and patients. While the COVID-19 public health emergency (PHE) has subsided to a certain degree, it persists. The AMA has stood by America's physicians and patients throughout the pandemic, securing billions in relief to protect private practices; reducing reporting burdens and penalties; advancing telehealth; enabling investments in therapeutics and vaccines to end the pandemic; standing up for health equity to achieve optimal health for all; and strongly advocating for science in the halls of power. At the same time, the AMA has been advocating extensively on other issues critical to physicians and patients.

At the 2022 Annual Meeting, the AMA launched a Recovery Plan for America's Physicians targeting some of the toughest issues physicians face today—on both professional and personal levels. Components of the plan include:

- Reforming Medicare payment to promote thriving physician practices and innovation;
- Stopping scope creep that threatens patient safety;
- Fixing prior authorization to reduce the burden on practices and minimize patient care delays;
- Supporting telehealth to maintain coverage and payment; and
- Reducing physician burnout and addressing the stigma around mental health.

Success on these issues will be key to helping physicians get back on track after the practice interruptions and shutdowns they have faced in the last two years.

While the AMA is focusing on tackling the issues contained in the recovery plan, other issues have arisen that need heightened advocacy efforts too. The mass shootings in Buffalo, NY, and Uvalde, TX, forced policymakers to finally come to the table and consider some initial steps to halt such massacres. Further, the *Dobbs v. Jackson Women's Health Organization* decision to overturn *Roe v. Wade* allows lawmakers to invade the exam room in ways not seen in decades and has created a whirlwind of clinical questions facing physicians trying to provide the best care while avoiding legal liability.

The AMA is fighting to advance our policy on these issues and many more that are updated in this report.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 11-I-22

Subject: 2022 AMA Advocacy Efforts

Presented by: Sandra Adamson Fryhofer, MD, Chair

BACKGROUND

Policy G-640.005, "AMA Advocacy Analysis," calls on the Board of Trustees (the Board) to provide a report to the House of Delegates (HOD) at each Interim Meeting highlighting the year's advocacy activities and should include efforts, successes, challenges, and recommendations/actions to further optimize advocacy efforts. The Board has prepared the following report to provide an update on American Medical Association (AMA) advocacy activities for the year. (Note: This report was prepared in August based on approval deadlines, so more recent developments may not be reflected in it.)

DISCUSSION OF 2022 ADVOCACY EFFORTS

Numerous advocacy challenges emerged in 2022, but once again, our AMA rose to the moment and achieved significant progress on the issues most important to America's physicians and patients. While the COVID-19 public health emergency (PHE) has subsided to a certain degree, it persists. The AMA has stood by America's physicians and patients throughout the pandemic, securing billions in relief to protect private practices; reducing reporting burdens and penalties; advancing telehealth; enabling investments in therapeutics and vaccines to end the pandemic; standing up for health equity to achieve optimal health for all; and strongly advocating for science in the halls of power. At the same time, the AMA has been advocating extensively on other issues critical to physicians and patients.

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ways not seen in decades and has created a whirlwind of clinical questions facing physicians trying to provide the best care while avoiding legal liability.

The AMA is fighting to advance AMA policy on these issues and many more that are updated in this report.

Medicare Payment Reform

The AMA is focused on reforming our nation's Medicare physician payment system. The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) made needed improvements to the system including eliminating the Sustainable Growth Rate (SGR), but time has revealed significant statutory flaws. The promise of a viable glide path to voluntary participation in alternative payment models (APMs) never materialized, with 30 physician-proposed models being rejected for implementation. Meanwhile, the increasingly aggressive financial incentives to participate in APMs continue. The quality and reporting programs for physicians in the Merit-based Incentive Payment System (MIPS) are burdensome and lack clinical relevance. The Medicare fee schedule is chronically underfunded. No annual updates will be provided for physician services for several years, and those received over the past two decades have collectively fallen well below the rising costs of medical practice.

The 2023 Medicare payment schedule proposed rule released in July fails to account for inflation in practice costs and COVID-related challenges to practice sustainability and also includes a significant and damaging across-the-board reduction in payment rates. Such a move would create long-term financial instability in the Medicare physician payment system and threaten patient access to Medicare-participating physicians. The AMA is working with Congress to prevent this harmful outcome in the short term and to advance more comprehensive reform in coming sessions.

To achieve the needed level of reform, the AMA and 120 Federation groups have agreed on the following "Characteristics of a Rational Medicare Payment System" and will be advocating to see these principles implemented by Congress and the Administration.

Simplicity, relevance, alignment, and predictability, for physician practices and the Centers for Medicare & Medicaid Services.

- Ensuring financial stability and predictability
  - Provide financial stability through a baseline positive annual update reflecting inflation in practice costs, and eliminate, replace, or revise budget neutrality requirements to allow for appropriate changes in spending growth.
  - Recognize fiscal responsibility. Payment models should invest in and recognize physicians' contributions in providing high-value care and the associated savings and quality improvements across all parts of Medicare and the health care system (e.g., preventing hospitalizations).
  - Encourage collaboration, competition, and patient choice rather than consolidation through innovation, stability, and reduced complexity by eliminating the need for physicians to choose between retirement, selling their practices or suffering continued burnout.
- Promoting value-based care
  - Reward the value of care provided to patients, rather than administrative activities, such as data entry, that may not be relevant to the service being provided or the patient receiving care.
  - Encourage innovation, so that practices and systems can be redesigned and continuously refined to provide high-value care and include historically non-covered services that

improve care for all or a specific subset of patients (e.g., COPD, Crohn's Disease), as well as for higher risk and higher cost populations.
    - Offer a variety of payment models and incentives tailored to the distinct characteristics of different specialties and practice settings. Participation in new models must be voluntary and continue to be incentivized. A fee-for-service payment model must also remain a financially viable option.
    - Provide timely, actionable data. Physicians need timely access to analyses of their claims data, so they can identify and reduce avoidable costs. Though Congress took action to give physicians access to their data, they still do not receive timely, actionable feedback on their resource use and attributed costs in Medicare. Physicians should be held accountable only for the costs that they control or direct.
    - Recognize the value of clinical data registries as a tool for improving quality of care, with their outcome measures and prompt feedback on performance.
- Safeguarding access to high-quality care
    - Advance health equity and reduce disparities. Payment model innovations should be risk-adjusted and recognize physicians' contributions to reducing health disparities, addressing social drivers of care, and tackling health inequities; physicians need support as they care for historically marginalized, higher risk, hard to reach or sicker populations.
    - Support practices where they are by recognizing that high-value care is provided by both small practices and large systems, and in both rural and urban settings.

For the near term, AMA and the Federation are asking Congress to take the following steps before the end of the year to address cuts that are scheduled to take effect in 2023:

- Replace the 0% payment schedule conversion factor update scheduled for next year with one that is based on inflation;
- Stop the 4.5% combined budget neutrality adjustments that offset the costs of improved payments for office-based (-3%) and facility-based (-1.5%) E/M services;
- Waive the 4% PAYGO sequestration requirement that was triggered by the infrastructure and COVID relief bills passed last year;
- Extend the $500 million exceptional MIPS performance fund; and
- Extend current APM policies related to incentive bonuses and qualifying revenue thresholds.

Scope of Practice

The AMA defends the practice of medicine against inappropriate scope of practice expansions, supports physician-led team care, and ensures patients have access to physicians for their health care. All health care professionals play a critical role in caring for patients and are important members of the care team; however, their skillsets are not interchangeable with that of a fully trained physician. At the state level, the AMA works in strong collaboration and coordination with the state medical associations and national medical specialty societies. This includes sharing resources, reviewing, and advising on legislative language/strategy, testifying before state legislatures, submitting letters of opposition to lawmakers, and amplifying calls to action. The AMA also has a comprehensive library of resources to support our scope of practice campaign, including GEOMAPS, education and training modules, patient surveys, media toolkit, and one-pagers. These provide data and talking points to address the most common arguments to preserve physician-led care and refute assertions made by non-physicians. Since 2007 the AMA's Scope of Practice Partnership (SOPP) has played a key role in bringing organized medicine together on this issue, including by providing grants to SOPP members to support state efforts. There are currently 108 members of the SOPP and more than $2.7 million in grants have been awarded to date.

In 2022, the AMA has collaborated with more than 25 state medical associations on hundreds of bills to defeat scope expansions or encourage states to adopt truth in advertising legislation. Highlights to date include:

- In Colorado, Louisiana and South Dakota, physician assistant bills were defeated;
- Truth in advertising legislation was enacted in Indiana;
- Kentucky and Tennessee rejected efforts to expand nurse practitioner prescriptive authority;
- Louisiana, Mississippi, Missouri, and Wisconsin defeated efforts to pass advanced practice registered nurse (APRN) expansion bills; and
- Alabama and Missouri defeated legislation that would have expanded pharmacist scope of practice.

In 2021, the Department of Veterans Affairs (VA) created the Federal Supremacy Project which is establishing National Standards of Practice (NSP), irrespective of state scope of practice laws, for approximately 50 categories of health professionals. The AMA established a specialty workgroup that we have been working with since the VA started this effort. Initially the VA was fast tracking the project, but the efforts of the AMA and the specialty societies have greatly slowed the pace. We were also able to secure a much more transparent process. The VA has committed to publishing the NSPs in the Federal Register and allowing for a 60-day comment period. In addition, the VA agreed to stagger the publication of the NSPs so stakeholders would have a better ability to comment. To date, the VA has published 3 NSPs. The AMA will continue to inform the Federation and work with the specialty society workgroup as the VA publishes the NSPs.

Prior Authorization

Payers continue to overuse prior authorization and do so on far too wide a basis despite agreeing to a consensus statement with the AMA in 2018 aimed at alleviating many of the concerns with this practice. For patients, prior authorization delays or denies access to care, often resulting in harm (e.g., hospitalization, permanent impairment, or death) and/or negative clinical outcomes—also, less value for premiums paid. For physicians, prior authorization wastes resources (time and money) and is related to burnout. For employers, restrictive prior authorization requirements will reduce the health of their workforce and provide less value for premiums. The AMA is advocating to right-size and streamline the prior authorization process through state, federal and private sector advocacy to provide patients, physicians, and employers relief.

To further illustrate the problems with indiscriminate prior authorization use, the AMA published its annual survey on the topic, which found:

- 93% of physicians report care delays;
- 82% percent of physicians report that prior authorization can sometimes lead to treatment abandonment;
- 34% of respondents report that prior authorization has led to a serious adverse event for a patient (including hospitalization, life-threatening event, or disability);
- On average, practices complete 41 prior authorizations per physician per week;
- Physicians/staff spend approximately 13 hours each week completing prior authorizations; and
- 40% of physicians have staff dedicated to working exclusively on prior authorization.

To address these issues at the federal level, the AMA strongly supports:

- The “Improving Seniors’ Timely Access to Care Act of 2021” (H.R. 8487/S. 3018), which would require Medicare Advantage (MA) plans to implement a streamlined electronic prior

authorization (PA) process; increase transparency for beneficiaries and providers; enhance oversight by the Centers for Medicare & Medicaid Services (CMS) on the processes used for PA; ensure that care and treatments that routinely receive PA approvals are not subjected to unnecessary delays through real-time decisions by MA plans; and mandate that MA plans meet certain beneficiary protection standards. This legislation passed the House Ways and Means Committee in July.

- The "Getting Over Lengthy Delays in Care as Required by Doctors" (GOLD CARD) Act (H.R. 7995) of 2022, which would exempt physicians from MA plan prior authorization requirements so long as 90% of a physician's prior authorization requests were approved in the preceding 12 months. The MA plan-issued gold cards would only be applicable to items and services (excluding drugs) and remain in effect for at least a year. The federal legislation is based on a similar law enacted in Texas that took effect in 2021.

The AMA is also continuing to advocate at the state level where several states have enacted comprehensive reform legislation while others are at earlier stages in the legislative process. In 2022, strong legislation has been enacted in Georgia, Iowa, Louisiana, and Michigan. The AMA also worked with members of the Federation to push Aetna to stop requiring prior authorization for cataract surgery. Aetna recently changed this policy with the exceptions of Florida and Georgia Medicare Advantage patients.

Telehealth

The AMA has long supported making telehealth services widely available to patients, but prior to the COVID-19 pandemic and the resulting loss of access to in-person medical care, most patients could not access telehealth services from their regular physicians. Due to restrictions in the Medicare statute, the Medicare program only covered telehealth services for patients in rural areas and, even then, the patient had to go to a medical facility to receive the telehealth services from a physician at another site. While private plans may not have had the same geographic restrictions, they often had limitations on coverage and payment of services provided via telehealth, as well as acceptable modalities. Many plans also often limited or incentivized patients to receive telehealth only from a separate telehealth company, not their regular physicians. Early in the pandemic, with strong support from the AMA, the restrictions on coverage for telehealth services were lifted by Medicare and other health plans. State laws and state Medicaid policies were also modified to permit widespread use of telehealth during the pandemic.

The AMA has prioritized making the telehealth expansion permanent. As an intermediate step, the AMA successfully urged Congress to extend the telehealth expansion through five months after the public health emergency ends. Further, CMS has also proposed to extend payment for a number of services that were added to the Medicare Telehealth List for an additional 5 months after the public health emergency ends.

And in July, the full House passed H.R. 4040, a bill that would extend telehealth payment and regulatory flexibilities for an additional two years, through the end of 2024, on a bipartisan vote of 416-12.

At the state level, the AMA has updated its model state telehealth legislation and continues to support state efforts to advance telehealth legislation and policy to ensure patient access to high quality care.

Physician Wellness

Prior to the COVID-19 pandemic, physician burnout, depression and suicide already were major challenges for the U.S. health care system, impacting nearly every aspect of clinical care as well as being a heavy burden for physicians and their families. Physicians are very resilient, but the environments in which physicians work drive these high levels of burnout. Compounding the problems are medical licensing applications, employment and credentialing applications, and professional liability insurance applications. The problem is when these contain questions that include problematic and potentially illegal questions requiring disclosure of whether a potential licensee or applicant has ever been diagnosed or received treatment for a mental illness or substance use disorder (SUD) or even sought counseling for a mental health or wellness issue. These questions about past diagnosis or treatment are strongly opposed by the AMA, Federation of State Medical Boards, The Joint Commission, the Federation of State Physician Health Programs, and The Dr. Lorna Breen Heroes' Foundation.

At the federal level, the AMA strongly advocated for the Dr. Lorna Breen Health Care Provider Protection Act (H.R. 1667), named for a physician who died by suicide in 2020. The bill provides grants to help create evidence-based strategies to reduce burnout and the associated secondary mental health conditions related to job stress. It includes a national campaign to encourage health professionals to prioritize their mental health and to use available mental and behavioral health services. It also establishes grants for employee education and peer-support programming.

AMA advocacy and partnership with state medical associations has also helped enact state laws in Arizona, Indiana, South Dakota, and Virginia to provide strong confidentiality protections for physicians and medical students who seek care for burnout and wellness-related issues. The AMA is also continuing to urge state medical boards to remove stigmatizing questions that inappropriately ask about past diagnoses. In addition, the AMA is working with key stakeholders to bolster state physician health programs as well as identify health systems and others who can play a powerful role in removing stigma and supporting physicians' health and wellness.

Surprise Billing

The AMA is taking a two-pronged approach to the No Surprises Act of 2021 (NSA). The AMA is educating physicians on how to comply with the NSA while also advocating for implementation of the law as Congress intended. Specifically, the AMA has:

- Initiated litigation (along with the American Hospital Association) arguing that the government's interim final rule is contrary to the law and exceeds statutory authority by creating a rebuttable presumption that the arbiter in the Independent Dispute Resolution (IDR) process considers the "qualifying payment amount" (essentially the median in-network rate) as the appropriate out-of-network payment amount. (The Texas Medical Association has also filed litigation and secured a positive initial ruling.);
- Released an initial toolkit (PDF) on the implementation of the No Surprises Act and a second toolkit (PDF) on implementation of the billing process for certain out-of-network care under the No Surprises Act. We have also compiled a number of other resources, including regulatory summaries and comment letters;
- Held two national webinars on the No Surprises Act, the first on its implementation and the second on the payment process for physicians and other providers in surprise medical billing situations;

- Continues to advocate for a fair IDR process, recently arguing in a letter to the Administration that a balanced IDR process is not anti-patient, pushing back on payer and employer efforts to undermine the process;
- Working with other stakeholders to develop recommendations on the good faith estimate and advanced EOB requirements, to highlight administrative burdens and ensure minimal workflow disruption;
- Working directly with CMS to address operational challenges with additional physician and provider resources—CMS has already held two physician-focused webinars on the good faith estimate provisions and notice and consent and enforcement. A webinar on the payment process is expected soon; and
- Calling on CMS to conduct more physician outreach and education which CMS has agreed to do.

COVID-19 Response and Monkeypox Outbreak

As mentioned above, the AMA continues to mount a multi-pronged effort advocating for a comprehensive response to the COVID-19 public health emergency (PHE) as the virus continues to evolve and different variants continue to thwart recovery efforts. The AMA steadfastly supports financial relief for physician practices still negatively affected by the pandemic; robust testing to limit spread; vaccination in line with U.S. Centers for Disease Control and Prevention recommendations including for children; and permanent implementation of the telehealth expansion granted during the PHE. For a full list of AMA activities on this topic please visit this website. More specifically the AMA produces a regular video segment update on recent developments with COVID-19 and other public health issues.

One recent development is that the Health Resources and Services Administration (HRSA) has announced that it will set up a process for physicians who received funds from the Provider Relief Fund to contest recoupment of the relief funds. Physicians receiving $10,000 or more from the program are required to spend the funds within a year and report how the relief funds were spent. These requirements have been difficult for many practices to fulfill during the continued instability caused by the pandemic. The AMA pressed HRSA for this decision and is pleased that HRSA will work with physicians to ensure the intent of the relief program is achieved.

The AMA is also active in the courts defending the authority of public health agencies. The Litigation Center of the American Medical Association and State Medical Societies and Wisconsin Medical Society filed an amicus brief supporting state and local officials and their authority to issue emergency orders during a public health crisis. The Wisconsin Supreme Court sided with public health officials in a 4-3 vote which was a win for organized medicine.

Finally, the AMA is closely monitoring monkeypox and its progression throughout the U.S. and is ready to respond as needed. The AMA is posting clinical information for physicians as the virus spreads and has established a new CPT code for monkeypox vaccines.

Reproductive Health

When the Supreme Court of the United States issued its ruling in the *Dobbs c*ase overturning *Roe*, AMA President Jack Resneck Jr., MD, stated "The American Medical Association is deeply disturbed by the U.S. Supreme Court's decision to overturn nearly a half century of precedent protecting patients' right to critical reproductive health care—representing an egregious allowance of government intrusion into the medical examination room, a direct attack on the practice of medicine and the patient-physician relationship, and a brazen violation of patients' rights to

evidence-based reproductive health services. States that end legal abortion will not end abortion—they will end safe abortion, risking devastating consequences, including patients' lives." The AMA filed an amicus brief in the case when it first came before the Supreme Court stating our opposition to overturning this established right.

In a post-*Roe* landscape, the AMA is pursuing multiple strategies to address the broad spectrum of issues that the *Dobbs* decision created. At the federal level, the AMA immediately called for greater digital privacy for patients out of concern that minimal oversight of data use by digital apps could place women in jeopardy in states seeking to enforce abortion restrictions. The AMA in conjunction with the American College of Obstetricians and Gynecologists (ACOG) also called for the removal or revision of the Risk Evaluation and Mitigation Strategies (REMS) and Elements to Assure Safe Use (ETASU) requirements for mifepristone, to eliminate medically unsupported and unnecessary barriers for physicians, patients, and pharmacies. The Biden Administration also reminded hospitals and health care providers of their obligation to comply with the provisions of the Emergency Medical Treatment and Labor Act (EMTALA) that preempt any state laws that restrict access to stabilizing medical treatment, including abortion procedures and other treatments that may result in the termination of a pregnancy. Dr. Resneck also testified to the Subcommittee on Oversight and Investigations for the House Committee on Energy and Commerce at a hearing titled, "Roe Reversal: The Impacts of Taking Away the Constitutional Right to an Abortion" and discussed the impact that the *Dobbs* case is having on patients and physicians.

At the state level, the AMA is working with the Federation to determine how to best protect patients and physicians from aggressive legislative intrusions into the exam room. Some states are seeking to create new protections for patients while others are pressing for tougher abortion bans and other restrictions. The legal situation for physicians and their practices is very muddled in many states. The AMA is collecting information and conducting legislative analyses to help states sort through their best paths forward. We are also preparing to be very active on both the legislative and litigation fronts as the country works through this new set of legislative realities.

Firearm Violence

"Gun violence is a plague on our nation. It's a public health crisis, and much of it is preventable," then-AMA President Gerald E. Harmon, MD, said in remarks to the House of Delegates at the 2022 AMA Annual Meeting. With over 45,000 firearm-related deaths in 2020 and a continuing string of mass shootings, this public health crisis needs heightened efforts and new strategies. Congress did take a positive step by passing the first piece of major firearm legislation in over 30 years with the Bipartisan Safer Communities Act, which the AMA supported and President Biden signed on June 25. Key provisions of the bill include:

- Providing grants for states to establish or strengthen extreme risk protection orders;
- Adding convicted domestic violence abusers in dating relationships to the National Instant Criminal Background Check System (NICS);
- Requiring the Federal Bureau of Investigation National Instant Criminal Background Check System to contact authorities to see whether an individual under the age of 21 has a "disqualifying" juvenile record for buying a firearm;
- Making it a federal crime to buy a firearm on behalf of an individual who is prohibited from doing so; and
- Including new spending for school security and mental health treatment.

However, significant work still needs to be done to avoid more senseless tragedies as witnessed in Buffalo, Uvalde, and Highland Park, among other cities. Besides seeking further legislative options, AMA strategies include encouraging intervention by physicians and nurses when patients demonstrate risk factors for firearm violence; amplifying AMA work with other organizations related to firearm safety and violence prevention; and reaching out to law enforcement and educators to explore how collaborative progress can be made. Further, the AMA adopted several new policies in June calling for active-shooter and live-crisis drills to consider the mental health of children; regulating ghost guns; and advocating for warning labels on ammunition packages.

Maternal Mortality

The AMA continues to be very active advocating for improved maternal health in 2022 with a particular focus on the inequitable impact seen by Black women. The AMA has lobbied the Congressional Healthy Future Task Force Security Subcommittee to focus on this issue; called on Congress to increase funding in fiscal year 2023 for federal programs at the Health Resources Services Administration (HRSA), the U.S. Centers for Disease Control and Prevention (CDC), and the National Institutes of Health; and focused our comments on maternal health equity issues in the Hospital Inpatient Prospective Payment Systems (IPPS) Rule. Additionally, the House of Representatives passed the TRIUMPH for New Moms Act as part of the Restoring Hope for Mental Health and Well-Being Act of 2022, a bipartisan mental health and substance abuse package that would reauthorize key programs within the Substance Abuse and Mental Health Services Administration. The AMA previously wrote letters to the House of Representatives and Senate encouraging the passage of TRIUMPH, which would create a Task Force on Maternal Mental Health to identify, evaluate and make recommendations to coordinate and improve federal responses to maternal mental health conditions, as well as create a national strategic plan for addressing maternal mental health disorders.

At the state level, CMS approved California, Florida, Kentucky, and Oregon actions to expand Medicaid and Children's Health Insurance Program coverage to 12 months postpartum. This extension provides over 120,000 more families with guaranteed coverage as they navigate this critical postpartum period. The AMA supports the extension of Medicaid coverage to 12 months postpartum and has provided comments on the importance of the matter.

Drug Overdose

Ending the nation's drug-related overdose and death epidemic—as well as improving care for patients with pain, mental illness or substance use disorder—requires partnership, collaboration, and commitment to individualized patient care decision-making to implement impactful changes. Due to AMA and Federation advocacy, there were several positive steps in 2022:

- CDC proposed removing arbitrary prescribing thresholds from its 2022 revised guideline—per AMA recommendations to CDC;
- Arizona, New Mexico, and Wisconsin are three of the states that AMA has helped enact legislation to decriminalize fentanyl test strips; several other states have passed bills in one house and are continuing to consider these bills;
- More than a dozen states have enacted legislation or other policies to help ensure that opioid litigation settlement funds are focused on public health efforts;
- AMA worked closely with the Rhode Island Medical Society to help develop regulations implementing the nation's first legally authorized harm reduction center;

- The National Association of Insurance Commissioners (NAIC) continues to develop tools and resources to help state departments of insurance and the U.S. Department of Labor better enforce state and federal parity laws—at the urging of the AMA and our partner medical societies; and
- The AMA continues to work closely with the Administration on policies to increase access to harm reduction efforts and reduce barriers to medications for opioid use disorder (MOUD), including support for federal funding for states to purchase fentanyl test strips, mobile methadone vans and retain telehealth flexibilities that allow for audio-only induction of buprenorphine.

The AMA also supports S. 445/H.R. 1384, the Mainstreaming Addiction Treatment (MAT) Act in the Senate Health, Education, Labor and Pensions Committee (HELP). The MAT Act would increase access to evidence-based treatment for opioid use disorder and end longstanding administrative barriers to prescribing buprenorphine in-office for the treatment of opioid use disorder.

Access

The AMA works tirelessly to preserve health care access and coverage for Americans across the nation—especially the country's most vulnerable patient populations. The 2022 updates include:

- Successfully urged the Biden Administration to take action to fix the "family glitch" and provide affordable health care coverage;
- Working with health care stakeholder groups, urged the Administration to maintain the public health emergency that expands coverage for care and extends key regulatory flexibilities until there is an extended period of greater stability (the nationwide uninsured rate has dropped to 8%);
- Advocating to Congress to make the Affordable Care Act (ACA) subsidy expansions permanent (extended for three years in Senate Reconciliation bill); and
- Successfully urged adoption of stronger network adequacy rules for Qualified Health Plans and Medicare Advantage plans.

The AMA is also sounding the alarm that a federal court case could cause millions of Americans to lose access to preventive services. *Kelley v. Becerra*, a lawsuit before a federal district court judge in the Northern District of Texas, threatens the section of the Affordable Care Act (ACA) requiring insurers and group health plans to cover more than 100 preventive health services—with no additional cost to consumers. One of the ACA's most popular and widely recognized benefits, the provision resulted in an estimated 151.6 million people receiving preventive care without cost sharing in 2020 alone.

Drug Pricing

As Congress prepared to leave Washington for its August recess, Senate negotiators reached agreement on a reconciliation package passed by the Senate that addressed a number of important issues, including provisions that promise to rein in the escalating costs of prescription drugs. Specifically, the legislation would allow Medicare to negotiate its purchasing prices for drugs, with the first 10 negotiated prices set to take effect in 2026. The legislation would also cap drug price increases at the annual rate of inflation and end a Trump-era drug rebate rule. All of these provisions promise to save money for both Medicare and for patients, although there are concerns about the impact of lower prices on the amount practices receive for the acquisition of physician-

administered drugs under the average sales price (ASP) +6 percent payment methodology, particularly for small physician practices. The AMA will work with affected specialties during the implementation period to assess the impact and identify and advocate for solutions that preserve access to these drugs in physician offices.

Tobacco

The AMA supported the U.S. Food and Drug Administration's (FDA) proposal to ban menthol-flavored cigarettes, a move that will save hundreds of thousands of lives in the coming decades while reducing health inequities. If the sale of menthol-flavored cigarettes is indeed banned, the FDA projects a 15.1% drop in smoking within 40 years, which would help save between 324,000 to 654,000 lives. The agency also projects the ban would stop between 92,000 and 238,000 smoking-related deaths among African Americans—that is up to 6,000 Black lives saved each year.

The AMA has also warned of the dangers of electronic nicotine delivery systems and long called for these products to have the same marketing and sales restrictions that are applied to tobacco cigarettes, including bans on TV advertising. This year the AMA successfully pressured social media companies to reject advertisements of e-cigarettes to youth. The AMA also recently applauded the FDA's decision ordering the removal of all JUUL Labs Inc. e-cigarette products from the U.S. market, recognizing that for too long, companies like JUUL have been allowed to sell e-cigarettes that appeal to our nation's youth—ultimately creating another generation of young people hooked on tobacco products.

Gender-Affirming Care

Despite the evidence base and consensus in the medical community that supports gender-affirming care for transgender youth, some state legislators have pursued legislation to prohibit physicians and other health care professionals from providing such care to minors. The AMA has worked with the Federation to mitigate the harm these bills could have on patients.

To date, two states, Alabama and Arkansas, have enacted laws that prohibit gender-affirming medical care for all minors, including puberty suppressing medication, hormone therapy, and surgery. Both laws are currently tied up with legal challenges. Two additional states, Arizona and Tennessee, have enacted legislation prohibiting surgery on minors and hormone therapy prior to puberty, respectively. Because these interventions are not recommended for the age groups specified, Arizona's and Tennessee's laws essentially—and unnecessarily—codify existing standards of care.

In addition to legislation, two states have sought to prohibit access to gender-affirming care through executive action. In February 2022, the Texas Attorney General issued an opinion deeming puberty suppressing drugs, hormone therapy, and surgeries child abuse. Shortly thereafter, Texas Governor Greg Abbott directed the Texas Department of Family and Protective Services to investigate any reported instances of minors receiving gender-affirming treatments. The directive was blocked by a Texas District Court. Lastly, in April 2022 the Florida Department of Health issued guidance stating that social gender transition, puberty blockers, hormone therapy, and gender reassignment surgery should not be treatment options for children or adolescents. The Florida guidance is not law or regulation and therefore is not legally enforceable. However, following a report by the Florida Agency for Health Care Administration finding insufficient evidence that medical intervention for the treatment for gender dysphoria is safe and effective, the Florida Board of Medicine began the rulemaking process in August 2022 to establish a new standard of care for the treatment of minors with gender dysphoria.

Public Service Loan Forgiveness Program

The AMA is calling on the U.S. Department of Education (DOE) to make improvements to the Public Service Loan Forgiveness (PSLF) program. In 2021, the DOE announced a change to the PSLF program rules for a limited time as a result of COVID-19 that made millions of non-profit and government employees eligible for loan forgiveness or additional credit through the Limited PSLF Waiver. This waiver ends on October 31, 2022, but the AMA has called for an extension. Further, the AMA is urging the DOE to amend the program to assist California and Texas physicians because those states' bans on the corporate practice of medicine interfere with participation in the program. The AMA is also advocating for 501(c)(6) employers to potentially qualify for the program as well. These changes would directly assist physicians with their loan burdens and would encourage more physicians to practice in underserved areas.

Immigration

The AMA continues to fight for equitable treatment of physicians, residents, and students immigrating to the U.S. The AMA wrote to the U.S. House of Representatives Committee on the Judiciary Subcommittee on Immigration and Citizenship urging lawmakers to seek bipartisan policy solutions that will ensure that patients are provided the best care and that immigration barriers are addressed to resolve the physician workforce shortage and preserve patient access to care. The AMA also submitted comments on the Temporary Increase of the Automatic Extension Period of Employment Authorization and Documentation for Certain Renewal Applicants temporary final rule. With the growing backlog of cases within the Department of Homeland Security (DHS) negatively impacting both immigrants and U.S. businesses, the AMA applauded the temporary final rule (TFR) and asked that this same extension be provided to physicians so that they can maintain their lawful immigration status while DHS is working on streamlining their extensions for employment authorization.

The AMA sent a letter strongly opposing any rules, regulations, or policies that would deter immigrants, nonimmigrants, and their dependents from seeking visas or from utilizing noncash public benefits including, but not limited to, Medicaid, Supplemental Nutrition Assistance Program (SNAP), and housing assistance. Impeding access to non-cash public benefits for these individuals and families could undermine population health.

AMA ADVOCACY ONGOING UPDATES

The AMA offers several ways to stay up to date on our advocacy efforts:

- Sign up for AMA Advocacy Update—a biweekly newsletter that provides updates on AMA legislative, regulatory, and private sector efforts. Subscribers can read stories from previous editions here and those looking to subscribe can use this link.
- Join the Physicians Grassroots Network for updates on AMA calls to action on federal legislative issues. And if you have connections with members of Congress, or are interested in developing one, the Very Influential Physician (VIP) program can help grow these relationships.
- Connect with the Physicians Grassroots Network on Facebook, Twitter, LinkedIn and Instagram.

CONCLUSION

There was no shortage of advocacy challenges for America's physicians in 2022. The AMA in conjunction with the Federation represented physicians and patients very well once again; however, significant work needs to be done to advance AMA policy on key issues as well as avoiding further erosion of prior gains. The Recovery Plan for America's Physicians offers a blueprint moving forward, and the AMA will continue to provide updates as efforts proceed.

OPINION OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Opinion 1-I-22

Subject: Amendment to E-9.3.2, "Physician Responsibilities to Colleagues with Illness, Disability or Impairment"

Presented by: Peter A. Schwartz, MD, Chair

INTRODUCTION

At the 2022 Annual Meeting, the American Medical Association House of Delegates adopted the recommendations of Council on Ethical and Judicial Affairs Report 3-A-22, "Amendment to E-9.3.2, "Physician Responsibilities to Colleagues with Illness, Disability or Impairment." The Council issues this Opinion, which will appear in the next version of AMA PolicyFinder and the next print edition of the *Code of Medical Ethics*.

E-9.3.2 - Physician Responsibilities to Colleagues with Illness, Disability or Impairment

Providing safe, high-quality care is fundamental to physicians' fiduciary obligation to promote patient welfare. Yet a variety of physical and mental health conditions—including physical disability, medical illness, and substance use—can undermine physicians' ability to fulfill that obligation. These conditions in turn can put patients at risk, compromise physicians' relationships with patients, as well as colleagues, and undermine public trust in the profession. While some conditions may render it impossible for a physician to provide care safely, with appropriate accommodations or treatment many can responsibly continue to practice, or resume practice once those needs have been met. In carrying out their responsibilities to colleagues, patients, and the public, physicians should strive to employ a process that distinguishes conditions that are permanently incompatible with the safe practice of medicine from those that are not and respond accordingly.

As individuals, physicians should:

(a) Maintain their own physical and mental health, strive for self-awareness, and promote recognition of and resources to address conditions that may cause impairment.

(b) Seek assistance as needed when continuing to practice is unsafe for patients, in keeping with ethics guidance on physician health and competence.

(c) Intervene with respect and compassion when a colleague is not able to practice safely. Such intervention should strive to ensure that the colleague is no longer endangering

* Opinions of the Council on Ethical and Judicial Affairs will be placed on the Consent Calendar for informational reports, but may be withdrawn from the Consent Calendar on motion of any member of the House of Delegates and referred to a Reference Committee. The members of the House may discuss an Opinion fully in Reference Committee and on the floor of the House. After concluding its discussion, the House shall file the Opinion. The House may adopt a resolution requesting the Council on Ethical and Judicial Affairs to reconsider or withdraw the Opinion.

patients and that the individual receive appropriate evaluation and care to treat any impairing conditions.

(d) Protect the interests of patients by promoting appropriate interventions when a colleague continues to provide unsafe care despite efforts to dissuade them from practice.

(e) Seek assistance when intervening, in keeping with institutional policies, regulatory requirements, or applicable law.

Collectively, physicians should nurture a respectful, supportive professional culture by:

(f) Encouraging the development of practice environments that promote collegial mutual support in the interest of patient safety.

(g) Encouraging development of inclusive training standards that enable individuals with disabilities to enter the profession and have safe, successful careers.

(h) Eliminating stigma within the profession regarding illness and disability.

(i) Advocating for supportive services, including physician health programs, and accommodations to enable physicians and physicians-in-training who require assistance to provide safe, effective care.

(j) Advocating for respectful and supportive, evidence-based peer review policies and practices to ensure fair, objective, and independent assessment of potential impairment whenever and by whomever assessment is deemed appropriate to ensure patient safety and practice competency. (II)

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS

CEJA Report 4-I-22

Subject: Research Handling of De-Identified Patient Information

Presented by: Peter A. Schwartz, MD, Chair

Policy D-315.969 adopted in November 2021 directs the Council on Ethical and Judicial Affairs to "consider re-examining existing guidance relevant to the confidentiality of patient information, striving to preserve the benefits of widespread use of de-identified patient data for purposes of promoting quality improvement, research, and public health while mitigating the risks of re-identification of such data."

Independently, at its August 2021 meeting the Council concluded that in light of the complex issues arising with the rapid development of data science and increasing research use of large health-related data sets, along with recent changes in the Common Rule governing research with human participants, it would reconsider guidance in Opinion 7.3.7, "Safeguards in the Use of DNA Databanks" and would in addition review other existing guidance on confidentiality last updated in 2016 as part of the overall project to modernize the AMA *Code of Medical Ethics.*

This review is ongoing. The Council anticipates submitting its preliminary report to the House of Delegates at the June 2023 Annual Meeting.

REPORT 3 OF THE COUNCIL ON MEDICAL SERVICE (I-22)
Health System Consolidation
Informational Report

EXECUTIVE SUMMARY

There are two types of integration for firms to pursue when merging with or acquiring other firms. Horizontal consolidation occurs when one entity acquires or merges with another entity at the same level in an industry. An example of horizontal integration in health care would be two hospitals merging with one another. Vertical consolidation occurs when one entity acquires or merges with another entity at a different level of industry. In health care, an example of vertical consolidation would be a hospital or health system acquiring a physician practice.

Firms' market shares are a critical metric in the assessment of the competitive effects of mergers and acquisitions. In general, firms with larger market shares may be more able to engage in anticompetitive conduct. Market concentration can be measured by calculating the Herfindahl-Hirschman Index (HHI), which is a useful indicator of market power and serves as a signal of the likely impact of a merger on competition. The Department of Justice (DOJ) and the Federal Trade Commission (FTC) use the HHI as an aid in assessing the potential for anticompetitive effects of proposed horizontal mergers. They may also consider market shares and market concentration in the evaluation of vertical mergers. Over half (55 percent) of US health care markets experienced an increase in concentration between 2013 and 2017.

Consolidation in health care is under increased scrutiny by antitrust authorities and state regulators. At the federal level, the FTC is tasked with reviewing mergers involving hospitals and physicians. While a handful of mergers have been blocked in recent years, health care markets continue to become more consolidated. A challenge arises because such transactions mostly fall under the threshold required for FTC/DOJ notification and review. Thus, they can proceed without antitrust scrutiny that could otherwise assess and weigh their benefits and harms.

Hospital and hospital-physician mergers are shown to increase health care prices and spending. The impact of hospital and hospital-physician mergers on the quality of health care and patient outcomes is limited and inconclusive at this time. The American Medical Association (AMA) has robust policy and guidelines on hospital and hospital-physician mergers and acquisitions. In accordance with Policy D-215.984, the Council will continue to review and report back to the House of Delegates any new data that become available, especially with regards to the impact of these mergers on health care prices and quality of care.

This report is the first in a series on this and related topics. Potential future topics may include physician satisfaction and burnout associated with mergers, acquisitions, and consolidation; anti-trust issues; hurdles physicians face when starting a private practice; quality of care; and impacts on patient outcomes and mortality.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 3-I-22

Subject: Health System Consolidation

Presented by: Lynn Jeffers, MD, MBA, Chair

At the 2022 Annual Meeting, the House of Delegates adopted Policy D-215.984, "Health System Consolidation," which was sponsored by the Private Practice Physicians Section. Policy D-215.984 asks the American Medical Association (AMA) to (1) "study nationwide health system and hospital consolidation for the benefit of patients and physicians who face an existential threat from health care consolidation," and (2) "regularly review and report back on these issues to keep the House of Delegates apprised on relevant changes that may impact the practice of medicine, with the first report no later than A-23." This report, which is presented for the information of the House of Delegates, summarizes hospital and hospital-physician group merger and acquisition activity, including background and trends on hospital and hospital-physician group consolidation. This is the first report of a series the Council will be working on addressing this and related topics.

The Council notes that this report specifically addresses hospital and hospital-physician group consolidation, regardless of ownership model. Further information on the corporate practice of medicine and private equity investment in health care can be found in CMS Report 2-I-22, which is before the House at this meeting. A primary purpose of this report is to provide background and baseline knowledge for upcoming reports on this topic. A glossary of common terms and abbreviations can be found in Appendix A.

BACKGROUND

Horizontal and Vertical Integration

There are two types of integration for firms to pursue when merging with or acquiring other firms. Horizontal consolidation occurs when one entity acquires or merges with another entity at the same level in an industry. An example of horizontal integration in health care would be two hospitals merging with one another. Vertical consolidation occurs when one entity acquires or merges with another entity at a different level of industry. In health care, an example of vertical consolidation would be a hospital or health system acquiring a physician practice.

A critical question is whether mergers and acquisitions are beneficial or harmful to society. Theoretically, both types of integration can result in both benefits and harms. Horizontal integration can lead to economies of scale, which could reduce the cost of production and lower prices, but it can also lead to the exercise of market power and increase prices or lower quality. Horizontal integration could also lead to potential loss of physician autonomy. Vertical integration between physicians and hospitals has several potential benefits, including improved care coordination, improved alignment of provider incentives through the "internalization" of externalities, less duplication of services, and economies of scale for administrative functions such as deployment of health records, which reduce prices or improve quality. However, vertical integration could also hurt merging parties' competitors by inhibiting them from accessing needed supplies for production or raising their costs. Moreover, Medicare billing practices could make

hospital-based outpatient care more expensive than that based in a physician office. In these cases, vertical integration could lead to higher prices or spending. In short, each type of integration could lead to different outcomes and could have different impacts on price, quality, and/or spending.

Market Definition, Market Shares, and the Herfindahl-Hirschman Index (HHI)

Firms' market shares are a critical metric in the assessment of the competitive effects of mergers and acquisitions. In general, firms with larger market shares may be more able to engage in anticompetitive conduct. One way to assess the level of market competition is by determining the level of market concentration. Market concentration can be measured by calculating the HHI, which is a useful indicator of market power and serves as a signal of the likely impact of a merger on competition. The Department of Justice (DOJ) and the Federal Trade Commission (FTC) use the HHI as an aid in assessing the potential for anticompetitive effects of proposed horizontal mergers. They may also consider market shares and market concentration in the evaluation of vertical mergers. The HHI is the sum of the squared market shares for all firms in a market. As an example, a market with 4 firms that each held 25 percent of the market share would have an HHI of 2,500. The largest value HHI can reach is 10,000, indicating a monopoly, where one entity holds the entire market share. A higher HHI indicates greater concentration and suggests lower market competition.[1]

Health care markets are generally considered to be local, as health care consumers need to travel to obtain care. Studies typically define hospital geographic markets as metropolitan statistical areas (MSAs). Markets that are very large (e.g., New York, Chicago), can be defined as smaller parts of those MSAs called metropolitan divisions. The HHI is calculated for each MSA. Using data from 2013, 2016, and 2017, one study found that in 95 percent of MSA-level markets in the United States, at least one hospital (or hospital system) had a market share of 30 percent or greater in those years. Seventy-two percent of markets had one hospital (or hospital system) with a share of 50 percent or more in 2016 and 2017. Additionally, in 40 percent of markets, a single hospital (or hospital system) had a market share of 70 percent or more in 2016 and 2017.[2] Over half (55 percent) of markets experienced an increase in concentration between 2013 and 2017. In 17 percent of markets, the HHI equaled 10,000 in both of those years, indicating a monopoly. In 2017, the average HHI across markets was 3,853 and 92 percent of markets were considered highly concentrated.[3] It is crucial to note that the study cited here considers the potential weakness with HHI calculation and looked only at comparable hospitals within a market when calculating market concentration. The study specifically outlines this when explaining the data and methods used in calculating HHI for these markets.

Changes in Practice Ownership and Physician Employment

The COVID-19 pandemic put tremendous strain on the health care industry, particularly on smaller practices. With smaller practices finding it difficult to continue to operate independently, larger health systems had an opportunity to acquire them. The Coronavirus Aid, Relief, and Economic Security Act and the Paycheck Protection Program and Health Care Enhancement Act allocated $175 billion for grants to providers that were partly intended to make up for revenue lost due to coronavirus, but analysis shows that the first $50 billion in grants were not targeted to providers most vulnerable to revenue losses.[4] The resulting economic pressure on physicians could potentially lead to more mergers or closing of private practices, resulting in physicians then seeking employment within a hospital or health system.

However, changes in physician practice arrangements were already underway prior to the COVID-19 pandemic. According to the AMA's 2020 Physician Practice Benchmark Survey, almost 40

percent of physicians worked directly for a hospital or for a practice that was at least partially owned by a hospital or health system—up from 29 percent in 2012. In 2020, 50.2 percent of physicians were employed, compared to 41.8 percent in 2012, and 44 percent had an ownership stake in their practice—lower than the 53.2 percent who were owners in 2012. In fact, 2020 was the first year in which less than half (49.1 percent) of physicians worked in practices that were wholly owned by physicians (i.e., private practice).[5] This percentage includes the physicians who are private practice owners (38.4 percent of all physicians), the employed physicians who work for them (8.2 percent), and the physicians who are on contract with the practice (2.5 percent).[6] As the number of physicians in private practice has fallen, the share of physicians who work directly for a hospital or for a practice at least partially owned by a hospital or health system has increased.

Antitrust Enforcement and Regulation

Consolidation in health care is under increased scrutiny by antitrust authorities and state regulators.[7] At the federal level, the FTC is tasked with reviewing mergers involving hospitals and physicians. While a handful of mergers have been blocked in recent years, health care markets continue to become more consolidated. The FTC cites several constraints on their ability to enforce antitrust laws in the health care sector. Most notably, the FTC and DOJ antitrust division budgets have remained flat, even as the pace of mergers has increased.[8] It is important to note that vertical integration is a particular challenge to regulate. For example, this would include a hospital or health system acquiring a physician practice. A challenge arises because such transactions mostly fall under the threshold required for FTC/DOJ notification and review. Thus, they can proceed without antitrust scrutiny that could otherwise assess and weigh their benefits and harms. Another noted challenge is the inability of the FTC to enforce antitrust rules on non-profit hospitals (although it can review mergers that involve a non-profit hospital). In 2019, 66 percent of hospital and health system mergers and acquisitions involved a non-profit entity purchasing another non-profit entity, putting these transactions out of the scope of FTC review.[9]

In 2013, the FTC and state of Idaho sued St Luke's Health System and Saltzer Medical Group for violating the Clayton Act and state antitrust laws. The complaint alleged anticompetitive effects in the primary care market. According to the complaint, the combination of St. Luke's and Saltzer would give it the market power to demand higher rates for health care services provided by primary care physicians in Nampa, Idaho and surrounding areas, leading to higher costs for health care consumers.[10] The district court did note that they believed that St. Luke's and Saltzer genuinely intended to move towards a better health care system, but ultimately found that the "huge market share" of the post-merger entity "creates a substantial risk of anticompetitive price increases" in the primary care market in Nampa, Idaho, where the facilities are located. The ruling was appealed and upheld in 2015, resulting in the unwinding of the merger of these two entities.[11]

States play a significant role in regulating hospital markets. States have their own antitrust laws, and state attorneys general and other regulators have access to the local market level data needed to oversee and challenge proposed mergers in their states. In addition to challenging hospital mergers outright, state strategies to address consolidation include all-payer rate setting for hospitals (Maryland, Pennsylvania, and Vermont) and the Massachusetts Health Policy Commission.

Summary of Recent Transactions

The 2021 Health Care Services Acquisition Report highlights hospital merger and acquisition activities for the past five years. Hospital merger and acquisition activity dropped off in 2020 as the coronavirus pandemic swept the United States and hospitals' finances were ravaged as a result.[12] Sixty-five of the 79 hospital merger and acquisition deals announced in 2020 were United States-

only targets that were not involved in bankruptcy proceedings.[13] These deals covered 119 hospitals and 15,996 beds. The total acquired revenue figure for 2020 was nearly $16.4 billion.[14] Full details on all hospital and health system mergers and acquisitions can be found in the 2021 Health Care Services Acquisition Report (Twenty-Seventh Edition). The table below shows notable hospital transactions in the United States in 2020:[15]

Notable US Hospital Transactions, 2020

Acquirer	Target	Price	Hospitals	Beds
Novant Health	New Hanover Regional Medical Center	$1,500,000,000	1	677
Prime Healthcare Services	St. Francis Medical Center	$275,000,000	1	344
Banner Health	Wyoming Medical Center	$207,000,000	1	212
Carle	2 Advocate Aurora hospitals	$190,000,000	2	231
Orlando Health	Bayfront Health St. Petersburg	$147,135,471	1	343
Chan Soon-Shiong Family Foundation	St. Vincent Medical Center	$135,000,000	1	320
LCMC Health	East Jefferson General Hospital	$90,000,000	1	309
Iron Stone Real Estate Partners	St. Christopher's Hospital for Children	$65,000,000	1	188

Source: HealthCareMandA.com, January 2021. Health Care Services Acquisition Report (Twenty-Seventh Edition. Does not include transactions that took place outside of the United States.)

The table below shows the largest physician medical group transactions from 2016-2020:[15]

Notable US Physician Medical Group Transactions, 2020

Acquirer	Target	Price	Year
KKR & Co. L.P.	Envision Healthcare Corporation	$9,900,000,000	2018
Envision Healthcare Holdings, Inc.	AmSurg Corp.	$6,726,000,000	2016
The Blackstone Group	TeamHealth Holdings, Inc.	$6,100,000,000	2016
Optum	DaVita Medical Group	$4,340,000,000	2017
Optum	Surgical Care Affiliates, Inc.	$3,277,410,000	2017
West Street Capital Partners VII	Capital Vision Services LP	$2,700,000,000	2019
Partners Group	EyeCare Partners	$2,200,000,000	2019
Summit Partners	Sound Inpatient Physicians Holdings, LLC	$2,150,000,000	2018
Ares Management L.P.	DuPage Medical Group	$1,450,000,000	2017
Aspen Dental Management, Inc.	Clear Choice Management Services	$1,100,000,000	2020

Source: HealthCareMandA.com, January 2021. Health Care Services Acquisition Report (Twenty-Seventh Edition. Does not include transactions that took place outside of the United States.)

Impacts on Health Care Price and Quality

Previous studies show that both horizontal and vertical integration impact the price of health care. However, research on the impact of hospital and hospital-physician consolidation on quality of care is limited and inconclusive. Research suggests that horizontal and vertical integration among providers is associated with higher health care prices paid by private insurers. In Medicare, payment policies protect Medicare from increased prices due to horizontal consolidation but have led to higher Medicare costs in the case of vertical integration.

In the case of horizontal integration, the 2020 Medicare Payment Advisory Commission reviewed published research on hospital consolidation and concluded that the "preponderance of evidence suggests that hospital consolidation leads to higher prices." An analysis of data from employer-sponsored coverage found that hospitals that do not have any competitors within a 15-mile radius have prices that are 12 percent higher than hospitals in markets with four or more competitors. Furthermore, a separate analysis of hospital mergers over a 5-year period found that mergers of two hospitals within five miles of one another resulted in an average price increase of 6.2 percent and that price increases continued in the two years following the merger.[16]

There is evidence that prices increase even when hospitals merge with other hospitals in different geographic markets. One analysis found that prices at hospitals acquired by out-of-market systems increased by about 17 percent more than unacquired, stand-alone hospitals. One reason for rising prices following mergers is that larger hospital systems can influence the dynamics of negotiations with insurers and shift volume to higher cost facilities. For example, hospital systems with significant bargaining power may require that insurers include all hospitals in their system in a provider network. This can lead to higher cost hospitals being in a provider network when there are lower cost hospitals nearby. In one recent antitrust case in California, the Sutter Health system was accused of violating antitrust laws by using its market power to illegally drive up prices. In the settlement, Sutter Health agreed to stop requiring that all of its hospitals be included in an insurer's network and also agreed to pay additional damages.[17]

Vertical integration between hospitals and physicians can also raise prices or spending. A study analyzing highly concentrated markets in California found that an increase in the share of physicians in practices owned by a hospital was associated with a 12 percent increase in premiums for private plans sold in the state's Affordable Care Act Marketplace. Additionally, a study conducted to examine Medicare beneficiaries' pattern of health care utilization found that "patients are more likely to choose a high-cost, low-quality hospital when their physician is owned by that hospital." In May 2022, *Health Affairs* published a study on the price effects of vertical integration and joint contracting in Massachusetts. This study found that vertical integration and joint contracting led to price increases from 2013 to 2017, from 2.1 percent to 12.0 percent for primary care physicians and from 0.7 percent to 6.0 percent for specialists, with the greatest increases seen in large health systems.[18]

Studies examining the impact of consolidation on quality of care have produced mixed results. Some studies have shown that quality does not improve, or even gets worse, after vertical integration and others have shown modest improvements. One study of 15 integrated delivery networks found no evidence that hospitals in these systems provide better clinical quality or safety scores than competitors. Another study found that larger hospital-based provider groups had higher per beneficiary Medicare spending and higher readmission rates than smaller groups. However, one other study found that vertical integration had a limited positive effect on a small subset of quality measures.[19] Regarding horizontal consolidation, studies have shown that quality may decrease in highly concentrated markets. One study found that risk-adjusted one-year mortality for heart

attacks in Medicare patients was 4.4 percent higher in more highly concentrated hospital markets compared to less concentrated markets. A study published in 2020 followed hospitals for three years after a merger and compared outcome measures with a control group of hospitals that had no change in ownership. The analysis found that scores for 30-day readmissions and mortality rates among patients discharged from a hospital did not improve in the hospitals that merged, when compared to the control group. Given the differences in these results, it is imperative for these systems to continue to collect data and monitor potential impacts of consolidation on the quality of care. In sum, although previous research generally finds that horizontal and vertical integration among providers is associated with higher health care prices, the net effect of such integration on quality is yet unknown.

AMA POLICY AND ADVOCACY

The Council reviewed relevant AMA policy and highlights Policy H-215.960, established by Council on Medical Service Report 7-A-19: (a) health care entity mergers should be examined individually, taking into account case-specific variables of market power and patient needs; (b) the AMA strongly supports and encourages competition in all health care markets; (c) the AMA supports rigorous review and scrutiny of proposed mergers to determine their effects on patients and providers; (d) antitrust relief for physicians remains a top AMA priority; and (e) close monitoring of health care markets is a key aspect of AMA antitrust activity.

The AMA has long been a strong advocate for competitive health care markets and antitrust relief for physicians and maintains that health care markets should be sufficiently competitive to allow physicians to have adequate choices and practice options. AMA efforts to obtain antitrust relief for physicians, maximize their practice options, and protect patient-physician relationships include legislative advocacy, advocacy at the FTC and DOJ, and the creation of practical physician resources. Furthermore, the AMA has pursued alternative solutions that promote competition and choice, including: eliminating state certificate of need laws; repealing the ban on physician-owned hospitals; reducing the administrative burden to enable physicians to compete with hospitals; and achieving meaningful price transparency (Policy H-215.960).

In addition, the AMA strongly advocates that Congress repeal limits to the whole hospital exception of the Stark physician self-referral law, which essentially bans physician ownership of hospitals and places restrictions on expansions of already existing physician-led hospitals. Repealing this ban would allow new entrants into hospital markets, thereby increasing competition. The AMA firmly believes that physician-owned hospitals should be allowed to compete equally with other hospitals, and that the federal ban restricts competition and choice (Policy D-215.995).

In the event of a hospital or health system merger, acquisition, consolidation or affiliation, the AMA believes a joint committee with merging medical staffs should be established to resolve at least the following issues: (a) medical staff representation on the board of directors; (b) clinical services to be offered by the institutions; (c) process for approving and amending medical staff bylaws; (d) physicians are encouraged and expected to work with others to deliver effective, efficient, and appropriate care; (e) a mechanism is provided for the open and transparent sharing of clinical and business information by all parties to improve care; and (f) a clinical information system infrastructure exists that allows capture and reporting of key clinical quality and efficient performance data for all participants and accountability across the system to those measures (Policy H-215.969).

DISCUSSION

While it is recognized that most hospital markets are highly concentrated and do not function as well as they could, or should, it is also recognized that hospital markets are local, and states play a significant role in regulating them. States have their own antitrust laws, and state attorneys general and other regulators have better access to the local market-level data needed to oversee and challenge proposed mergers in their states. States can take on mergers themselves or join federal antitrust efforts.

Consistent with Policy D-215.984, the Council will continue to monitor trends in health system consolidation and the impact on physicians and their patients, using additional data when available. As previously noted in CMS Report 7-A-19, the Council remains concerned regarding the potential negative consequences for physicians and patients in highly concentrated hospital markets (such as increased prices, reduced choice, and fewer physician practice options). In addition to reviewing the current literature, the Council received input from AMA antitrust experts during the development of this report, and notes that AMA staff are readily available to assist and advise AMA members and state medical associations with questions or concerns about physician-hospital relations or hospital consolidation. Nonetheless, the Council believes it is not possible to actively oppose all future hospital mergers. Attempting to address hospital mergers in the same manner the AMA has addressed major health insurance mergers would require enormous resources and may alienate AMA members who work for hospitals and health systems.

While previous studies suggest that hospital and hospital-physician consolidation is associated with higher health care prices, the impact on quality of care is still unknown. The economic pressures facing physicians were exacerbated by the COVID-19 pandemic and could result in continued mergers—both horizontal and vertical. Struggling private practices may find it beneficial to join with other private practices to form a larger practice (horizontal integration) or be acquired by a hospital or health system (vertical integration).

CONCLUSION

Hospital and hospital-physician mergers are shown to increase health care prices and spending. Nonetheless, the impact of hospital and hospital-physician mergers on the quality of health care and patient outcomes is limited and inconclusive at this time. The AMA has robust policy and guidelines on hospital and hospital-physician mergers and acquisitions. In accordance with Policy D-215.984, the Council will continue to review and report back to the House of Delegates as any new data become available, especially with respect to the impact of these mergers on health care prices and quality of care. The Council's review could include monitoring relevant FTC-DOJ mergers to determine trends and better understand the impact of these mergers on hospitals, health systems, and physician groups.

This report represents the first in a series on health system consolidation and related topics. Potential future report topics may include physician satisfaction and burnout associated with mergers, acquisitions, and consolidation; anti-trust issues; hurdles physicians face when starting a private practice either within a hospital employment or non-employed setting before and after a hospital merger; quality of care; and impacts on patient outcomes and mortality.

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[18] Curto, *Supra* note 7.
[19] Schwartz, *Supra* note 4.

APPENDIX A

Glossary of Terms

Antitrust – The regulation of the concentration of economic power, particularly in regard to monopolies and other anticompetitive practices. Antitrust laws exist as both federal and state statutes.

Department of Justice (DOJ) – A federal executive department of the United States government. Specific Antitrust Division housed within the Department whose mission is to promote economic competition through enforcing and providing guidance on antitrust laws and principles. The DOJ Antitrust Division works closely with the Federal Trade Commission (FTC) to review potential mergers and acquisitions.

Federal Trade Commission (FTC) – An independent agency of the United States government whose principal mission is the enforcement of civil U.S. antitrust law and the promotion of consumer protection. These laws promote vigorous competition and protect consumers from anticompetitive mergers and business practices. The FTC shares jurisdiction over federal civil antitrust enforcement with the DOJ Antitrust Division.

Herfindahl-Hirschman Index (HHI) – A commonly accepted measure of market concentration calculated by squaring the market share of each firm competing in the market and then summing the resulting numbers. HHI calculations of 10,000 indicate a monopoly.

Horizontal Integration – A business strategy in which one company acquires or merges with another that operates at the same level in an industry. An example in health care would be two hospitals merging or two physician practices merging.

Integration vs. Consolidation – Closely related, but not synonymous. Consolidation typically refers to mergers and acquisitions. Consolidation does not necessarily imply integration. Integration means firms are truly integrating their operations, for the purpose of aligning and creating efficiency.

Metropolitan Statistical Area (MSA) – A core area containing a substantial population nucleus, together with adjacent communities having a high degree of economic and social integration with that core. MSAs are determined with the U.S. Census and are one way to define geographic markets when calculating the HHI. Particularly large MSAs (i.e., New York City, Chicago, Los Angeles, etc.) are further broken down into submarkets.

Vertical Integration – The combination in one company of two or more stages of production normally operated by separate companies. An example in health care: hospitals can buy physician groups or health systems can form drug companies.