

Reference Committee J

CMS Report(s)

- 01 Incentives to Encourage Efficient Use of Emergency Departments
- 02 Corporate Practice of Medicine

Resolution(s)

- 801 Parity in Military Reproductive Health Insurance Coverage for All Service Members and Veterans
- 802 FAIR Health Database
- 803 Patient Centered Medical Home – Administrative Burdens
- 804 Centers for Medicare & Medicaid Innovation Projects
- 805 COVID Vaccine Administration Fee
- 806 Healthcare Marketplace Plan Selection
- 807 Medicare Advantage Record Requests
- 808 Reinstatement of Consultation Codes
- 809 Uniformity and Enforcement of Medicare Advantage Plans and Regulations
- 810 Medicare Drug Pricing and Pharmacy Costs
- 811 Covering Vaccinations for Seniors Through Medicare Part B
- 812 Implant-Associated Anaplastic Large Cell Lymphoma
- 813 Amending Policy on a Public Option to Maximize AMA Advocacy
- 814 Socioeconomics of CT Coronary Calcium: Is it Scored or Ignored?
- 815* Opposition to Debt Litigation Against Patients
- 816* Medicaid and CHIP Coverage for Glucose Monitoring Devices for Patients with Diabetes
- 817* Promoting Oral Anticancer Drug Parity
- 818* Pediatric Obesity Treatment Insurance Coverage
- 819* Advocating for the Implementation of Updated U.S. Preventive Services Task Force Recommendations for Colorectal Cancer Screening Among Primary Care Physicians and Major Payors by the AMA
- 820* Third-Party Pharmacy Benefit Administrators

REPORT 1 OF THE COUNCIL ON MEDICAL SERVICE (I-22)
Incentives to Encourage Efficient Use of Emergency Departments
(Reference Committee J)

EXECUTIVE SUMMARY

At the 2022 Annual Meeting, the House of Delegates adopted Policy D-130.959, “Study of Incentives to Encourage Efficient Use of Emergency Departments,” which directs the American Medical Association (AMA) to study and report on the positive and negative experiences of programs in various states that provide Medicaid beneficiaries with incentives for choosing alternate sites of care, for physical and mental health conditions, when it is appropriate to their symptoms and/or conditions instead of hospital emergency departments (EDs).

Medicaid/Children’s Health Insurance Program (CHIP) enrollees have higher rates of ED visits than Medicare, privately insured, and even uninsured individuals, thereby utilizing higher-cost services than those provided in other ambulatory care settings. To address this issue, and contain costs, states—and managed care plans that enroll Medicaid patients—have long sought ways to incentivize more efficient ED use. Financial incentives, including increased patient cost-sharing and retrospective payment denials, are among the variety of strategies that have been employed across states to try to reduce ED visits perceived to be non-emergency, nonurgent, or avoidable. Consistent with Policy D-130.959, the Council reviewed the literature on these financial incentives and finds that: 1) modest cost-sharing requirements, on their own, may not be very effective at either reducing ED services or generating significant cost-savings; and 2) diagnosis-based payment and coverage denials for non-emergency ED services may potentially harm some patients—by dissuading them from seeking emergency care when needed—as well as physicians and hospitals, when payment is denied.

The Council believes that interventions aimed at reducing ED use for services that could be provided elsewhere, and at lower cost, are worthy of ongoing monitoring and testing by the Centers for Medicare & Medicaid Services and other stakeholders. Accordingly, the Council recommends support for continued monitoring and testing of strategies and best practices for reducing non-emergency ED use, particularly among patients with the highest number of ED visits. Given the abundance of AMA policy that is relevant to this report topic, and the need for state flexibility to design strategies well suited to a state’s Medicaid population, the Council also recommends support for state efforts to encourage appropriate ED use among Medicaid/CHIP enrollees that are consistent with the standards and safeguards outlined in AMA policy on ED services. Finally, the Council recommends reaffirmation of AMA policies supporting the prudent layperson standard of determining when to seek emergency care (Policy H-130.970); criteria to be used in Medicaid managed care monitoring and oversight (Policy H-290.985); and reasonable Medicaid payment (Policy H-290.959).

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 1-I-22

Subject: Incentives to Encourage Efficient Use of Emergency Departments

Presented by: Lynn Jeffers, MD, MBA, Chair

Referred to: Reference Committee J

At the 2022 Annual Meeting, the House of Delegates adopted Policy D-130.959, “Study of Incentives to Encourage Efficient Use of Emergency Departments,” which directs the American Medical Association (AMA) to study and report on the positive and negative experiences of programs in various states that provide Medicaid beneficiaries with incentives for choosing alternate sites of care, for physical and mental health conditions, when it is appropriate to their symptoms and/or conditions instead of hospital emergency departments (EDs). The Board of Trustees assigned this policy to the Council on Medical Service for a report back to the House of Delegates at the 2022 Interim Meeting. This report describes the positive and negative experiences of two commonly used incentives intended to reduce non-emergency ED use (increased patient cost-sharing and retrospective payment denials), summarizes relevant AMA policy, and makes policy recommendations.

BACKGROUND

Medicaid spending makes up an increasingly large share of most state budgets and continues to be a focus of policymakers seeking ways to contain costs without compromising care quality. EDs have been targeted for cost-savings in many states because, for a variety of complex reasons, Medicaid/Children’s Health Insurance Program (CHIP) enrollees have higher rates of ED use than Medicare, privately insured, and even uninsured individuals.^{1,2} Because services cost significantly more when provided in EDs than in other ambulatory care settings (e.g., physician offices and outpatient clinics), states—and managed care plans that enroll Medicaid patients—have long prioritized incentivizing more efficient ED use by Medicaid enrollees. Financial incentives, including increased patient cost-sharing and retrospective payment denials, are among the variety of strategies employed to try to reduce ED visits perceived to be non-emergency, nonurgent, or avoidable. Although there is no standard definition of what constitutes non-emergency, nonurgent, avoidable ED care, it is generally described as that which can be appropriately provided in a primary care or other outpatient setting at reduced cost.

Due to the lack of consensus around defining non-emergency, nonurgent, avoidable ED visits, researchers have employed an array of methodologies to assess the effectiveness of strategies to reduce those patient visits that could be effectively treated elsewhere. As a result, studies have produced a range of estimates of ED visits classified as non-emergency, nonurgent, or avoidable, depending on methodology and how these visits are defined. Importantly, a 2013 *JAMA* study revealed what many physicians already knew—that non-emergency visits cannot easily be discerned from patients’ presenting complaints and symptoms, since symptoms for many non-emergency conditions overlap with symptoms of conditions that require emergency care.³ This suggests that, in many cases, decisions about emergency versus non-emergency care are far from clear-cut and may not be evident at triage. Although exact percentages are not known, most

estimates of non-emergency ED visits as a proportion of all ED visits are relatively small. Analyses by the Centers for Disease Control and Prevention (CDC) of ED data from the National Hospital Ambulatory Medical Care Survey found that 5.5 percent of all ED visits in 2015,⁴ 3.9 percent in 2017,⁵ and 3.1 percent in 2018,⁶ were classified as nonurgent. A 2015 report of the Washington Health Alliance found that nearly 12 percent of Medicaid enrollee ED visits in the Puget Sound region could be described as avoidable, compared to 8.5 percent of ED visits by privately insured individuals.⁷

Experts have long posited that a lack of regular access to primary care drives many patients to EDs for nonurgent reasons. Furthermore, Medicaid enrollees, and individuals dually eligible for Medicare and Medicaid, are known to experience added barriers to accessing health care, in part because they are more likely to experience inequities in social determinants of health (SDOH) that lead to complex and chronic health needs. Other factors that lower access to health care include a lack of available transportation, the distance one must travel to obtain care (especially in rural areas), an inability to get needed specialty care, difficulties taking time off to attend medical appointments, cost concerns among patients, lack of community behavioral health resources, and inadequate Medicaid physician payment rates.

MEDICAID PAYMENT RATES AND ENROLLEE ACCESS TO CARE

For decades, the AMA has highlighted the inadequacy of physician payment rates across state Medicaid programs—rates that are substantially below Medicare and private insurance fees and often do not come close to covering the cost of providing care. In enacting the equal access provision in section 1902(a)(30)(A) of the Social Security Act, Congress recognized that, “without adequate payment levels, it is simply unrealistic to expect physicians to participate in the [Medicaid] program.”⁸ While physicians have a strong sense of responsibility to provide care for Medicaid patients, physician practices cannot remain economically viable if they lose money on the care they provide. Without an adequate supply of participating physicians, Medicaid patients have coverage but may lack access to care. And without access to needed primary and specialty care, Medicaid enrollees tend to visit EDs more often for conditions that could be handled in alternate sites of service.

Because physicians participating in Medicaid remain sparse in many areas of the country, enrollees often experience lengthy wait times, travel long distances to access care, or may go without care altogether. Medicaid payment rates have been shown to significantly impact patient access to care, with increases in payments found to improve access to care.⁹ Accordingly, the AMA has long advocated at the federal and state levels that physicians be provided fair and reasonable Medicaid payment, defined in AMA policy as a minimum of 100 percent of Medicare rates. The AMA further advocates that the Centers for Medicare & Medicaid Services (CMS) ensure that states maintain Medicaid rate structures at levels that ensure there is sufficient physician participation, so that Medicaid patients can access care in a timely manner.

FACTORS CONTRIBUTING TO NON-EMERGENCY ED USE

EDs have historically served as an essential source of care for people struggling with economic marginalization, and research has shown an association between socioeconomic variables and potentially avoidable ED use.¹⁰ Medicaid enrollees experiencing inequities in SDOH—such as housing instability, food insecurity, or lack of transportation—may be more likely to use the ED for non-emergency care.

1 As previously noted, patients who do not have an established relationship with a primary care
2 provider may be more likely to seek care at an ED for non-emergency conditions. Moreover, across
3 some states, and especially in rural areas, it can be difficult for some Medicaid enrollees to obtain
4 needed specialty care; in turn, these patients may visit EDs because alternative care sites are simply
5 not available. Lack of access to behavioral health and substance use disorder services may be an
6 additional barrier in some areas. Physician workforce shortages in certain specialties likely
7 compound these access barriers that contribute to higher ED use among Medicaid enrollees.

8
9 Although some people may seek non-emergency care at EDs out of convenience, or on weekends
10 or evenings when other outpatient care is not available, analyses have been mixed and some
11 hospitals have found that non-emergency visits predominantly occur during regular hours when
12 physician offices are open. A subset of Medicaid enrollees may turn to hospital EDs for services
13 that cannot be accessed at primary care offices, while others may be motivated to have multiple
14 health concerns addressed during a single ED visit. Patients who perceive that they cannot access
15 timely or needed care in another setting, including individuals with mental health needs and/or
16 substance use disorder, may also seek non-emergency ED care, as will patients who believe they
17 are experiencing emergencies requiring immediate attention.

18
19 Insurer prior authorization (PA) requirements are also important drivers of non-emergency ED use,
20 especially when they preclude patients from getting timely needed care. In some cases, patients
21 may resort to EDs for certain medically indicated services that would otherwise be delayed while
22 approval is sought from the patient's insurer. PA rules that impede quick access to services ranging
23 from mental health and substance use disorder treatment to imaging may lead some patients to seek
24 care at EDs. According to one study, a new outpatient PA process for radiologic studies may have
25 led to an increase in ED visits for outpatient MRI scans.¹¹

26
27 Lack of insurance, or limited insurance, also impacts ED use, although people with health
28 insurance still experience time and access barriers to receiving regular care. Although the
29 expansion of Medicaid under the Affordable Care Act has been found to reduce the number of
30 uninsured individuals and increase access to primary care,¹² research findings on the association
31 between Medicaid expansion and ED use have been mixed, in part because newly insured patients
32 may use more health care services.

33 34 STRATEGIES TO REDUCE NON-EMERGENCY ED USE

35
36 Beyond financial incentives, strategies to reduce non-emergency ED use are numerous and varied
37 and have produced mixed results in the literature in terms of their impact. One strategy that is
38 central to many state efforts is care coordination designed to connect Medicaid enrollees to services
39 that address their physical and mental health needs as well as non-medical issues such as housing,
40 nutrition, and transportation. To improve care coordination, many states have focused on enrolling
41 Medicaid patients in patient-centered medical homes that use a physician-led team approach to
42 coordinating and managing care for individuals. Consistent with value-based care, care
43 coordination and the use of patient-centered medical homes assist patients in getting the right care
44 at the right time in the appropriate setting. Many medical home programs have successfully
45 reduced hospitalizations and ED use including, for example, Community Care of North Carolina,
46 which was found to decrease ED visits among individuals enrolled compared to those not
47 enrolled.¹³ In the Medicare population, enrollees with patient-centered medical homes have also
48 been found to have slower growth in ED use than those not treated by medical homes.¹⁴

49
50 Additional mechanisms employed to help reduce non-emergency ED use include integrating
51 behavioral health care into primary care and expanding access to after-hours primary care, which

1 have been implemented by some health systems along with expanded telehealth availability. In the
2 Netherlands, linkages between primary care physician cooperatives and EDs have significantly
3 reduced ED use.¹⁵ Rural health clinics, community health centers, and federally qualified health
4 centers serving economically marginalized communities may also play a role in reducing non-
5 emergency ED visits by providing accessible and timely care that would otherwise not be available.
6 Research has shown that the availability of health centers lowers ED use, and that many centers
7 actively work with local hospitals to further reduce ED visits.¹⁶

8
9 Ensuring the availability of community mental health resources is also key to addressing ED use by
10 mental health and substance use disorder patients and enabling them to access treatment outside of
11 EDs. Crisis response services and same-day access to treatment in one's community have also been
12 cited as important mechanisms for reducing the use of EDs.¹⁷ Notably, some states, health plans,
13 hospitals and health systems pursue cost-savings opportunities by targeting high-need, high-cost
14 Medicaid patients who have the greatest number of ED visits. Case management/care management
15 interventions of varying designs are often employed to help meet these patients' complex physical,
16 behavioral, and social needs, thereby reducing their use of EDs. Extensivist clinics, employed by
17 some hospitals and health systems to coordinate and manage care for patients with multiple
18 complex health needs, have also been found to incur cost-savings by decreasing ED utilization and
19 hospitalizations.¹⁸ Consistent with Policy D-130.959, this report summarizes the literature on two
20 commonly used financial incentives—increased cost-sharing for non-emergency ED use and
21 retrospective payment denials for non-emergency diagnoses.

22 23 INCREASED PATIENT COST-SHARING FOR NON-EMERGENCY ED VISITS

24
25 Although federal law prohibits the imposition of cost-sharing for certain services in Medicaid,
26 including “emergency services,”¹⁹ the Deficit Reduction Act of 2005 (DRA) gave states the option
27 to impose cost-sharing for “non-emergency services.”²⁰ In 2013, CMS established through
28 rulemaking that a maximum eight dollars in cost-sharing for non-emergency use of the ED could
29 be imposed by states without an approved waiver.²¹ Accordingly, over the ensuing years, many
30 states have imposed limited cost-sharing amounts of eight dollars or less. Although the Kaiser
31 Family Foundation reported in 2020 that 21 states had mandated cost-sharing requirements for non-
32 emergency use of EDs,²² it is unclear how many states have waived those requirements for the
33 duration of the COVID-19 public health emergency. Notably, South Dakota's Medicaid program
34 informs enrollees that they will be responsible for paying the full cost of non-referred, non-
35 emergency ED services.²³

36
37 A handful of states have used Section 1115 demonstration waivers to establish cost-sharing
38 amounts exceeding the eight-dollar maximum, although most of these waivers—including those
39 from Kentucky and New Mexico—are no longer in effect. Under Georgia's current waiver, \$30
40 can be retroactively deducted from enrollees' Member Rewards Accounts—used to deduct and
41 deposit non-monetary dollar-value equivalent credits for healthy behavior activities—for non-
42 emergency use of EDs. Because enrollees are not charged with any out-of-pocket costs, the \$30
43 deduction in Georgia is considered an incentive but is not true cost-sharing.²⁴ Other states have
44 provided prepaid cards to cover cost-sharing expenses that may allow enrollees to keep remaining
45 amounts on the card at the end of the year; however, no analyses of such programs were located
46 during the development of this report.

Relevant Research

The landmark RAND Health Insurance Experiment, conducted between 1971 and 1982, is frequently cited as the benchmark study of cost-sharing and its effects on health care utilization, quality of care, and health. This experiment found that cost-sharing reduced utilization of almost all services, whether needed or not, and that the sickest and lowest-income people had better outcomes under free plans, suggesting that cost-sharing should not be applied to them.²⁵ Prior to enactment of the DRA, research had found that even minimal cost-sharing could lead Medicaid enrollees to use fewer health care services.²⁶

More recent studies of cost-sharing requirements for ED visits labeled non-emergency or nonurgent have produced mixed results. A study of state ED cost-sharing requirements in the five years following DRA enactment found no differences in ED use between states with and without those cost-sharing requirements, and no increases in the use of alternative outpatient settings.²⁷ A 2010 study of data in nine states that had imposed cost-sharing for non-emergency ED visits also suggested that cost-sharing requirements did not reduce these visits and were therefore not effective.²⁸ However, a 2015 analysis of nine years of data (from 2001 to 2009) concluded that ED visits by Medicaid enrollees in states with cost-sharing requirements were less likely to be nonurgent.²⁹

Positive and Negative Experiences

Cost-sharing requirements are intended to incentivize appropriate health care utilization while discouraging unnecessary or inappropriate care. The DRA policy allowing limited cost-sharing requirements intended to incentivize Medicaid enrollees to reduce their reliance on EDs for services that can be provided in alternate settings at reduced costs. Cost-sharing requirements have also been touted for encouraging personal responsibility and incentivizing patients to make better health care choices, which could benefit both patients and the Medicaid program overall.

However, increased cost-sharing in state Medicaid programs has been somewhat controversial because of the risks that imposing even limited cost-sharing amounts will dissuade economically marginalized enrollees from seeking ED care in emergency situations. Critics of these cost-sharing requirements maintain that most Medicaid enrollees use EDs for actual emergencies and, as discussed earlier in this report, a relatively small percentage of enrollees turn to EDs for non-emergency services that could be provided elsewhere. Accordingly, on their own, cost-sharing requirements may not incur much cost-savings and could lead some patients to avoid seeking or delay needed care.

An additional drawback of cost-sharing increases for non-emergency ED visits is that it can be challenging for hospitals to administer since, in many cases, it is frequently not possible to determine at triage whether services will be considered non-emergency and thus subject to cost-sharing. Moreover, hospitals may be hesitant to request that cost-sharing be paid upfront due to potentially violating the Emergency Medical Treatment and Labor Act (EMTALA), which requires individuals to be stabilized and treated, regardless of insurance status or ability to pay. Lastly, the administrative burden on hospitals of collecting cost-sharing amounts after care is provided may be higher than any savings incurred from the minimal cost-sharing that is collected.³⁰

RETROSPECTIVE PAYMENT DENIALS FOR NON-EMERGENCY ED SERVICES

Some states and insurers have attempted to rein in Medicaid costs by reducing or denying payment and coverage for ED services when the diagnosis is retrospectively determined to be non-

emergency. One state using a variation of this incentive is Indiana, where the Indiana Health Coverage Program (IHCP) will pay hospitals for emergency services only if a screening determines that the patient has an emergency condition. Although the IHCP does not deny payment for non-emergency services, a site-of-service payment reduction is applied to those services so that payment is based on office visit rates.³¹

In 2011, the Washington State Health Care Authority made headlines by announcing its intention to limit non-emergency ED visits to three per year and to deny payment to physicians and hospitals for services related to a lengthy list of diagnoses labeled non-emergent.³² Facing significant opposition from physicians and hospitals, this policy was nixed at the last minute and replaced by an alternative plan that arose from a partnership between the Washington State Medical Association, the Washington Chapter of the American College of Emergency Physicians, the Washington State Hospital Association, and the Health Care Authority. This multifaceted effort to reduce nonurgent ED visits coalesced around a series of best practices that saved nearly \$34 million in the program's first year, during which ED visits by Medicaid enrollees declined by 10 percent.³³ The following "ER is for Emergencies" best practices became integral to Washington State's efforts to reduce avoidable ED visits:

1. Adoption and use of an interoperable health information exchange;
2. Dissemination of materials intended to educate patients about appropriate care utilization and the difference between emergencies and non-emergencies;
3. Identification by hospitals of frequent ED users;
4. Development of care management plans for frequent ED users that incorporate information on social determinants of health;
5. Implementation of state guidelines for prescribing opioids;
6. Implementation of the state's prescription monitoring program; and
7. Engaging ED and care management staff to track ED utilization data and provide feedback.³⁴

While not specifically targeting Medicaid, large private insurers have periodically proposed coverage denials that limit payment for ED services retrospectively determined to have non-emergency ED discharge diagnoses. The AMA has advocated against such policies, as it did in 2017, when Anthem implemented policies in several states that denied coverage for many ED services and shifted the cost burden onto patients.³⁵

Relevant Research

Some studies have questioned the accuracy of retrospective payment denial policies for nonurgent ED services, which are based on claims data and assume there is a clear association between presenting symptoms and discharge diagnoses. The findings from the 2013 *JAMA* study, cited earlier in this report, cast doubt on this association and further suggest that policies that deny or limit payment based on diagnosis at discharge are not appropriate and may put some patients at risk of not getting emergency care that they need. According to the *JAMA* study:

Among ED visits with the same presenting complaint as those ultimately given a primary care-treatable diagnosis based on ED discharge diagnosis, a substantial proportion required immediate emergency care or hospital admission. The limited correspondence between presenting complaint and ED discharge diagnosis suggests that these discharge diagnoses are unable to accurately identify nonemergency ED visits.³⁶

1 Similar results were found in a 2018 study of a large private insurer's policy to deny coverage for
2 ED visits when the ED discharge diagnosis is determined to be nonurgent.³⁷ This analysis of ED
3 visits of privately insured patients between 2011 and 2015 found that nearly 40 percent of the more
4 than 15 percent of visits with non-emergency diagnoses were in fact urgent, as evidenced by the
5 fact that patients received emergency care. Furthermore, the presenting symptoms of patients in
6 nearly 90 percent of the ED visits were the same as symptoms of those patients with diagnoses
7 labeled nonemergent.³⁸

8 9 *Positive and Negative Experiences*

10
11 Although retrospective payment denials are likely to save money, they also violate important
12 patient protections and undercut the practice of emergency medicine. Federal law requires
13 insurance coverage of emergency services as defined using a prudent layperson standard that is
14 based on symptoms, not eventual diagnoses.³⁹ Retrospective payment denial policies run the risk of
15 violating the prudent layperson standard and also disregard patients' perceptions of their own
16 symptoms and whether they need emergency care. Patients make care decisions based on
17 symptoms and they should be neither encouraged to second guess their instincts that emergency
18 care is needed nor expected to self-diagnose to determine whether, for example, chest pain is a
19 heart attack or indigestion. Finally, the impact of policies that deny coverage and payment for
20 emergency services based on diagnoses risks leading Medicaid patients, who may be seriously ill,
21 to either not seek or delay seeking needed emergency medical care.

22 23 AMA POLICY

24
25 The AMA has long-standing policy supporting the prudent layperson standard (Policy H-130.970).
26 Accordingly, this policy states that emergency services should be defined as those services
27 provided in a hospital emergency facility after the sudden onset of a medical condition that
28 manifests itself by symptoms of sufficient severity, including severe pain, that the absence of
29 immediate medical attention could reasonably be expected by a prudent layperson, who possesses
30 an average knowledge of health and medicine, to result in: (1) placing the patient's health in
31 serious jeopardy; (2) serious impairment to bodily function; or (3) serious dysfunction of any
32 bodily organ or part. Policy H-130.970 also directs the AMA to work with state insurance
33 regulators, insurance companies and other stakeholders to take action to halt the implementation of
34 policies that violate the prudent layperson standard of determining when to seek emergency care.
35 Policy H-290.965 supports the use of ED best practices that are evidence-based to reduce avoidable
36 ED visits.

37
38 Policy H-290.982 supports modest copays or income-adjusted premiums in Medicaid for non-
39 emergent, non-preventive services. Policy H-165.855 states that children qualified for Medicaid
40 should have no cost-sharing obligations. Under Policy H-290.985, the AMA advocates that
41 enrollees in Medicaid managed care plans be educated about appropriate use of services, including
42 at the emergency department, and availability of off-hours, walk-in primary care. This policy also
43 maintains that Medicaid managed care plans should be responsive to cultural, language and
44 transportation barriers to access, and provide intensive case management for high utilizers and
45 realistic financial disincentives for beneficiary misuse of services.

46
47 Policy H-450.941 supports initiatives that protect patient access and that do not contain
48 requirements that permit third-party interference in the patient-physician relationship, and it
49 strongly opposes attempts to steer patients towards certain physicians primarily based on cost.
50 Policy H-450.938 states that physicians should encourage their patients to participate in making
51 value-based health care decisions, while Policy H-155.960 supports value-based decision-making

and broad strategies for addressing rising health care costs. Policy H-155.960 also encourages third-party payers to use targeted benefit design, whereby patient cost-sharing requirements are determined based on the clinical value of a health care service or treatment, and tailoring cost-sharing requirements to patient income and other factors known to impact compliance. Policy H-185.939 supports value-based insurance design (VBID), consistent with several principles including that coverage and cost-sharing policies must be transparent and that VBID should not restrict access to care. Policy D-185.979 encourages national medical specialty societies to collaborate with payers to promote alignment of patient financial incentives with utilization of high-value services.

Under Policies H-385.921 and H-290.976, the AMA advocates for reasonable physician payments within Medicaid/CHIP, defined as a minimum of 100 percent of Medicare rates. Policy H-400.957 encourages CMS to expand the extent and amount of payment for procedures performed in the physician's office, to shift more procedures from the hospital to the office setting, which is more cost effective. Policy D-240.994 advocates that third-party payers be required to assess equal or lower facility cost-sharing for lower-cost sites of service.

The AMA has adopted principles for patient-centered medical homes, including that each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care (Policy H-160.919). These principles also maintain that enhanced access to care is available through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician, and practice staff. ED boarding and overcrowding are addressed by Policies H-130.940 and H-130.945. The latter policy encourages hospitals to use appropriate criteria to triage patients so those with simpler medical needs can be redirected to other appropriate ambulatory facilities. EMTALA is addressed by Policy D-130.982.

Policy H-165.822 (1) encourages new and continued partnerships to address non-medical, yet critical health needs and the underlying social determinants of health; (2) supports continued efforts by public and private health plans to address social determinants of health in health insurance benefit designs; and (3) encourages public and private health plans to examine implicit bias and the role of racism and social determinants of health. Policy H-185.920 supports continuity of care principles for financial incentive programs, including that these programs never interfere with a patient-physician relationship, and that only treating physicians can determine whether a lower-cost care option is medically appropriate. This policy also supports objective studies of the impacts of financial incentive programs.

Policy H-373.994 recognizes the increasing use of patient navigator and patient advocacy services to help improve access to care and help patients manage complex aspects of the health care system. Policy H-290.995 supports primary care case management programs for Medicaid enrollees: on a voluntary basis with incentives provided toward a prudent choice of care source; and on a mandatory basis only for those identified as overutilizers or mis-utilizers of services; and comparative analyses of these programs to determine their relative effectiveness regarding patient access, quality of and satisfaction with care, and cost reduction.

DISCUSSION

Policies aimed at reducing ED use for services that could be provided elsewhere, and at lower cost, have been debated for decades and are worthy of continued monitoring and testing. Since many states incorporate such policies into Section 1115 demonstration waivers and state Medicaid plan amendments, the Council recommends support for continued monitoring and pilot testing, by CMS and other stakeholders, of strategies and best practices for reducing non-emergency ED use among

Medicaid/CHIP enrollees, particularly among patients with the highest number of ED visits. The Council believes that ongoing study of state approaches to reducing ED use, and dissemination of study results, will greatly benefit state Medicaid programs as they strive to manage health care costs without compromising care quality.

State Medicaid programs, hospitals and health systems have employed a variety of strategies to reduce non-emergency ED use, and the Council supports state flexibility in this regard since best practices will depend in part on the health needs of a state's Medicaid population. Recognizing the abundance of AMA policy that is relevant to this topic, the Council recommends support for state efforts to encourage appropriate ED use among Medicaid/CHIP enrollees that are consistent with the standards and safeguards outlined in AMA policy on ED services.

The Council understands that a complex mix of factors influences ED use and that the share of visits that are non-emergency, while difficult to discern, is relatively low. We also recognize that modest cost-sharing for non-emergency ED visits for adult Medicaid enrollees, but not for children, is consistent with AMA policy (Policies H-290.982 and H-165.855) and may incentivize some patients to make better health care choices. Although we do not recommend changes to existing policy, we conclude from the literature that modest cost-sharing requirements, on their own, may not be very effective at either reducing nonurgent ED services or generating significant cost-savings. We further question whether the cost of administering nominal cost-sharing requirements may, in some cases, be higher than any savings they generate.

Although diagnosis-based payment and coverage denials for non-emergency ED services may effectively contain costs, the Council affirms that these policies risk violating important patient protections and may potentially harm some patients—by dissuading them from seeking emergency care when needed—as well as physicians and hospitals, when payment is denied. Accordingly, the Council recommends reaffirming Policy H-130.970, which supports the prudent layperson standard for determining the need for emergency services and directs the AMA to work with state insurance regulators, insurers, and other stakeholders to halt the implementation of policies that violate this standard.

The Council believes that most Medicaid enrollees turn to EDs when they do not have access to primary care or needed specialty care—including mental health and substance use disorder treatment—and when few or no other care options are available. We further believe that strategies may be more effective if they specifically target individuals with the highest numbers of ED visits, generally a small percentage of enrollees who account for a disproportionately high amount of ED utilization. Facilitating these patients' treatment for non-emergency services in alternate settings and linking them with primary care, mental health care, and other needed services, are more likely to significantly reduce ED use and incur some cost-savings. The Council emphasizes that strategies targeting frequent ED users should be comprehensive and multifaceted, addressing not only physical and mental health needs but also socioeconomic factors that could contribute to higher rates of ED utilization. Such strategies should strive to ensure access to primary, preventive and behavioral health care, as well as substance use disorder treatment, outside of EDs through the availability of community providers and resources.

Before the COVID-19 pandemic, available state Medicaid data showed that more than 60 percent of enrollees identified as Black, Latino/a, or other individuals of color, with studies finding that enrollees of color experienced poorer outcomes and more barriers to care than whites.⁴⁰ Accordingly, state Medicaid programs should consider the potential health equity implications of strategies to reduce ED visits and address SDOH. Consistent with numerous AMA site-of-service policies (i.e., Policies H-400.957 and D-240.994), state Medicaid program strategies should

focus—through patient education and empowerment, 24/7 telephone triage, and telehealth availability, among other efforts—on ensuring that all patients receive health care services in the outpatient setting most appropriate to their symptoms and needs. Accordingly, the Council recommends reaffirmation of Policy H-290.985, which advocates that a long list of criteria be used to monitor and oversee Medicaid managed care plans, including that enrollees are educated about appropriate use of services, including ED services; plans are responsive to cultural, language and transportation barriers to access; off-hours, walk-in primary care is available; there is geographic dispersion and accessibility of participating physicians and other providers; intensive case management is provided to high utilizers; and payment levels are realistic and based on costs of care and predicted utilization levels.

Because increases in Medicaid payment rates have been found to increase enrollee access to care, the Council recommends reaffirming Policy H-290.976, which affirms the AMA’s commitment to advocating that Medicaid should pay physicians at minimum 100 percent of Medicare rates. Finally, the Council recommends rescinding Policy D-130.959, which called for the development of this report.

RECOMMENDATIONS

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

1. That our American Medical Association (AMA) support continued monitoring, by the Centers for Medicare & Medicaid Services and other stakeholders, of strategies and best practices for reducing non-emergency emergency department (ED) use among Medicaid/Children’s Health Insurance Program (CHIP) enrollees, including frequent ED users. (New HOD Policy)
2. That our AMA support state efforts to encourage appropriate emergency department (ED) use among Medicaid/CHIP enrollees that are consistent with the standards and safeguards outlined in AMA policy on ED services. (New HOD Policy)
3. That our AMA reaffirm Policy H-130.970, which supports the prudent layperson standard and directs the AMA to work with state insurance regulators, insurers, and other stakeholders to halt the implementation of policies that violate the prudent layperson standard of determining when to seek emergency care. (Reaffirm HOD Policy)
4. That our AMA reaffirm Policy H-290.985, which advocates that numerous criteria be used in Medicaid managed care monitoring and oversight, including that enrollees are educated about appropriate use of services, including ED services; plans are responsive to cultural, language and transportation barriers to access; off-hours, walk-in primary care is available; and intensive case management is provided to high utilizers. (Reaffirm HOD Policy)
5. That our AMA reaffirm Policy H-290.976, which affirms the AMA’s commitment to advocating that Medicaid should pay physicians at minimum 100 percent of Medicare rates. (Reaffirm HOD Policy)
6. That our AMA rescind Policy D-130.959, which called for the development of this report. (Rescind HOD Policy)

Fiscal Note: Less than \$500.

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Appendix

AMA Policies Recommended for Reaffirmation

Policy H-130.970, “Access to Emergency Services”

1. Our AMA supports the following principles regarding access to emergency services; and these principles will form the basis for continued AMA legislative and private sector advocacy efforts to assure appropriate patient access to emergency services:

(A) Emergency services should be defined as those health care services that are provided in a hospital emergency facility after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson, who possesses an average knowledge of health and medicine, to result in: (1) placing the patient's health in serious jeopardy; (2) serious impairment to bodily function; or (3) serious dysfunction of any bodily organ or part.

(B) All physicians and health care facilities have an ethical obligation and moral responsibility to provide needed emergency services to all patients, regardless of their ability to pay. (Reaffirmed by CMS Rep. 1, I-96)

(C) All health plans should be prohibited from requiring prior authorization for emergency services.

(D) Health plans may require patients, when able, to notify the plan or primary physician at the time of presentation for emergency services, as long as such notification does not delay the initiation of appropriate assessment and medical treatment.

(E) All health payers should be required to cover emergency services provided by physicians and hospitals to plan enrollees, as required under Section 1867 of the Social Security Act (i.e., medical screening examination and further examination and treatment needed to stabilize an “emergency medical condition” as defined in the Act) without regard to prior authorization or the emergency care physician's contractual relationship with the payer.

(F) Failure to obtain prior authorization for emergency services should never constitute a basis for denial of payment by any health plan or third-party payer whether it is retrospectively determined that an emergency existed or not.

(G) States should be encouraged to enact legislation holding health plans and third-party payers liable for patient harm resulting from unreasonable application of prior authorization requirements or any restrictions on the provision of emergency services.

(H) Health plans should educate enrollees regarding the appropriate use of emergency facilities and the availability of community-wide 911 and other emergency access systems that can be utilized when for any reason plan resources are not readily available.

(I) In instances in which no private or public third-party coverage is applicable, the individual who seeks emergency services is responsible for payment for such services.

2. Our AMA will work with state insurance regulators, insurance companies and other stakeholders to immediately take action to halt the implementation of policies that violate the “prudent layperson” standard of determining when to seek emergency care. (CMS Rep. A, A-89; Modified by CMS Rep. 6, I-95; Reaffirmation A-97; Reaffirmed by Sub. Res. 707, A-98; Reaffirmed: Res. 705, A-99; Reaffirmed: CMS Rep. 3, I-99; Reaffirmation A-00; Reaffirmed: Sub. Res. 706, I-00; Amended: Res. 229, A-01; Reaffirmation and Reaffirmed: Res. 708, A-02; Reaffirmed: CMS Rep. 4, A-12; Reaffirmed: CMS Rep. 07, A-16; Appended: Res. 128, A-17; Reaffirmation: A-18; Reaffirmed in lieu of: Res. 807, I-18)

Policy H-290.985, “Monitoring Medicaid Managed Care”

As managed care plans increasingly become the source of care for Medicaid beneficiaries, the AMA advocates the same policies for the conduct of Medicaid managed care that the AMA advocates for private sector managed care plans. In addition, the AMA advocates that the following criteria be used in federal and/or state oversight and evaluation of managed care plans serving

Medicaid beneficiaries, and insists upon their use by the Federation in monitoring the implementation of managed care for Medicaid beneficiaries:

- (1) Adequate and timely public disclosure of pending implementation of managed care under a state program, so as to allow meaningful public comment.
- (2) Phased implementation to ensure availability of an adequate, sufficiently capitalized managed care infrastructure and an orderly transition for beneficiaries and providers.
- (3) Geographic dispersion and accessibility of participating physicians and other providers.
- (4) Education of beneficiaries regarding appropriate use of services, including the emergency department.
- (5) Availability of off-hours, walk-in primary care.
- (6) Coverage for clinically effective preventive services.
- (7) Responsiveness to cultural, language and transportation barriers to access.
- (8) In programs where more than one plan is available, beneficiary freedom to choose his/her plan, enforcement of standards for marketing/enrollment practices, and clear and comparable disclosure of plan benefits and limitations including financial incentives on providers.
- (9) Beneficiary freedom to choose and retain a given primary physician within the plan, and to request a change in physicians when dissatisfied.
- (10) Significant participating physician involvement and influence in plan medical policies, including development and conduct of quality assurance, credentialing and utilization review programs.
- (11) Ability of plan participating physicians to determine how many beneficiaries and the type of medical problems they will care for under the program.
- (12) Adequate identification of plan beneficiaries and plan treatment restrictions to out-of-plan physicians and other providers.
- (13) Intensive case management for high utilizers and realistic financial disincentives for beneficiary misuse of services.
- (14) Treatment authorization requirements and referral protocols that promote continuity rather than fragment the process of care.
- (15) Preservation of private right of action for physicians and other providers and beneficiaries.
- (16) Ongoing evaluation and public reporting of patient outcomes, patient satisfaction and service utilization.
- (17) Full disclosure of plan physician and other provider selection criteria, and concerted efforts to qualify and enroll traditional community physicians and other existing providers in the plan.
- (18) Absence of gag rules.
- (19) Fairness in procedures for selection and deselection.
- (20) Realistic payment levels based on costs of care and predicted utilization levels.
- (21) Payment arrangements that do not expose practitioners to excessive financial risk for their own or referral services, and that tie any financial incentives to performance of the physician group over significant time periods rather than to individual treatment decisions.
- (22) Our AMA urges CMS to direct those state Medicaid agencies with Medicaid managed care programs to disseminate data and other relevant information to the state medical associations in their respective states on a timely and regular basis. (CMS Rep. 5 A-96; Reaffirmed and Appended: Sub. Res. 704, I-97; Reaffirmation A-00; Reaffirmation I-04; Reaffirmed: CMS Rep. 1, A-14)

Policy H-290.976, “Enhanced SCHIP Enrollment, Outreach, and Reimbursement”

1. It is the policy of our AMA that prior to or concomitant with states’ expansion of State Children’s Health Insurance Programs (SCHIP) to adult coverage, our AMA urge all states to maximize their efforts at outreach and enrollment of SCHIP eligible children, using all available state and federal funds.

2. Our AMA affirms its commitment to advocating for reasonable SCHIP and Medicaid reimbursement for its medical providers, defined as at minimum 100 percent of RBRVS Medicare allowable. (Res. 103, I-01; Reaffirmation A-07; Reaffirmation A-11; Reaffirmed: CMS Rep. 7, I-14; Reaffirmation A-15; Reaffirmed: CMS Rep. 3, A-15; Reaffirmation: A-17; Reaffirmed: CMS Rep. 02, A-19; Reaffirmed: CMS Rep. 5, I-20; Reaffirmed: CMS Rep. 9, A-21; Reaffirmed: CMS Rep. 3, I-21)

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 2-I-22

Subject: Corporate Practice of Medicine
(Resolution 721-A-22)

Presented by: Lynn Jeffers, MD, MBA, Chair

Referred to: Reference Committee J

At the 2022 Annual Meeting, the House of Delegates referred Resolution 721, “Amend Policy H-215.981, ‘Corporate Practice of Medicine’,” which was sponsored by the Resident and Fellow Section. Resolution 721-A-22 asked the American Medical Association (AMA) to “amend AMA Policy H-215.981, ‘Corporate Practice of Medicine,’ by addition of a fourth clause that reads: ‘4. Our AMA acknowledges that the corporate practice of medicine has led to the erosion of the physician-patient relationship, erosion of physician-driven care and created a conflict of interest between profit and training the next generation of physicians.’”

The referral of Resolution 721-A-22 included specific concern that the study should include the impact of the corporate practice of medicine on all practice types. The Board of Trustees assigned this item to the Council on Medical Service for a report back to the House of Delegates. The Council notes that a related report is being presented by the Council on Medical Education at this meeting (CME Report 1-I-22 “The Impact of Private Equity on Medical Training”). The Council recognizes that private equity and corporate investors are becoming increasingly involved in graduate medical education, residencies, fellowships, and training of non-physician practitioner. We have chosen to focus this report on the general aspects of the corporate practice of medicine.

BACKGROUND

The Council recently prepared CMS Report 11 at the 2019 Annual Meeting which addressed a similar topic. The corporate practice of medicine is broadly defined as non-physician investment in medical practices. Two examples of corporate medicine include private equity investment funds and physician management groups. Private equity funds are pooled investments used to buy controlling shares of companies or other entities. After taking control, private equity funds typically streamline the business (which often includes cutting costs and reducing the ability for prior physician owners to make governance decisions) with the goal of selling the business for a profit in three to seven years. The types of investment range from venture capital (VC) firms that primarily invest in early-stage companies in exchange for minority ownership to more traditional private equity firms that borrow money to take a controlling stake in mature yet undervalued or underperforming companies through leveraged buyout deals.¹ Alternatively, a practice management company is a privately held or publicly traded for-profit company that manages the back-end administrative functions of medical practices, such as insurance contracting and billing. Many practice management companies, often referred to as staffing companies, also contract with hospitals and ambulatory surgical centers to provide professional staffing and management services. Investments in practice management companies by private equity funds have led to an increase in their utilization.²

1 While the extent of corporate investment in physician practices is not precisely known, a growing
2 number of physicians are employed by corporations including hospitals, health systems, and
3 insurers. Concerns regarding these partnerships have primarily centered on the potential for
4 subsequent increases in prices, service volume, and internal referrals, as well as the use of
5 unsupervised non-physician practitioners. An array of factors has led to these changes, including
6 changes in payment and delivery models, physician payment challenges, high costs of new
7 technology and equipment, and increased administrative and regulatory burdens.

8
9 In addition to employment by hospitals, health systems, and insurers, private equity firms and
10 publicly traded for-profit corporations may invest in physician practices. Increasingly, private
11 equity firms have acquired majority and/or controlling interests in entities that manage physician
12 practices. However, there is little peer-reviewed evidence regarding the impact of these
13 arrangements on physicians, patients or health care prices, and physician opinions vary. Hospitals,
14 health systems, academic medical centers, large multispecialty groups, and corporate buyers
15 frequently compete with private equity investors for the same physician practice targets. Corporate
16 buyers may also partner with private equity investors or form consortia of buyers to acquire highly
17 sought-after practices. Increased competition for physician groups in some specialties has led price
18 valuations of these practices to rise. Because many private equity transactions are not disclosed
19 (non-disclosure agreements are commonly used), the degree of investment in physician practices,
20 while believed to be relatively small overall, cannot be precisely determined. Incomplete data on
21 corporate transactions involving physician practices is a significant impediment to determining the
22 impact of corporate investors on physicians, patients, and the health care marketplace.³

23 24 *State-by-State Differences*

25
26 Generally, corporate practice of medicine doctrines prohibit corporations from practicing or
27 interfering with the practice of medicine. The doctrines arise from state medical practice acts and
28 are based on a number of public policy concerns, such as: (1) allowing corporations to practice
29 medicine will result in the commercialization of the practice of medicine; (2) a corporation's
30 obligation to its shareholders may not align with a physician's obligation to their patients; and
31 (3) corporate interests may interfere with the physician's independent medical judgment.⁴ It is
32 important to note that while most states have a prohibition on the corporate practice of medicine,
33 every state provides an exception for professional corporations and many states provide an
34 exception for employment of physicians by certain entities. For example, some states explicitly
35 permit hospitals to employ physicians, some states allow nonprofit hospitals to employ physicians,
36 and other states recognize an unwritten exception to the corporate practice of medicine for
37 hospitals employing physicians.⁵ Many states that allow hospitals to employ physicians specifically
38 prohibit the hospital from interfering with the independent medical judgment of the physician,
39 thereby protecting the autonomy of the physician's clinical decision-making.⁶ For example, in
40 California and Indiana, clinics and hospitals may employ physicians as long as the entity does not
41 direct or control independent medical acts, decisions or judgments of the licensed physician. On the
42 other hand, in Colorado and Arkansas, all shareholders and officers of a medical corporation must
43 be licensed physicians, consistent with each state's licensing laws. In Texas, state laws allow
44 critical access hospitals, sole community hospitals, and hospitals in counties with fewer than
45 50,000 people to employ physicians, with the requirement that physicians must "retain independent
46 medical judgment in providing care to patients at the hospital or other health care facilities owned
47 or operated by the hospital and may not be disciplined for reasonably advocating for patient care."⁷

48
49 Recently, there have been complaints filed in state courts arguing that some of these firms have
50 overstepped and are in violation of state corporate practice of medicine doctrines. One example of
51 this is a lawsuit filed in California by the American Academy of Emergency Medicine Physician

Group (AAEM-PG) against Envision Healthcare Corporation. In its filing, AAEM-PG alleges that Envision is in violation of the state’s corporate practice of medicine doctrine, as Envision either forms new medical groups with non-physician officers or “installs Envision executives or officers in pre-existing medical groups.” Specifically, the lawsuit alleges that Envision: “decides how many and which physicians to hire, their compensation and work schedule...controls and influences advertising for physician vacancies, vetting physicians, establishing the terms of employment, the physician’s rate of pay, scheduling the hours physicians will work, staffing levels, the number of patient encounters and working conditions...when to terminate physicians and denies them rights to appeal via traditional medical staffing mechanisms...negotiates the groups’ contracts with third-party payers and health insurers and decides whether the group will agree to the terms...physicians are not made aware of the terms of their contracts with third-party payers.” The lawsuit was originally filed in December 2021. In May 2022, a judge for the United States District Court for the Northern District of California denied Envision Healthcare’s motion to dismiss the case; therefore, the case remains ongoing. The American College of Emergency Physicians and the California Medical Association have both filed amicus briefs in support of AAEM-PG.⁸ Further details and copies of court documents can be found on <https://www.aem.org/envision-lawsuit>.

As previously stated, there is limited data on the extent of physician practice acquisition by private equity firms; however, private equity acquisition of physician practices increased from 59 deals in 2013 to 136 deals in 2016.⁹ In April 2022, *JAMA Health Forum* published data on the geographic variations in private equity penetration of physician practices (defined as the share of physicians in private equity-acquired practices) across six specialties: dermatology, gastroenterology, ophthalmology, obstetrics/gynecology, orthopaedics, and urology. Private equity penetration was highest in the Northeast (6.8 percent) and lowest in the Midwest (3.8 percent). Twelve states and the District of Columbia (DC) have an above average share of physicians in private equity practices, while eleven states have no identified acquisitions. States with the highest private equity penetration are Washington, DC (18.2 percent), Arizona (17.5 percent), New Jersey (13.6 percent), Maryland (13.1 percent), Connecticut (12.6 percent), and Florida (10.8 percent). By specialty, private equity penetration was highest in dermatology, followed by gastroenterology, ophthalmology, obstetrics/gynecology, and orthopaedics.¹⁰

Risks and Benefits

As with any practice type, there are risks and benefits associated with entering into corporate partnerships. Risks include loss of control over the physician practice and future revenues, loss of autonomy in decision-making, an emphasis on profit or meeting financial goals, potential conflicts of interest, and potential uncertainties for non-owner early and mid-career physicians. Additionally, after a buyout there could be added layers of bureaucracy that could add burdens to physicians. Examples could be new checks and balances or updated workflows. Benefits include financially lucrative deals for physicians looking to exit ownership of their practices, access to capital for practice expenses or expansions (which may relieve physicians’ financial pressures), potentially fewer administrative and regulatory burdens on prior practice owners, and centralized resources for certain functions such as IT, marketing, and human resources.

There can also be risks to patients when physicians enter into these agreements. Recent evidence has shown a 10 percent increase in short-term mortality in private equity-owned nursing homes compared to non-private equity owned nursing homes. This is possibly due to decreases in nursing staff and declines in compliance with federal and state standards of care.¹¹ Another study evaluating private equity acquisitions of US hospitals demonstrated increased charges, increased net income, and increased patient risk scores, along with fewer Medicaid patients admitted, after private equity acquisition relative to control groups.¹² A third study showed that private

equity-owned dermatology practices were associated with 3 percent-5 percent higher prices for routine medical visits at 1.5 years after acquisition as compared with non-private equity-owned practices. Other studies have shown increased rates of surprise billing, overutilization of high-margin or low-value services, and pressure to up-code charges after private equity acquisition.¹³

Impact on Patient-Physician Relationship

Research is ongoing about the effects of corporate medicine investment on patient outcomes and cost-savings. A study of 176 hospitals acquired by private equity firms during 2005-2014 was conducted to compare financial performance to matched control hospitals.¹⁴ Private equity acquisition of short-term acute care hospitals was associated with decreased costs per discharge and increased margins. The study highlights early findings on the impact private equity investment has on the health care system. Preliminary data show that financial performance improved after acquisition; however, patient utilization of services increased, and staffing decreased. Importantly, the study found that the decline in total costs per discharge was not adjusted for total full time hospital personnel, which suggests that hospitals cut costs in other dimensions, not only labor, after private equity acquisition. The authors of the study note that although improved financial performance occurred broadly, the findings are not evidence that gains in efficacy translate to improved patient outcomes or clinical experiences in either the short or long term.¹⁵

Under private equity investment, maintaining physician autonomy and a physician-led care team is crucial. Physicians should retain complete control of clinical decision making, as well as decisions regarding who is a member of their care team. Care provided by non-physician practitioners has been shown to be more costly than care provided by a physician-led team. An example of this is at the Hattiesburg Clinic in Mississippi. An examination of cost data for the South Mississippi system's accountable care organization (ACO) revealed that care provided by non-physician practitioners working on their own patient panels was more expensive than care delivered by physicians. The 2017-2019 Centers for Medicare & Medicaid Services (CMS) cost data on Medicare patients without end-stage renal disease and who were not in a nursing home showed that per-member, per-month spending was \$43 higher for patients whose primary health professional was a nonphysician instead of a physician. This finding could translate to \$10.3 million more in spending annually if all patients were followed by non-physician practitioners. Citing the results of the clinic's study, researchers found that "the results are consistent and clear: By allowing advanced practice providers to function with independent panels under physician supervision, we failed to meet our goals in the primary care setting of providing patients with an equivalent value-based experience." These findings underscore the importance of physician-led care teams, regardless of business model or private equity investment, both to control costs and improve patient outcomes.¹⁶

AMA POLICY

Long-standing AMA policy states that physicians are free to choose their mode of practice and enter into contractual agreements as they see fit.

Policy H-215.981 opposes federal legislation preempting state laws prohibiting the corporate practice of medicine; states that the AMA will continue monitoring the corporate practice of medicine and its effect on the patient-physician relationship, financial conflicts of interest, and patient-centered care; and directs the AMA to provide guidance, consultation, and model legislation regarding the corporate practice of medicine, at the request of state medical associations, to ensure the autonomy of hospital medical staffs, employed physicians in non-hospital settings, and physicians contracting with corporately-owned management service organizations.

Policy H-285.951 states that physicians should have the right to enter into whatever contractual arrangements they deem desirable and necessary but should be aware of potential conflicts of interest due to the use of financial incentives in the management of care.

Policy H-215.968 supports and encourages competition between and among health facilities as a means of promoting the delivery of high-quality, cost-effective care.

Policy H-225.947 encourages physicians who seek employment as their mode of practice to strive for employment arrangements consistent with a series of principles, including: (a) physician clinical autonomy is preserved; (b) physicians are included and actively involved in integrated leadership opportunities; (c) physicians are encouraged and guaranteed the ability to organize under a formal self-governance and management structure; (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 efficiency performance data for all participants accountability across the system to those measures.

Policy H-160.960 states that when a private medical practice is purchased by corporate entities, patients shall be informed of the ownership arrangement by the corporate entities and/or physicians. Policy H-160.891 lists guidelines for physicians to consider when they are contemplating corporate investor partnerships. These guidelines include: (a) how the practice's current mission, vision, and long-term goals align with those of the corporate investor; (b) due diligence should be conducted that includes, at minimum, review of the corporate investor's business model, strategic plan, leadership and governance, and culture; (c) external legal, accounting and/or business counsels should be obtained to advise during the exploration and negotiation of corporate investor transactions; (d) retaining negotiators to advocate for best interests of the practice and its employees should be considered; (e) whether and how corporate investor partnerships may require physicians to cede varying degrees of control over practice decision-making and day-to-day management; (f) the potential impact of corporate investor partnerships on physician and practice employee satisfaction and future physician recruitment; (g) a clear understanding of compensation agreements, mechanisms for conflict resolution, processes for exiting corporate investor partnerships, and application of restrictive covenants; (h) corporate investor processes for medical staff representation on the board of directors and medical staff leadership selection; and (i) retain responsibility for clinical governance, patient welfare and outcomes, physician clinical autonomy, and physician due process under corporate investor partnerships. Additionally, Policy H-160.891 states that the AMA supports improved transparency regarding corporate investment in physician practices and subsequent changes in health care prices; encourages national medical specialty societies to research and develop tools and resources on the impact of corporate investor partnerships on patients and the physicians practicing in that specialty; and supports consideration of options for gathering information on the impact of private equity and corporate investors on the practice of medicine.

DISCUSSION

The Council recognizes that private equity investment and the corporate practice of medicine are continuing to change the health care landscape. This report describes various investment opportunities and their impact on medical practice. Anecdotally, there have been challenges associated with the corporate practice of medicine and evidence that some investment firms have overstepped and could be in violation of state corporate practice of medicine doctrines. It is clear

1 that in order to control spending and provide optimal care for patients, care teams should be
2 physician-led.

3
4 The AMA has long-standing policy that supports a physician's right to choose their mode of
5 practice and type of employment, and we acknowledge that investor partnerships can be lucrative
6 and successful. The AMA has published several resources and ethical opinions to guide physicians
7 as they make the choice that is best for them.

8
9 The Council recommends new policy to address the concerns outlined in this report, including the
10 potential to erode the patient-physician relationship and create conflicts of interest in medical
11 education. In addition, the Council recognizes that the nature of corporate investor relationships
12 could potentially change in the future and recommends amending Policy H-160.891 regarding
13 corporate investors to strengthen the physician's role in clinical decision-making, medical
14 education, and determining the composition of the care team.

15 16 RECOMMENDATIONS

17
18 The Council on Medical Service recommends that the following be adopted in lieu of Resolution
19 721-A-22, and the remainder of the report be filed:

- 20
21 1. That our American Medical Association (AMA) acknowledge that the corporate practice of
22 medicine has the potential to erode the patient-physician relationship. (New HOD Policy)
23
24 2. That our AMA acknowledge that the corporate practice of medicine may create a conflict of
25 interest between profit and best practices in residency and fellowship training. (New HOD
26 Policy)
27
28 3. That our AMA amend Policy H-160.891 by addition of two new clauses, as follows:
29 j. Each individual physician should have the ultimate decision for medical judgment in patient
30 care and medical care processes, including the use of mandated patient care algorithms or
31 supervision of non-physician practitioners.
32 k. Physicians should retain primary and final responsibility for structured medical education
33 inclusive of undergraduate and graduate medical education including the structure of the
34 program, program curriculum, selection of faculty and trainees, as well as educational and
35 disciplinary issues related to these programs. (Modify Current HOD Policy)

Fiscal Note: Less than \$500.

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- ² La Forgia, A. “Association of Physician Management Companies and Private Equity Investment with Commercial Health Care Prices Paid to Anesthesia Practitioners.” *Journal of the American Medical Association – Internal Medicine*. February 28, 2022. Available at: <https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2789280>
- ³ Issue Brief: Corporate Investors. American Medical Association. 2019. Available at: <https://www.ama-assn.org/system/files/2019-12/issue-brief-corporate-investors.pdf>
- ⁴ Issue Brief: Corporate Practice of Medicine. AMA Advocacy Resource Center. American Medical Association. 2015.
- ⁵ *Ibid.*
- ⁶ *Ibid.*
- ⁷ *Ibid.*
- ⁸ American Academy of Emergency Medicine Physician Group vs. Envision Healthcare Corporation. Case No. 22-cv-00421-CRB. <https://www.aaem.org/envision-lawsuit>
- ⁹ DeCamp, M. “Ethical and Professionalism Implications of Physician Employment and Health Care Business Practices: A Policy Paper from the American College of Physicians.” *Annals of Internal Medicine*. March 2021. Available at: <https://www.acpjournals.org/doi/full/10.7326/M20-7093>
- ¹⁰ Singh, Y. “Geographic Variation in Private Equity Penetration Across Select Office-Based Physician Specialties in the US.” *JAMA Health Forum*. April 2022. Available at: <https://jamanetwork.com/journals/jama-health-forum/fullarticle/2791722>
- ¹¹ Ikram, *Supra* note 1.
- ¹² Ikram, *Supra* note 1.
- ¹³ Ikram, *Supra* note 1.
- ¹⁴ Cerullo, M. “Financial Impacts and Operational Implications of Private Equity Acquisition of US Hospitals.” *Health Affairs*. April 2022. Available at: <https://www.healthaffairs.org/doi/10.1377/hlthaff.2021.01284>
- ¹⁵ *Ibid.*
- ¹⁶ Robeznieks, A. “Amid doctor shortage, NPs and Pas seemed like a fix. Data’s in: Nope.” AMA News Story. March 17, 2022. Available at: <https://www.ama-assn.org/practice-management/scope-practice/amid-doctor-shortage-nps-and-pas-seemed-fix-data-s-nope>

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 801
(I-22)

Introduced by: Young Physicians Section

Subject: Parity in Military Reproductive Health Insurance Coverage for All Service Members and Veterans

Referred to: Reference Committee J

1 Whereas, The World Health Organization (WHO) defines infertility as “the failure to achieve a
2 pregnancy after 12 months or more of regular unprotected sexual intercourse;”¹ and
3

4 Whereas, Our AMA also recognizes infertility as a disease (AMA policy H-420.952);² and
5

6 Whereas, In an Ethics Committee Opinion, the American Society for Reproductive Medicine
7 (ASRM) states that “individuals and couples should have access to fertility services irrespective
8 of marital status, sexual orientation, or gender identity;”³ and
9

10 Whereas, This ASRM Ethics Committee Opinion also states that “results of research suggested
11 that the development, adjustment, and well-being of children are not markedly impacted by the
12 marital status, sexual orientation, or gender identity of the parents;”³ and
13

14 Whereas, This ASRM Ethics Committee Opinion also states that “programs should treat all
15 requests for assisted reproduction equally without regard to marital status, sexual orientation, or
16 gender identity;”³ and
17

18 Whereas, “Compared to the general population, military families face unique challenges that
19 can complicate family building and planning;”⁴ and
20

21 Whereas, “During military service, active duty service members may experience exposures to
22 potential chemical, physical, and environmental hazards such as jet fuel, burn pits, spent
23 uranium, nuclear power plants, and exposures associated with submarines and aviation, all of
24 which may be linked to negative effects on reproductive health;”⁴ and
25

26 Whereas, “Exposure to endocrine-disrupting chemical agents including lead, mercury, or certain
27 pesticides is shown to result in altered semen quality and sterility in men as well as menstrual
28 cycle interference in women;”⁴ and
29

30 Whereas, “Several studies demonstrate an association between military service and Post
31 Traumatic Stress Disorder, depression, toxic exposures, and their negative impact on fertility;”⁴
32 and
33

34 Whereas, “The Department of Defense (DOD) does not provide coverage for infertility services
35 for most with military insurance, including artificial (intrauterine) inseminations, costs related to
36 sperm or oocyte donation...;”⁴ and

Whereas, For veterans, Veterans Health Administration Directive 1334 (12 February 2018) specifically excludes fertility coverage for single women or same-sex couples that would otherwise be covered;^{4,5} and

Whereas, For active duty servicemembers, the Department of Defense (DoD) Policy for Assisted Reproductive Services for the Benefit of Seriously or Severely Ill/Injured (Category II or III) Active Duty Service Members (ADSMs) specifically states that “Third party donations and surrogacy are not covered benefits;”⁶ and

Whereas, Our AMA also “supports: (1) insurance coverage for fertility treatments regardless of marital status or sexual orientation when insurance provides coverage for fertility treatments; and (2) local and state efforts to promote reproductive health insurance coverage regardless of marital status or sexual orientation when insurance provides coverage for fertility treatments (AMA policy H-185.926);”⁷ therefore be it

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

Fiscal Note: Minimal - less than \$1,000

Received: 08/19/22

References:

1. “Infertility is a global public health issue” on the website of the World Health Organization, at <https://www.who.int/news-room/fact-sheets/detail/infertility>, accessed 30 April 2022.
2. AMA policy H-420.952 Recognition of Infertility as a Disease, at <https://policysearch.ama-assn.org/policyfinder/detail/infertility?uri=%2FAMADoc%2FHOD.xml-H-420.952.xml>, accessed 30 April 2022.
3. Access to fertility treatment irrespective of marital status, sexual orientation, or gender identity: an Ethics Committee Opinion, at https://www.asrm.org/globalassets/asrm/asrm-content/news-and-publications/ethics-committee-opinions/access_to_fertility_treatment_by_gays_lesbians_and_unmarried_persons-pdfmembers.pdf, accessed 30 April 2022.
4. Hamai CJ, Groves SD, Kostandinis T, Giraldo-Berlingeri S, Simon KE, Christy AY, Hsu AL. “Helping Military Families Grow”: Increasing Infertility Coverage for Active-duty Servicemembers and Veterans. *Fertil Steril Dialog*. Published online 7 Mar 2022: <https://www.fertsterdialog.com/posts/helping-military-families-grow-increasing-infertility-coverage-for-active-duty-servicemembers-and-veterans>.
5. Veterans Health Administration (VHA) Directive 1334 Assisted Reproductive Technology (ART) Services, including IN Vitro Fertilization (IVF) for the Benefit of Veterans with Service-Connected Illness or Injury Resulting in Infertility – Frequently Asked Questions (12 February 2018), accessible at: <https://www.fertsterdialog.com/documents/vha-directive-1334-bb1012b6-de5f-4626-a161-4e1a76b93f04>, accessed 30 April 2022.
6. DoD Policy for Assisted Reproductive Services for the Benefit of Seriously or Severely Ill/Injured (Category II or III) Active Duty Service Members (ADSMs), accessible at <https://www.fertsterdialog.com/documents/dod-policy-guidance>, accessed 30 April 2022.
7. AMA policy H-185.926 Reproductive Health Insurance Coverage, at <https://policysearch.ama-assn.org/policyfinder/detail/fertility?uri=%2FAMADoc%2FHOD-185.926.xml>, accessed 30 April 2022.

RELEVANT AMA POLICY

Reproductive Health Insurance Coverage H-185.926

Our AMA supports: (1) insurance coverage for fertility treatments regardless of marital status or sexual orientation when insurance provides coverage for fertility treatments; and (2) local and state efforts to promote reproductive health insurance coverage regardless of marital status or sexual orientation when insurance provides coverage for fertility treatments.

Citation: Res. 804, I-16

Recognition of Infertility as a Disease H-420.952

Our AMA supports the World Health Organizations designation of infertility as a disease state with multiple etiologies requiring a range of interventions to advance fertility treatment and prevention.

Citation: Res. 518, A-17

Health Care Disparities in Same-Sex Partner Households H-65.973

Our American Medical Association: (1) recognizes that denying civil marriage based on sexual orientation is discriminatory and imposes harmful stigma on gay and lesbian individuals and couples and their families; (2) recognizes that exclusion from civil marriage contributes to health care disparities affecting same-sex households; (3) will work to reduce health care disparities among members of same-sex households including minor children; and (4) will support measures providing same-sex households with the same rights and privileges to health care, health insurance, and survivor benefits, as afforded opposite-sex households.

Citation: CSAPH Rep. 1, I-09; BOT Action in response to referred for decision Res. 918, I-09; Reaffirmed in lieu of Res. 918, I-09; BOT Rep. 15, A-11; Reaffirmed in lieu of Res. 209, A-12; Reaffirmed: CSAPH Rep. 1, A-22

Health Disparities Among Gay, Lesbian, Bisexual, Transgender and Queer Families D-65.995

Our AMA supports reducing the health disparities suffered because of unequal treatment of minor children and same sex parents in same sex households by supporting equality in laws affecting health care of members in same sex partner households and their dependent children.

Citation: Res. 445, A-05; Modified: CSAPH Rep. 1, A-15; Res. 16, A-18

Eliminating Health Disparities - Promoting Awareness and Education of Sexual Orientation and Gender Identity Health Issues in Medical Education H-295.878

Our AMA: (1) supports the right of medical students and residents to form groups and meet on-site to further their medical education or enhance patient care without regard to their gender, gender identity, sexual orientation, race, religion, disability, ethnic origin, national origin or age; (2) supports students and residents who wish to conduct on-site educational seminars and workshops on health issues related to sexual orientation and gender identity; and (3) encourages medical education accreditation bodies to both continue to encourage and periodically reassess education on health issues related to sexual orientation and gender identity in the basic science, clinical care, and cultural competency curricula in undergraduate and graduate medical education.

Citation: Res. 323, A-05; Modified in lieu of Res. 906, I-10; Reaffirmation A-11; Reaffirmation A-12; Reaffirmation A-16; Modified: Res. 16, A-18; Modified: Res. 302, I-19

Health Care Needs of Lesbian, Gay, Bisexual, Transgender and Queer Populations H-160.991

1. Our AMA: (a) believes that the physician's nonjudgmental recognition of patients' sexual orientations, sexual behaviors, and gender identities enhances the ability to render optimal patient care in health as well as in illness. In the case of lesbian, gay, bisexual, transgender, queer/questioning, and other (LGBTQ) patients, this recognition is especially important to address the specific health care needs of people who are or may be LGBTQ; (b) is committed to taking a leadership role in: (i) educating physicians on the current state of research in and knowledge of LGBTQ Health and the need to elicit relevant gender and sexuality information from our patients; these efforts should start in medical school, but must also be a part of continuing medical education; (ii) educating physicians to recognize the physical and psychological needs of LGBTQ patients; (iii) encouraging the development of educational programs in LGBTQ Health; (iv) encouraging physicians to seek out local or national experts in the health care needs of LGBTQ people so that all physicians will achieve a better understanding of the medical needs of these populations; and (v) working with LGBTQ communities to offer physicians the opportunity to better understand the medical needs of LGBTQ patients; and (c) opposes, the use of "reparative" or "conversion" therapy for sexual orientation or gender identity.

2. Our AMA will collaborate with our partner organizations to educate physicians regarding: (i) the need for sexual and gender minority individuals to undergo regular cancer and sexually transmitted infection screenings based on anatomy due to their comparable or elevated risk for these conditions; and (ii) the need for comprehensive screening for sexually transmitted diseases in men who have sex with men; (iii) appropriate safe sex techniques to avoid the risk for sexually transmitted diseases; and (iv) that individuals who identify as a sexual and/or gender minority (lesbian, gay, bisexual, transgender, queer/questioning individuals) experience intimate partner violence, and how sexual and gender minorities present with intimate partner violence differs from their cisgender, heterosexual peers and may have unique complicating factors.

3. Our AMA will continue to work alongside our partner organizations, including GLMA, to increase physician competency on LGBTQ health issues.
4. Our AMA will continue to explore opportunities to collaborate with other organizations, focusing on issues of mutual concern in order to provide the most comprehensive and up-to-date education and information to enable the provision of high quality and culturally competent care to LGBTQ people.
Citation: CSA Rep. C, I-81; Reaffirmed: CLRPD Rep. F, I-91; CSA Rep. 8 - I-94; Appended: Res. 506, A-00; Modified and Reaffirmed: Res. 501, A-07; Modified: CSAPH Rep. 9, A-08; Reaffirmation A-12; Modified: Res. 08, A-16; Modified: Res. 903, I-17; Modified: Res. 904, I-17; Res. 16, A-18; Reaffirmed: CSAPH Rep. 01, I-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 802
(I-22)

Introduced by: New York

Subject: FAIR Health Database

Referred to: Reference Committee J

1 Whereas, The FAIR Health database was created to bring independent accuracy and
2 transparency to medical price data; and
3

4 Whereas, This database is now widely used, not just for charge data, but also for contracted
5 rate data; and
6

7 Whereas, One important piece of information that has been included in these listings was the
8 frequency of the Current Procedural Terminology (CPT) code's usage during the past 12-month
9 period that was used to calculate the statistical data; and
10

11 Whereas, This "frequency" information was of great relevance in understanding how much data
12 FAIR Health had obtained; and
13

14 Whereas, This "frequency" data was also useful for providers when they wanted to challenge
15 the accuracy of various statistics provided by FAIR Health; and
16

17 Whereas, The FAIR Health database no longer reports the specific "frequency" of the data
18 collected; therefore be it
19

20 RESOLVED, That our American Medical Association advocate to FAIR Health to ensure the
21 continued identification of the frequency by which a particular CPT code is used. (New HOD
22 Policy)

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

Received: 09/20/22

RELEVANT AMA POLICY

Network Adequacy H-285.908

1. Our AMA supports state regulators as the primary enforcer of network adequacy requirements.
2. Our AMA supports requiring that provider terminations without cause be done prior to the enrollment period, thereby allowing enrollees to have continued access throughout the coverage year to the network they reasonably relied upon when purchasing the product. Physicians may be added to the network at any time.
3. Our AMA supports requiring health insurers to submit and make publicly available, at least quarterly, reports to state regulators that provide data on several measures of network adequacy, including the number and type of providers that have joined or left the network; the number and type of specialists and subspecialists that have left or joined the network; the number and types of providers who have filed an in network claim within the calendar year; total number of claims by provider type made on an out-of-network basis; data that indicate the provision of Essential Health Benefits; and consumer complaints received.

4. Our AMA supports requiring health insurers to indemnify patients for any covered medical expenses provided by out-of-network providers incurred over the co-payments and deductibles that would apply to in-network providers, in the case that a provider network is deemed inadequate by the health plan or appropriate regulatory authorities.
5. Our AMA advocates for regulation and legislation to require that out-of-network expenses count toward a participant's annual deductibles and out-of-pocket maximums when a patient is enrolled in a plan with out-of-network benefits, or forced to go out-of-network due to network inadequacies.
6. Our AMA supports fair and equitable compensation to out-of-network providers in the event that a provider network is deemed inadequate by the health plan or appropriate regulatory authorities.
7. Our AMA supports health insurers paying out-of-network physicians fairly and equitably for emergency and out-of-network bills in a hospital. AMA policy is that any legislation which addresses this issue should assure that insurer payment for such care be based upon a number of factors, including the physicians' usual charge, the usual and customary charge for such service, the circumstances of the care and the expertise of the particular physician.
8. Our AMA provides assistance upon request to state medical associations in support of state legislative and regulatory efforts, and disseminate relevant model state legislation, to ensure physicians and patients have access to adequate and fair appeals processes in the event that they are harmed by inadequate networks.
9. Our AMA supports the development of a mechanism by which health insurance enrollees are able to file formal complaints about network adequacy with appropriate regulatory authorities.
10. Our AMA advocates for legislation that prohibits health insurers from falsely advertising that enrollees in their plans have access to physicians of their choosing if the health insurer's network is limited.
11. Our AMA advocates that health plans should be required to document to regulators that they have met requisite standards of network adequacy including hospital-based physician specialties (i.e. radiology, pathology, emergency medicine, anesthesiologists and hospitalists) at in-network facilities, and ensure in-network adequacy is both timely and geographically accessible.
12. Our AMA supports requiring that health insurers that terminate in-network providers: (a) notify providers of pending termination at least 90 days prior to removal from network; (b) give to providers, at least 60 days prior to distribution, a copy of the health insurers letter notifying patients of the providers change in network status; and (c) allow the provider 30 days to respond to and contest if necessary the letter prior to its distribution.

Citation: CMS Rep. 4, I-14; Reaffirmation I-15; Reaffirmed in lieu of Res. 808, I-15; Modified: Sub. Res. 811, I-15; Reaffirmed: CMS Rep. 03, A-17; Reaffirmed: Res. 108, A-17; Appended: Res. 809, I-17; Reaffirmed: Res. 116, A-18; Reaffirmation: A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 803
(I-22)

Introduced by: New York

Subject: Patient Centered Medical Home – Administrative Burdens

Referred to: Reference Committee J

1 Whereas, The “Medical Home Model” provides increased care to homebound patients but
2 increases the administrative burden on physicians and their office staff; and
3

4 Whereas, The effects of these additional administrative burdens limits physician care to other
5 patients in the office and hospital settings; and
6

7 Whereas, Administrative burdens are a leading cause of physician “burnout”; and
8

9 Whereas, The analytic data showing how the metrics which are required to be reported are
10 actually helping quality patient care is not provided; and
11

12 Whereas, Maintenance of Patient Centered Medical Home (PCMH) certification continually
13 requires additional metrics and “paper work” that takes time away from direct patient care;
14 therefore be it
15

16 RESOLVED, That our American Medical Association seek regulations which would reduce the
17 increasing strain that Patient Centered Medical Home (PCMH) metrics are placing on
18 physicians and patient care. (Directive to Take Action)

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

Received: 09/20/22

RELEVANT AMA POLICY

Principles of the Patient-Centered Medical Home H-160.919

1. Our AMA adopts the American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians and the American Osteopathic Association "Joint Principles of the Patient-Centered Medical Home" as follows:

Principles

Personal Physician - Each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.

Physician Directed Medical Practice - The personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.

Whole Person Orientation - The personal physician is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life; acute care; chronic care; preventive services; and end of life care.

Care is coordinated and/or integrated across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (e.g., family, public and private community-based services). Care is facilitated by registries, information

technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.

Quality and safety are hallmarks of the medical home:

Practices advocate for their patients to support the attainment of optimal, patient-centered outcomes that are defined by a care planning process driven by a compassionate, robust partnership between physicians, patients, and the patient's family.

Evidence-based medicine and clinical decision-support tools guide decision making.

Physicians in the practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement.

Patients actively participate in decision-making and feedback is sought to ensure patients' expectations are being met.

Information technology is utilized appropriately to support optimal patient care, performance measurement, patient education, and enhanced communication.

Practices go through a voluntary recognition process by an appropriate non-governmental entity to demonstrate that they have the capabilities to provide patient centered services consistent with the medical home model.

Patients and families participate in quality improvement activities at the practice level.

Enhanced access to care is available through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician, and practice staff.

Payment appropriately recognizes the added value provided to patients who have a patient-centered medical home. The payment structure should be based on the following framework:

It should reflect the value of physician and non-physician staff patient-centered care management work that falls outside of the face-to-face visit.

It should pay for services associated with coordination of care both within a given practice and between consultants, ancillary providers, and community resources.

It should support adoption and use of health information technology for quality improvement.

It should support provision of enhanced communication access such as secure e-mail and telephone consultation.

It should recognize the value of physician work associated with remote monitoring of clinical data using technology.

It should allow for separate fee-for-service payments for face-to-face visits. (Payments for care management services that fall outside of the face-to-face visit, as described above, should not result in a reduction in the payments for face-to-face visits).

It should recognize case mix differences in the patient population being treated within the practice.

It should allow physicians to share in savings from reduced hospitalizations associated with physician-guided care management in the office setting.

It should allow for additional payments for achieving measurable and continuous quality improvements.

2. Our AMA supports the patient-centered medical home (as defined in Policy H-160.919) as a way to provide care to patients without restricting access to specialty care.
3. It is the policy of our AMA that medical home participation criteria allow any physician practice to qualify as a medical home, provided it can fulfill the principles of a patient-centered medical home.
4. Our AMA will work with The Joint Commission (TJC) to examine the structures of TJC-accredited medical homes and determine whether differences exist in patient satisfaction, quality, value, and patient safety, as reflected by morbidity and mortality outcomes, between physician-led (MD/DO) and non-physician-led medical homes.
5. Our AMA supports the physician-led patient-centered medical home and advocate for the public

reporting/notification of the professional status (education, training, experience) of the primary care clinician who leads the primary care medical home.

Citation: Res. 804, I-08; CMS Rep. 8, A-09; Reaffirmed: CME Rep. 15, A-10; Reaffirmed: Res. 723, A-11; Appended: Res. 723, A-11; Reaffirmed: BOT Rep. 9, I-11; Reaffirmed in lieu of Res. 706, A-12; Reaffirmed: BOT Rep. 39, A-18; Reaffirmed: CMS Rep. 03, I-18

The Joint Commission Primary Care Home Initiative D-35.988

1. Our AMA Commissioners to The Joint Commission will strongly advocate that the requirements for any primary care home or medical home initiative of The Joint Commission strictly meet the requirements of the *Joint Principles of the Patient-Centered Medical Home* and more specifically that (1) each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care and (2) that a personal physician lead a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients. The *Joint Principles of the Patient-Centered Medical Home* were developed by the American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, American Osteopathic Association and approved by the AMA.
2. Our AMA will continue to support the concept of physician-led teams within the patient centered medical home (PCMH) as outlined in the Joint Principles of the Patient-Centered Medical Home.
3. Our AMA will respond to The Joint Commission's interpretation of its primary care medical home certification standards addressing non-physician-led PCMHs.
4. Our AMA will oppose any interpretation by The Joint Commission, or any other entity, of primary care medical home or patient centered medical home (PCMH) as being anything other than MD/DO physician led.

Citation: (Res. 831, I-10; Reaffirmed: BOT Rep. 9, I-11; Appended: Res. 738, A-14)

The Patient-Centered Medical Home H-160.918

Our AMA:

1. will urge the Centers for Medicare and Medicaid Services (CMS) to work with our AMA and national medical specialty societies to design incentives to enhance care coordination among providers who provide medical care for patients outside the medical home;
2. will urge CMS to assist physician practices seeking to qualify for and sustain medical home status with financial and other resources;
3. will advocate that Medicare incentive payments associated with the medical home model be paid for through system-wide savings – such as reductions in hospital admissions and readmissions (Part A), more effective use of pharmacologic therapies (Part D), and elimination of government subsidies for Medicare Advantage plans (Part C) – and not be subject to a budget neutrality offset in the Medicare physician payment schedule;
4. will advocate that all payers support and assist PCMH transformation and maintenance efforts at levels that provide a stable platform for optimized patient-centered care recognizing that payer support is crucial to the long-term sustainability of delivery reform; and
5. encourages health agencies, health systems, and other stakeholders to support and assist patient-centered medical home transformation and maintenance efforts at levels that provide a stable platform for optimized patient-centered care.

Citation: CMS Rep. 8, A-09; Modified: CMS Rep. 03, I-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 804
(I-22)

Introduced by: New York

Subject: Centers for Medicare & Medicaid Innovation Projects

Referred to: Reference Committee J

1 Whereas, Centers for Medicare & Medicaid Services' (CMS) Center for Medicare & Medicaid
2 Innovation (CMMI), which has been developing proposals for new health care payment and
3 service delivery models, was given broad authority by the Affordable Care Act to scale up any of
4 these models for potential application to the entire Medicare program, without approval or
5 oversight by Congress; and
6

7 Whereas, Two of CMMI's models, the Direct Contracting Entities and Value-based Payment
8 Models, are designed in such a way as to incentivize the rationing and restricting of care for
9 senior patients and patients with disabilities; and
10

11 Whereas, The Direct Contracting Entities and Value-based Payment Models have not been
12 shown to improve quality of care or significantly reduce cost; therefore be it
13

14 RESOLVED, That our American Medical Association advocate against mandatory participation
15 in Centers for Medicare and Medicaid Innovation (CMMI) demonstration projects, and advocate
16 for CMMI instead to focus on the development of voluntary pilot projects (Directive to Take
17 Action); and be it further
18

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

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

Received: 09/20/22

RELEVANT AMA POLICY

Medicare Physician Payment Reform D-390.961

1. Our AMA will continue to advocate for adequate investment in comparative effectiveness research that is consistent with AMA Policy H-460.909, and in effective methods of translating research findings relating to quality of care into clinical practice.
2. Our AMA will advocate for better methods of data collection, development, reporting and dissemination of practical clinical decision-making tools for patients and physicians, and rapid, confidential feedback about comparative practice patterns to physicians to enable them to make the best use of the information at the local and specialty level.
3. Our AMA urges physician organizations, including state medical associations and national medical specialty societies, to develop and recruit groups of physicians to experiment with diverse ideas for achieving Medicare savings, including the development of organizational structures that maximize participation opportunities for physician practices.

4. Our AMA will continue to advocate for changes in antitrust and other laws that would facilitate shared-savings arrangements, and enable solo and small group practices to make innovations that could enhance care coordination and increase the value of health care delivery.

5. Our AMA supports local innovation and funding of demonstration projects that allow physicians to benefit from increased efficiencies based on practice changes that best fit local needs.

6. Our AMA will work with appropriate public and private officials and advisory bodies to ensure that bundled payments, if implemented, do not lead to hospital-controlled payments to physicians.

Citation: CMS 6, A-09; Reaffirmation A-10; Reaffirmation I-13; CMS Rep. 5, I-16; Reaffirmation: A-22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 805
(I-22)

Introduced by: Utah

Subject: COVID Vaccine Administration Fee

Referred to: Reference Committee J

1 Whereas, To assist the public health effort against SARS CoV2 virus in the US, health care
2 providers have contracted with the CDC to administer COVID-19 vaccines to patients and
3 community members; and
4

5 Whereas, Contracted COVID-19 vaccine providers are required to administer vaccine equitably
6 and to refrain from directly billing patients for the cost of administering the vaccine
7 (administration fee); and
8

9 Whereas, Providers previously billed the Health Resources and Services Administration (HRSA)
10 for the administration fee for uninsured patients; and
11

12 Whereas, Since the emergency funding appropriated by the HRSA was exhausted in April 2022,
13 HRSA ceased reimbursing the administration fee for uninsured citizens; and
14

15 Whereas, The US government has recently begun providing a reformulated bivalent COVID-19
16 vaccine booster to the US population; and
17

18 Whereas, A large portion of the US population is eligible for this bivalent COVID-19 booster; and
19

20 Whereas, Contracted COVID-19 vaccine providers will be expected to use their resources to
21 provide the bivalent booster; and
22

23 Whereas, The uninsured patients of physician offices can comprise 5 to 10% of their practice
24 and may be higher for those physician practices located in rural and underserved geographies;
25 and
26

27 Whereas, The lack of reimbursement from the federal government puts providers at financial
28 risk and may cause providers to no longer contract to be access points for their patients and
29 community members to receive COVID-19 vaccines; and
30

31 Whereas, The lack of access to providers who offer COVID-19 vaccines to uninsured patients is
32 an issue of health equity; therefore be it

1 RESOLVED, That American Medical Association policy D-440.981, "Appropriate
2 Reimbursements and Carve-outs for Vaccines," be amended by addition to read as follows:

3
4 **Appropriate Reimbursements and Carve-outs for Vaccines D-440.981**

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

Fiscal Note: Minimal – less than \$1,000

Received: 09/23/22

RELEVANT AMA POLICY

Appropriate Reimbursements and Carve-outs for Vaccines D-440.981

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

Citation: BOT Rep. 20, A-03; Reaffirmation A-07; Res. 128, A-09; Reaffirmation I-10;
Reaffirmed: Res. 807, I-11; Appended: Res. 217, A-19; Reaffirmed: CMS Rep. 3, I-20; Res.
408, I-21

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 806
(I-22)

Introduced by: Georgia

Subject: Healthcare Marketplace Plan Selection

Referred to: Reference Committee J

1 Whereas, Insurance plans purchased on the Healthcare Marketplace often have very narrow
2 networks; and

3
4 Whereas, These narrow networks often require patients to only see physicians within the county
5 in which the plan was purchased; and

6
7 Whereas, Patients are required to purchase a plan based on the county in which they reside;
8 and

9
10 Whereas, Some patients must pay for care in cash outside their plan to keep their doctor of
11 choice making their comprehensive plan more of an expensive catastrophic plan; and

12
13 Whereas, This limits patient choice by preventing patients from choosing their plan based on
14 access to their physician of choice; therefore be it

15
16 RESOLVED, That our American Medical Association advocate for patients to have expanded
17 plan options on the Healthcare Marketplace beyond the current options based solely on the zip
18 code of their primary residence or where their physician practices, including the interstate
19 portability of plans. (Directive to Take Action)

Fiscal Note: Modest – between \$1,000 - \$5,000

Received: 09/26/22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 807
(I-22)

Introduced by: Georgia

Subject: Medicare Advantage Record Requests

Referred to: Reference Committee J

1 Whereas, Medicare Advantage rules for plans do not stipulate how record requests are handled,
2 nor any limits to number or repetitiveness of these requests; and
3

4 Whereas, Complying with these record requests can require extensive staff time and other
5 associated costs; and
6

7 Whereas, Practices are not reimbursed by Medicare Advantage companies for the staff time
8 involved in complying with these requests; and
9

10 Whereas, Each Medicare Advantage plan has different rules for record requests governed by
11 the contract between the plan and provider; therefore be it
12

13 RESOLVED, That our American Medical Association advocate for the relevant agencies and
14 stakeholders to prevent Medicare Advantage plans from requesting records from practices
15 solely to data mine for more funds and limit requests to 2% of plan participants, and otherwise
16 advocate that the plan will reimburse the practices for their efforts in obtaining additional
17 requested information. (Directive to Take Action)

Fiscal Note: Modest – between \$1,000 - \$5,000

Received: 09/26/22

RELEVANT AMA POLICY

Limiting Access to Medical Records H-315.987

Our AMA: (1) will pursue the adoption of federal legislation and regulations that will: limit third party payers' random access to patient records unrelated to required quality assurance activities; limit third party payers' access to medical records to only that portion of the record (or only an abstract of the patient's records) necessary to evaluate for reimbursement purposes; require that requests for information and completion of forms be delineated and case specific; allow a summary of pertinent information relative to any inquiry into a patient's medical record be provided in lieu of a full copy of the records (except in instances of litigation where the records would be discoverable); and provide proper compensation for the time and skill spent by physicians and others in preparing and completing forms or summaries pertaining to patient records; and (2) supports the policy that copies of medical records of service no longer be required to be sent to insurance companies, Medicaid or Medicare with medical bills. Citation: Sub. Res. 222, I-94; Appended: Res. 218, A-02; Reaffirmed: BOT Rep. 19, I-06; Reaffirmed: BOT Rep. 06, A-16; Reaffirmed: BOT Rep. 16, I-21

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 808
(I-22)

Introduced by: Georgia

Subject: Reinstatement of Consultation Codes

Referred to: Reference Committee J

1 Whereas, In 2010, due to a perception of abuse or misuse of consult codes, Medicare
2 eliminated consult codes in what they calculated to be a revenue neutral manner, whereby they
3 increased the value of other evaluation and management (E+M) codes; and
4

5 Whereas, Medicare has proposed re-valuation of E+M codes, effective 2021 if finalized; and
6

7 Whereas, United Health Care (UHC) and Cigna are moving to eliminate consult codes; and
8

9 Whereas, The American Medical Association House of Delegates passed Resolution 819 in
10 2017, which passed without changes but has progressed negatively; and
11

12 Whereas, It appears cognitive care is undervalued; therefore be it
13

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

Fiscal Note: Modest – between \$1,000 - \$5,000

Received: 09/26/22

RELEVANT AMA POLICY

Medicare's Proposal to Eliminate Payments for Consultation Service Codes D-70.953

1. Our American Medical Association opposes all public and private payer efforts to eliminate payments for inpatient and outpatient consultation service codes, and supports legislation to overturn recent Center for Medicare & Medicaid Services' (CMS) action to eliminate consultation codes. 2. Our AMA will work with CMS and interested physician groups through the CPT Editorial Panel to address all concerns with billing consultation services either through revision or replacement of the current code sets or by some other means. 3. Our AMA will, at the conclusion of the CPT Editorial Panel's work to address concerns with billing consultation services, work with CMS and interested physician groups to engage in an extensive education campaign regarding appropriate billing for consultation services. 4. Our AMA will: (a) work with the Centers for Medicare & Medicaid Services to consider a two-year moratorium on RAC audit claims based on three-year rule violations for E/M services previously paid for as consultations; and (b) pursue Congressional action through legislation to reinstate payment for consultation codes within the Medicare Program and all other governmental programs. 5. Our AMA will petition the CMS to limit RAC reviews to less than one year from payment of claims.

Citation: Res. 807, I-09; Appended: Sub. Res. 212, I-10; Reaffirmation A-12; Appended: Res. 216, A-12; Modified: CCB/CLRPD Rep. 2, A-14; Reaffirmation: A-17

Consultation Codes and Private Payers D-385.955

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

Citation: Res. 819, I-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 809
(I-22)

Introduced by: Senior Physicians Section

Subject: Uniformity and Enforcement of Medicare Advantage Plans and Regulations

Referred to: Reference Committee J

1 Whereas, Medicare Advantage plans must provide enrollees with coverage of all services
2 covered by Medicare Parts A and B, plus additional benefits beyond those covered by
3 Medicare; and
4

5 Whereas, Seniors are determining specifics of plans across the US, looking for uniformity to
6 compare policies in advance of enrollment; and
7

8 Whereas, Many seniors select Medicare Advantage plans because they have lower premiums
9 than Medicare; and
10

11 Whereas, When Medicare supplement plans cannot be used in Medicare Advantage, patients
12 are required to pay the copayments themselves; and
13

14 Whereas, Medicare Advantage plans often employ prior authorization and deny claims that
15 would have been paid if the patient had been in regular Medicare; and
16

17 Whereas, Many seniors have little interest in the choice of health plans and more of an interest
18 in the choice of physicians in their geographical areas; therefore be it
19

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

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

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

Fiscal Note: Modest – between \$1,000 - \$5,000

Received: 09/29/22

RELEVANT AMA POLICY

Medicare Advantage Policies H-285.913

Our AMA will:

1. pursue legislation requiring that any Medicare Advantage policy sold to a Medicare patient must include a seven-day waiting period that allows for cancellation without penalty;
2. pursue legislation to require that Medicare Advantage policies carry a separate distinct page, which the patient must sign, including the statement, "THIS COVERAGE IS NOT TRADITIONAL MEDICARE. YOU HAVE CHOSEN TO CANCEL YOUR TRADITIONAL MEDICARE COVERAGE; NOT ALL PHYSICIANS, HOSPITALS AND LABORATORIES ACCEPT THIS NEW MEDICARE ADVANTAGE POLICY AND YOU MAY PERMANENTLY LOSE THE ABILITY TO PURCHASE MEDIGAP SECONDARY INSURANCE" (or equivalent statement) and specifying the time period before they can resume their traditional Medicare coverage; and
3. petition the Centers for Medicare and Medicaid Services to implement the patient's signature page in a Medicare Advantage policy.

Citation: Res. 907, I-07; Reaffirmation A-08; Reaffirmed: CMS Rep. 01, A-18; Reaffirmation: I-18

Prevent Medicare Advantage Plans from Limiting Care D-285.959

Our AMA will: (1) ask the Centers for Medicare and Medicaid Services to further regulate Medicare Advantage Plans so that the same treatment and authorization guidelines are followed for both fee-for-service Medicare and Medicare Advantage patients, including admission to inpatient rehabilitation facilities; and (2) advocate that proprietary criteria shall not supersede the professional judgment of the patient's physician when determining Medicare and Medicare Advantage patient eligibility for procedures and admissions. Citation: Res. 706, A-21;

Transparency of Costs to Patients for Their Prescription Medications Under Medicare Part D and Medicare Advantage Plans H-330.870

Our AMA will: (1) advocate for provision of transparent print and audio/video patient educational resources to patients and families in multiple languages from health care systems and from Medicare - directly accessible - by consumers and families, explaining clearly the different benefits, as well as the varied, programmatic and other out-of-pocket costs for their medications under Medicare, Medicare Supplemental and Medicare Advantage plans; (2) advocate for printed and audio/video patient educational resources regarding personal costs, changes in benefits and provider panels that may be incurred when switching (voluntarily or otherwise) between Medicare, Medical Supplemental and Medicare Advantage or other plans, including additional information regarding federal and state health insurance assistance programs that patients and consumers could access directly; and (3) advocate for increased funding for federal and state health insurance assistance programs and educate physicians, hospitals, and patients about the availability of and access to such programs.

Citation: Res. 817, I-19; Modified: Res. 125, A-22

Medicare Advantage Opt Out Rules H-330.913

Our AMA: (1) opposes managed care "bait and switch" practices, whereby a plan entices patients to enroll by advertising large physician panels and/or generous patient benefits, then reduces physician reimbursement and/or patient benefits, so that physicians leave the plan, but patients who can't must choose new doctors; (2) supports current proposals to extend the 30 day waiting period that limits when Medicare recipients may opt out of managed care plans, if such proposals can be amended to create an exemption to protect patients whenever a plan alters benefits or whenever a patient's physician leaves the plan; and (3) supports changes in CMS regulations which would require Medicare Advantage plans to immediately notify patients, whenever such a plan alters benefits or whenever a patient's physician leaves the plan, and to give affected patients a reasonable opportunity to switch plans.

Citation: Res. 707, A-99; Reaffirmed: CMS Rep. 5, A-09; Modified: CMS Rep. 01, A-19

Legislation for Assuring Equitable Participation of Physicians in Medicare Advantage H-330.916

Our AMA seeks to have the CMS, while contracting with Medicare Advantage organizations for Medicare services, require the following guarantees to assure quality patient care to medical beneficiaries: (1) a Medicare Advantage patient shall have the right to see a duly licensed physician of the appropriate training and specialty; (2) if CMS decertifies a Medicare Advantage plan, enrollees in that plan who are undergoing a course of treatment by a physician at the time of such termination shall continue to receive care from their treating physician until an appropriate transfer is accomplished; and (3) any Medicare Advantage plan deselection of participating physicians may occur only after the physician has been given the opportunity to appeal the deselection decision to an Independent Review Body.

Citation: Res. 707, I-98; Reaffirmed: BOT Rep. 23, A-09; Modified: CMS Rep. 01, A-19

Deemed Participation and Misleading Marketing by Medicare Advantage Private Fee for Service Plans D-330.930

Our AMA will continue its efforts to educate physicians and the general public on the implications of participating in programs offered under Medicare Advantage and educate physicians and the public about the lack of secondary coverage (Medigap policies) with Medicare Advantage plans and how this may affect enrollees.

Citation: BOT Action in response to referred for decision Res. 711, I-06; Reaffirmation A-08; Modified: CMS Rep. 01, A-19;

Medicare Cost-Sharing D-330.951

Our AMA will urge the Centers for Medicare and Medicaid Services to require companies that participate in the Medicare Advantage program to provide enrollees and potential enrollees timely information in a comparable, standardized, and clearly-written format that details enrollment restrictions, as well as all coverage restrictions and beneficiary cost-sharing requirements for all services.

Citation: CMS Rep. 2, I-04; Reaffirmation A-08; Reaffirmed: CMS Rep. 01, A-18; Reaffirmation: I-18

Support for Seamless Physician Continuity of Care H-390.836

Our AMA encourages physicians who encounter contractual difficulties with Medicare Advantage (MA) plans to contact their Centers for Medicare & Medicaid Services (CMS) Regional office.

Citation: BOT Action in response to referred for decision Res. 816, I-16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 810
(I-22)

Introduced by: Senior Physicians Section

Subject: Medicare Drug Pricing and Pharmacy Costs

Referred to: Reference Committee J

1 Whereas, Many seniors look to the federal government to negotiate prices for prescription drugs
2 covered under Medicare; and
3

4 Whereas, For seniors 65 years of age and older, 40% have at least five prescription drugs,
5 compared with 23% of 50- to 64-year-olds and fewer than 10% of those under 50;¹ and
6

7 Whereas, With increased attention among policymakers towards prescription drug costs, a
8 February 2019 poll found that a majority of adults, including seniors, are in favor of policy
9 options to curb prescription drug costs;² and
10

11 Whereas, With the Inflation Reduction Act of 2022, the Centers for Medicare & Medicaid
12 Services (CMS) will be required to negotiate prices of certain prescription drugs beginning in
13 2026;³ and
14

15 Whereas, There are 510 different drugs recognized in the US, but the Inflation Reduction Act of
16 2022 requires CMS to negotiate the prices of only 10 drugs in 2026, 15 drugs in 2027 and 2028,
17 and 20 drugs in 2029 and each year after;⁴ and
18

19 Whereas, The pace of negotiating a miniscule number of prescription prices each year is not
20 beneficial to seniors or the general public; and
21

22 Whereas, The business model of making profits for pharmaceutical company's shareholders
23 should not be at the expense of generating profits; and
24

25 Whereas, Seniors should not be stretched to find funding for needed medications; therefore be
26 it
27

28 RESOLVED, That our American Medical Association advocate for immediate, timely and
29 transparent negotiations for how Medicare drug prices are set to be incorporated into law
30 (Directive to Take Action); and be it further
31

32 RESOLVED, That our AMA advocate to eliminate loopholes such as new usage for current
33 medications (commonly known as patent evergreening) (Directive to Take Action); and be it
34 further
35

36 RESOLVED, That our AMA advocate for a ban on direct-to-consumer advertising for
37 prescription drugs by no later than five years, in 2027. (Reaffirm HOD policy)

Fiscal Note: Modest – between \$1,000 - \$5,000

Received: 09/29/22

REFERENCES:

1. Kirzinger A, et al. KFF Health Tracking Poll - February 2019: Prescription Drugs. Internet Document : 1 Mar 2019. Available from: URL: <https://www.kff.org/health-costs/poll-finding/kff-health-tracking-poll-february-2019-prescription-drugs/>
2. Kirzinger A, et al. KFF Health Tracking Poll - February 2019: Prescription Drugs. Internet Document : 1 Mar 2019. Available from: URL: <https://www.kff.org/health-costs/poll-finding/kff-health-tracking-poll-february-2019-prescription-drugs/>
3. Congress.gov. "Text – H.R. 5376 – 117th Congress (2021-2022): Inflation Reduction Act of 2022." August 16, 2022. <http://www.congress.gov/>.
4. Congress.gov. "Text – H.R. 5376 – 117th Congress (2021-2022): Inflation Reduction Act of 2022." August 16, 2022. <http://www.congress.gov/>.

RELEVANT AMA POLICY

Direct-to-Consumer Advertising (DTCA) of Prescription Drugs and Implantable Devices H-105.988

1. To support a ban on direct-to-consumer advertising for prescription drugs and implantable medical devices.
2. That until such a ban is in place, our AMA opposes product-claim DTCA that does not satisfy the following guidelines:
 - (a) The advertisement should be indication-specific and enhance consumer education about the drug or implantable medical device, and the disease, disorder, or condition for which the drug or device is used.
 - (b) In addition to creating awareness about a drug or implantable medical device for the treatment or prevention of a disease, disorder, or condition, the advertisement should convey a clear, accurate and responsible health education message by providing objective information about the benefits and risks of the drug or implantable medical device for a given indication. Information about benefits should reflect the true efficacy of the drug or implantable medical device as determined by clinical trials that resulted in the drug's or device's approval for marketing.
 - (c) The advertisement should clearly indicate that the product is a prescription drug or implantable medical device to distinguish such advertising from other advertising for non-prescription products.
 - (d) The advertisement should not encourage self-diagnosis and self-treatment, but should refer patients to their physicians for more information. A statement, such as "Your physician may recommend other appropriate treatments," is recommended.
 - (e) The advertisement should exhibit fair balance between benefit and risk information when discussing the use of the drug or implantable medical device product for the disease, disorder, or condition. The amount of time or space devoted to benefit and risk information, as well as its cognitive accessibility, should be comparable.
 - (f) The advertisement should present information about warnings, precautions, and potential adverse reactions associated with the drug or implantable medical device product in a manner (e.g., at a reading grade level) such that it will be understood by a majority of consumers, without distraction of content, and will help facilitate communication between physician and patient.
 - (g) The advertisement should not make comparative claims for the product versus other prescription drug or implantable medical device products; however, the advertisement should include information about the availability of alternative non-drug or non-operative management options such as diet and lifestyle changes, where appropriate, for the disease, disorder, or condition.
 - (h) In general, product-claim DTCA should not use an actor to portray a health care professional who promotes the drug or implantable medical device product, because this portrayal may be misleading and deceptive. If actors portray health care professionals in DTCA, a disclaimer should be prominently displayed.
 - (i) The use of actual health care professionals, either practicing or retired, in DTCA to endorse a specific drug or implantable medical device product is discouraged but if utilized, the advertisement must include a clearly visible disclaimer that the health care professional is compensated for the endorsement.
 - (j) The advertisement should be targeted for placement in print, broadcast, or other electronic media so as to avoid audiences that are not age appropriate for the messages involved.
 - (k) In addition to the above, the advertisement must comply with all other applicable Food and Drug Administration (FDA) regulations, policies and guidelines.

3. That the FDA review and pre-approve all DTCA for prescription drugs or implantable medical device products before pharmaceutical and medical device manufacturers (sponsors) run the ads, both to ensure compliance with federal regulations and consistency with FDA-approved labeling for the drug or implantable medical device product.
 4. That the Congress provide sufficient funding to the FDA, either through direct appropriations or through prescription drug or implantable medical device user fees, to ensure effective regulation of DTCA.
 5. That DTCA for newly approved prescription drug or implantable medical device products not be run until sufficient post-marketing experience has been obtained to determine product risks in the general population and until physicians have been appropriately educated about the drug or implantable medical device. The time interval for this moratorium on DTCA for newly approved drugs or implantable medical devices should be determined by the FDA, in negotiations with the drug or medical device product's sponsor, at the time of drug or implantable medical device approval. The length of the moratorium may vary from drug to drug and device to device depending on various factors, such as: the innovative nature of the drug or implantable medical device; the severity of the disease that the drug or implantable medical device is intended to treat; the availability of alternative therapies; and the intensity and timeliness of the education about the drug or implantable medical device for physicians who are most likely to prescribe it.
 6. That our AMA opposes any manufacturer (drug or device sponsor) incentive programs for physician prescribing and pharmacist dispensing that are run concurrently with DTCA.
 7. That our AMA encourages the FDA, other appropriate federal agencies, and the pharmaceutical and medical device industries to conduct or fund research on the effect of DTCA, focusing on its impact on the patient-physician relationship as well as overall health outcomes and cost benefit analyses; research results should be available to the public.
 8. That our AMA supports the concept that when companies engage in DTCA, they assume an increased responsibility for the informational content and an increased duty to warn consumers, and they may lose an element of protection normally accorded under the learned intermediary doctrine.
 9. That our AMA encourages physicians to be familiar with the above AMA guidelines for product-claim DTCA and with the Council on Ethical and Judicial Affairs Ethical Opinion E-9.6.7 and to adhere to the ethical guidance provided in that Opinion.
 10. That the Congress should request the Agency for Healthcare Research and Quality or other appropriate entity to perform periodic evidence-based reviews of DTCA in the United States to determine the impact of DTCA on health outcomes and the public health. If DTCA is found to have a negative impact on health outcomes and is detrimental to the public health, the Congress should consider enacting legislation to increase DTCA regulation or, if necessary, to prohibit DTCA in some or all media. In such legislation, every effort should be made to not violate protections on commercial speech, as provided by the First Amendment to the U.S. Constitution.
 11. That our AMA supports eliminating the costs for DTCA of prescription drugs as a deductible business expense for tax purposes.
 12. That our AMA continues to monitor DTCA, including new research findings, and work with the FDA and the pharmaceutical and medical device industries to make policy changes regarding DTCA, as necessary.
 13. That our AMA supports "help-seeking" or "disease awareness" advertisements (i.e., advertisements that discuss a disease, disorder, or condition and advise consumers to see their physicians, but do not mention a drug or implantable medical device or other medical product and are not regulated by the FDA).
 14. Our AMA will advocate to the applicable Federal agencies (including the Food and Drug Administration, the Federal Trade Commission, and the Federal Communications Commission) which regulate or influence direct-to-consumer advertising of prescription drugs that such advertising should be required to state the manufacturer's suggested retail price of those drugs.
- Citation: BOT Rep. 38 and Sub. Res. 513, A-99; Reaffirmed: CMS Rep. 9, Amended: Res. 509, and Reaffirmation I-99; Appended & Reaffirmed: Sub. Res. 503, A-01; Reaffirmed: Res. 522, A-02; Reaffirmed: Res. 914, I-02; Reaffirmed: Sub. Res. 504, A-03; Reaffirmation A-04; Reaffirmation A-05; Modified: BOT Rep. 9, A-06; Reaffirmed in lieu of Res. 514, A-07; BOT Action in response to referred for decision: Res. 927, I-15; Modified: BOT Rep. 09, I-16; Appended: Res. 236, A-17; Reaffirmed in lieu of: Res. 223, A-17; Reaffirmed in lieu of: Res. 112, A-19

Additional Mechanisms to Address High and Escalating Pharmaceutical Prices H-110.980

1. Our AMA will advocate that the use of arbitration in determining the price of prescription drugs meet the following standards to lower the cost of prescription drugs without stifling innovation:

- a. The arbitration process should be overseen by objective, independent entities;
 - b. The objective, independent entity overseeing arbitration should have the authority to select neutral arbitrators or an arbitration panel;
 - c. All conflicts of interest of arbitrators must be disclosed and safeguards developed to minimize actual and potential conflicts of interest to ensure that they do not undermine the integrity and legitimacy of the arbitration process;
 - d. The arbitration process should be informed by comparative effectiveness research and cost-effectiveness analysis addressing the drug in question;
 - e. The arbitration process should include the submission of a value-based price for the drug in question to inform the arbitrator's decision;
 - f. The arbitrator should be required to choose either the bid of the pharmaceutical manufacturer or the bid of the payer;
 - g. The arbitration process should be used for pharmaceuticals that have insufficient competition; have high list prices; or have experienced unjustifiable price increases;
 - h. The arbitration process should include a mechanism for either party to appeal the arbitrator's decision; and
 - i. The arbitration process should include a mechanism to revisit the arbitrator's decision due to new evidence or data.
2. Our AMA will advocate that any use of international price indices and averages in determining the price of and payment for drugs should abide by the following principles:
- a. Any international drug price index or average should not be used to determine or set a drug's price, or determine whether a drug's price is excessive, in isolation;
 - b. The use of any international drug price index or average should preserve patient access to necessary medications;
 - c. The use of any international drug price index or average should limit burdens on physician practices; and
 - d. Any data used to determine an international price index or average to guide prescription drug pricing should be transparent and updated regularly.
3. Our AMA supports the use of contingent exclusivity periods for pharmaceuticals, which would tie the length of the exclusivity period of the drug product to its cost-effectiveness at its list price at the time of market introduction.
- Citation: CMS Rep. 4, I-19; Reaffirmed: CMS Rep. 3, I-20; Modified: CMS Rep. 4, A-22

The Impact of Pharmacy Benefit Managers on Patients and Physicians D-110.987

1. Our AMA supports the active regulation of pharmacy benefit managers (PBMs) under state departments of insurance.
 2. Our AMA will develop model state legislation addressing the state regulation of PBMs, which shall include provisions to maximize the number of PBMs under state regulatory oversight.
 3. Our AMA supports requiring the application of manufacturer rebates and pharmacy price concessions, including direct and indirect remuneration (DIR) fees, to drug prices at the point-of-sale.
 4. Our AMA supports efforts to ensure that PBMs are subject to state and federal laws that prevent discrimination against patients, including those related to discriminatory benefit design and mental health and substance use disorder parity.
 5. Our AMA supports improved transparency of PBM operations, including disclosing:
 - Utilization information;
 - Rebate and discount information;
 - Financial incentive information;
 - Pharmacy and therapeutics (P&T) committee information, including records describing why a medication is chosen for or removed in the P&T committee's formulary, whether P&T committee members have a financial or other conflict of interest, and decisions related to tiering, prior authorization and step therapy;
 - Formulary information, specifically information as to whether certain drugs are preferred over others and patient cost-sharing responsibilities, made available to patients and to prescribers at the point-of-care in electronic health records;
 - Methodology and sources utilized to determine drug classification and multiple source generic pricing; and
 - Percentage of sole source contracts awarded annually.
 6. Our AMA encourages increased transparency in how DIR fees are determined and calculated.
- Citation: CMS Rep. 05, A-19; Reaffirmed: CMS Rep. 6, I-20

Reducing Prescription Drug Prices D-110.993

Our AMA will (1) continue to meet with the Pharmaceutical Research and Manufacturers of America to engage in effective dialogue that urges the pharmaceutical industry to exercise reasonable restraint in the pricing of drugs; and (2) encourage state medical associations and others that are interested in pharmaceutical bulk purchasing alliances, pharmaceutical assistance and drug discount programs, and other related pharmaceutical pricing legislation, to contact the National Conference of State Legislatures, which maintains a comprehensive database on all such programs and legislation.

Citation: (CMS Rep. 3, I-04; Modified: CMS Rep. 1, A-14; Reaffirmation A-14; Reaffirmed in lieu of Res. 229, I-14)

Cost of New Prescription Drugs H-110.998

Our AMA urges the pharmaceutical industry to exercise reasonable restraint in the pricing of drugs.

Citation: (Res. 112, I-89; Reaffirmed: Res. 520, A-99; Reaffirmed: CSAPH Rep. 1, A-09; Reaffirmed in lieu of Res. 229, I-14)

Prescription Drug Prices and Medicare D-330.954

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

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

3. Our AMA will prioritize its support for the Centers for Medicare & Medicaid Services to negotiate pharmaceutical pricing for all applicable medications covered by CMS.

Citation: Res. 211, A-04; Reaffirmation I-04; Reaffirmed in lieu of Res. 201, I-11; Appended: Res. 206, I-14; Reaffirmed: CMS Rep. 2, I-15; Appended: Res. 203, A-17; Reaffirmed: CMS Rep. 4, I-19; Reaffirmed: CMS Rep. 3, I-20; Reaffirmed: Res. 113, I-21; Reaffirmed: CMS Rep. 4, A-22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 811
(I-22)

Introduced by: Senior Physicians Section

Subject: Covering Vaccinations for Seniors through Medicare Part B

Referred to: Reference Committee J

1 Whereas, The recently passed Inflation Reduction Act of 2022 eliminates cost-sharing in
2 Medicare for vaccines; and

3
4 Whereas, Medicare coverage rules vary across vaccines as well as Parts B and D; and

5
6 Whereas, These differences can act as significant barriers to vaccination especially in different
7 socioeconomic groups of seniors; and

8
9 Whereas, It is difficult for physician practices to contract with multiple individual Medicare
10 Part D plans; therefore be it

11
12 RESOLVED, That our American Medical Association advocate that Medicare Part B cover the
13 full cost of all vaccinations administered to Medicare patients that are recommended by the
14 Advisory Committee on Immunization Practices (ACIP), the US Preventive Services Task Force
15 (USPSTF), or based on prevailing preventive clinical health guidelines. (Directive to Take
16 Action)

Fiscal Note: Modest – between \$1,000 - \$5,000

Received: 09/29/22

RELEVANT AMA POLICY

Medicare Prescription Drug and Vaccine Coverage and Payment D-330.898

Our AMA will: (1) continue to solicit input from national medical specialty societies and state medical associations for their recommendations to ensure adequate Medicare Part B drug reimbursement; (2) work with interested national medical specialty societies on alternative methods to reimburse physicians and hospitals for the cost of Part B drugs; and (3) continue working with interested stakeholders to improve the utilization rates of adult vaccines by individuals enrolled in Medicare.

Citation: CMS Rep. 3, I-20;

Reimbursement for Influenza Vaccine H-440.848

Our AMA: (1) will work with third party payers, including the Centers for Medicare and Medicaid Services, to establish a fair reimbursement price for the flu vaccine; (2) encourage the manufacturers of influenza vaccine to publish the purchase price by June 1st each year; (3) shall seek federal legislation or regulatory relief, or otherwise work with the federal government to increase Medicare reimbursement levels for flu vaccination and other vaccinations.

Citation: CSAPH Rep. 5, I-12; Reaffirmed: CSAPH Rep. 1, A-22

Financing of Adult Vaccines: Recommendations for Action H-440.860

1. Our AMA supports the concepts to improve adult immunization as advanced in the Infectious Diseases Society of America's 2007 document "Actions to Strengthen Adult and Adolescent Immunization Coverage in the United States," and support the recommendations as advanced by the National Vaccine Advisory Committee's 2008 white paper on pediatric vaccine financing.
2. Our AMA will advocate for the following actions to address the inadequate financing of adult vaccination in the United States:

Provider-related

- a. Develop a data-driven rationale for improved vaccine administration fees.
- b. Identify and explore new methods of providing financial relief for adult immunization providers through, for example, vaccine company replacement systems/deferred payment/funding for physician inventories, buyback for unused inventory, and patient assistance programs.
- c. Encourage and facilitate adult immunization at all appropriate points of patient contact; e.g., hospitals, visitors to long-term care facilities, etc.
- d. Encourage counseling of adults on the importance of immunization by creating a mechanism through which immunization counseling alone can be reimbursed, even when a vaccine is not given.

Federal-related

- a. Increase federal resources for adult immunization to: (i) Improve Section 317 funding so that the program can meet its purpose of improving adult immunizations; (ii) Provide universal coverage for adult vaccines and minimally, uninsured adults should be covered; (iii) Fund an adequate universal reimbursement rate for all federal and state immunization programs.
- b. Optimize use of existing federal resources by, for example: (i) Vaccinating eligible adolescents before they turn 19 years of age to capitalize on VFC funding; (ii) Capitalizing on public health preparedness funding.
- c. Ease federally imposed immunization burdens by, for example: (i) Providing coverage for Medicare-eligible individuals for all vaccines, including new vaccines, under Medicare Part B; (ii) Creating web-based billing mechanisms for physicians to assess coverage of the patient in real time and handle the claim, eliminating out-of-pocket expenses for the patient; (iii) Simplifying the reimbursement process to eliminate payment-related barriers to immunization.
- d. The Centers for Medicare & Medicaid Services should raise vaccine administration fees annually, synchronous with the increasing cost of providing vaccinations.

State-related

- a. State Medicaid programs should increase state resources for funding vaccines by, for example: (i) Raising and funding the maximum Medicaid reimbursement rate for vaccine administration fees; (ii) Establishing and requiring payment of a minimum reimbursement rate for administration fees; (iii) Increasing state contributions to vaccination costs; and (iv) Exploring the possibility of mandating immunization coverage by third party payers.
- b. Strengthen support for adult vaccination and appropriate budgets accordingly.

Insurance-related

1. Provide assistance to providers in creating efficiencies in vaccine management by: (i) Providing model vaccine coverage contracts for purchasers of health insurance; (ii) Creating simplified rules for eligibility verification, billing, and reimbursement; (iii) Providing vouchers to patients to clarify eligibility and coverage for patients and providers; and (iv) Eliminating provider/public confusion over insurance payment of vaccines by universally covering all Advisory Committee on Immunization Practices (ACIP)-recommended vaccines.
- b. Increase resources for funding vaccines by providing first-dollar coverage for immunizations.
- c. Improve accountability by adopting performance measurements.
- d. Work with businesses that purchase private insurance to include all ACIP-recommended immunizations as part of the health plan.
- e. Provide incentives to encourage providers to begin immunizing by, for example: (i) Including start up costs (freezer, back up alarms/power supply, reminder-recall systems, etc.) in the formula for reimbursing the provision of immunizations; (ii) Simplifying payment to and encouraging immunization by nontraditional providers; (iii) Facilitating coverage of vaccines administered in complementary locations (e.g., relatives visiting a resident of a long-term care facility).

Manufacturer-related

Market stability for adult vaccines is essential. Thus: (i) Solutions to the adult vaccine financing problem should not deter research and development of new vaccines; (ii) Solutions should consider the maintenance of vibrant public and private sector adult vaccine markets; (iii) Liability protection for manufacturers should be assured by including Vaccine Injury Compensation Program coverage for all ACIP-recommended adult vaccines; (iv) Educational outreach to both providers and the public is needed to improve acceptance of adult immunization.

3. Our AMA will conduct a survey of small- and middle-sized medical practices, hospitals, and other medical facilities to identify the impact on the adult vaccine supply (including influenza vaccine) that results from the large contracts between vaccine manufacturers/distributors and large non-government purchasers, such as national retail health clinics, other medical practices, and group purchasing programs, with particular attention to patient outcomes for clinical preventive services and chronic disease management.

Citation: CSAPH Rep. 4, I-08; Reaffirmation I-10; Reaffirmation: I-12; Reaffirmation I-14; Reaffirmed: CMS Rep. 3, I-20; Reaffirmation: A-22

Assuring Access to ACIP/AAFP/AAP-Recommended Vaccines H-440.875

1. It is AMA policy that all persons, regardless of economic and insurance status, receive all Advisory Committee on Immunization Practices (ACIP)-recommended vaccines as soon as possible following publication of these recommendations in the Centers for Disease Control and Prevention's (CDC) Morbidity and Mortality Weekly Report (MMWR).

2. Our AMA will continue to work with the federal government, Congress, and other stakeholders to improve liability protection for vaccine manufacturers and health care professionals who provide immunization services and to examine and improve compensation mechanisms for patients who were legitimately injured by a vaccine.

3. Our AMA will continue to work with the federal government, Congress, and other appropriate stakeholders to enhance public opinion of vaccines and to monitor and ensure the continued safety of existing and newly approved vaccines (including providing adequate resources for post-approval surveillance) so as to maintain and improve public confidence in the safety of vaccines.

4. Our AMA will work with appropriate stakeholders, including vaccine manufacturers, vaccine distributors, the federal government, medical specialty societies, and third party payers, to guarantee a robust vaccine delivery infrastructure (including but not limited to, the research and development of new vaccines, the ability to track the real-time supply status of ACIP-recommended vaccines, and the timely distribution of ACIP-recommended vaccines to providers).

5. Our AMA will work with appropriate federal and state agencies and private sector entities to ensure that state Medicaid agencies and private insurance plans pay health care professionals at least the approved Relative Value Unit (RVU) administration Medicare rates for payment when they administer ACIP-recommended vaccines.

6. Our AMA will work with the Centers for Medicare and Medicaid Services (CMS) to address barriers associated with Medicare recipients receiving live zoster vaccine and the routine boosters Td and Tdap in physicians' offices.

7. Our AMA will work through appropriate state entities to ensure all health insurance plans rapidly include newly ACIP-recommended vaccines in their list of covered benefits, and to pay health care professionals fairly for the purchase and administration of ACIP-recommended vaccines.

8. Our AMA will urge Medicare to include Tdap (Tetanus, Diphtheria, Acellular Pertussis) under Medicare Part B as a national public health measure to help prevent the spread of Pertussis.

9. Until compliance of AMA Policy H-440.875(6) is actualized to the AMA's satisfaction regarding the tetanus vaccine, our AMA will aggressively petition CMS to include tetanus and Tdap at both the "Welcome to Medicare" and Annual Medicare Wellness visits, and other clinically appropriate encounters, as additional "triggering event codes" (using the AT or another modifier) that allow for coverage and payment of vaccines to Medicare recipients.

10. Our AMA will aggressively petition CMS to include coverage and payment for any vaccinations administered to Medicare patients that are recommended by the ACIP, the US Preventive Services Task Force (USPSTF), or based on prevailing preventive clinical health guidelines.

Citation: BOT Action in response to referred for decision Res. 524, A-06; Reaffirmation A-07; Appended: Res. 531, A-07; Reaffirmation A-09; Reaffirmed: Res. 501, A-09; Reaffirmation I-10; Reaffirmation A-11; Reaffirmed in lieu of Res. 422, A-11: BOT action in response to referred for decision Res. 422, A-11;

Reaffirmation: I-12; Appended: Res. 227, I-12; Appended: Res. 824, I-14; Reaffirmed: Res. 411, A-17; Reaffirmed: CMS Rep. 3, I-20; Reaffirmed: Res. 228, A-21; Reaffirmation: A-22

Appropriate Reimbursements and Carve-outs for Vaccines D-440.981

Our AMA will: (1) continue to work with the Centers for Medicare and Medicaid Services (CMS) and provide comment on the Medicare Program payment policy for vaccine services; (2) continue to pursue adequate reimbursement for vaccines and their administration from all public and private payers; (3) encourage health plans to recognize that physicians incur costs associated with the procurement, storage and administration of vaccines that may be beyond the average wholesale price of any one particular vaccine; (4) seek legislation mandating that health insurance companies in applicable states either adequately pay for vaccines recommended by the Advisory Committee on Immunization Practices, or clearly state in large bold font in their notices to patients and businesses that they do not follow the federal advisory body on vaccine recommendations, the Advisory Committee on Immunization Practices; and (5) advocate that a physician's office can bill Medicare for all vaccines administered to Medicare beneficiaries and that the patient shall only pay the applicable copay to prevent fragmentation of care. Citation: BOT Rep. 20, A-03; Reaffirmation A-07; Res. 128, A-09; Reaffirmation I-10; Reaffirmed: Res. 807, I-11; Appended: Res. 217, A-19; Reaffirmed: CMS Rep. 3, I-20; Res. 408, I-21

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 812
(I-22)

Introduced by: Resident and Fellow Section

Subject: Implant-Associated Anaplastic Large Cell Lymphoma

Referred to: Reference Committee J

Whereas, In 2016, the World Health Organization provisionally classified breast implant-associated anaplastic large cell lymphoma (BIA-ALCL) as a T-cell lymphoma¹; and

Whereas, Policies concerning breast cancer treatment do not encompass BIA-ALCL given that this cancer is a lymphoma; and

Whereas, The 2019 National Comprehensive Cancer Care Network consensus guidelines state clearly that, "Essential to the treatment of BIA-ALCL is timely diagnosis and complete surgical excision."²; and

Whereas, Patients with BIA-ALCL suffer delays in care as they fight with their insurance companies to cover surgery to remove the cancer and their breast implants, as the insurance company may initially classify the surgery as cosmetic and not cover it,³ therefore be it

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

Fiscal Note: Minimal - less than \$1,000

Received: 09/30/22

1. Steven H. Swerdlow, Elias Campo, Stefano A. Pileri, Nancy Lee Harris, Harald Stein, Reiner Siebert, Ranjana Advani, Michele Ghielmini, Gilles A. Salles, Andrew D. Zelenetz and Elaine S. Jaffe "The 2016 revision of the World Health Organization classification of lymphoid neoplasms, section on Mature T-cell lymphomas and NK - lymphomas." *Blood*. 2016, 127:2375-2390.
2. Mark W Clemens, MD, FACS, Eric D Jacobsen, MD, Steven M Horwitz, MD "2019 NCCN Consensus Guidelines on the Diagnosis and Treatment of Breast Implant-Associated Anaplastic Large Cell Lymphoma (BIA-ALCL)." *Aesthetic Surgery Journal*. 2019, 39 (Supplement 1):S3–S13.
3. Denise Grady. A shocking diagnosis: breast implants 'gave me cancer.' *The New York Times*. 2017 May 14. Available at: <https://www.nytimes.com/2017/05/14/health/breast-implants-cancer.html>

RELEVANT AMA POLICY

Breast Implants H-525.984

Our AMA: (1) supports that individuals be fully informed about the risks and benefits associated with breast implants and that once fully informed the patient should have the right to choose; and (2) based on current scientific knowledge, supports the continued practice of breast augmentation or reconstruction with implants when indicated.

Citation: CSA Rep. M, I-91; Modified: Sunset Report, I-01; Reaffirmed: Res. 727, I-02; Modified: CSAPH Rep. 1, A-12; Modified: CSAPH Rep. 1, A-22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 813
(I-22)

Introduced by: Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island,
Vermont, Washington

Subject: Amending Policy on a Public Option to Maximize AMA Advocacy

Referred to: Reference Committee J

1 Whereas, The Patient Protection and Affordable Care Act of 2010 (ACA) reduced the
2 uninsurance rate in the United States but has not achieved universal coverage^{1,2}; and
3

4 Whereas, Tens of millions of Americans are either uninsured or underinsured with insurance
5 that is too expensive to actually be used, significantly limiting their access to affordable
6 healthcare³⁻⁵; and
7

8 Whereas, Many individual insurance plans offered on the ACA's Health Insurance Marketplaces
9 (hereafter referred to as "ACA Exchanges") have high premiums, deductibles, and other out-of-
10 pocket costs that leave beneficiaries exposed to financial risk and limit their access to
11 healthcare services^{2,6-8}; and
12

13 Whereas, Some ACA Exchanges, particularly those covering rural areas, offer only a small
14 number of plans that are limited by very few insurers participating, which has been shown to
15 lead to higher costs and faster premium growth due to limited competition⁹⁻¹³; and
16

17 Whereas, Plans offered on the ACA Exchanges frequently have narrow provider networks,
18 which reduces access to care and can lead to high out-of-pocket costs if patients go out-of-
19 network¹⁴⁻¹⁶; and
20

21 Whereas, A federally-managed public insurance plan ("public option") has been proffered as a
22 mechanism to improve competition, increase access to affordable healthcare, and lower costs,
23 particularly in areas where there are few participating insurers and a commensurate lack of
24 competition between plans^{8,17-19}; and
25

26 Whereas, A recent analysis from the Urban Institute found that various public option proposals
27 with different eligibility criteria and payment rates would all decrease the uninsured rate,
28 significantly reduce premiums, and reduce the federal deficit²⁰; and
29

30 Whereas, RAND modeled four different scenarios under which a public option could be
31 implemented and found that under all scenarios, premium costs in the public option were lower
32 than in private plans, leading to more people being covered²¹; and
33

34 Whereas, A Commonwealth Fund analysis of various healthcare reform proposals found that a
35 public option would reduce the uninsured rate and significantly reduce costs to the federal
36 government, permitting the implementation of more generous premium tax credits that could
37 further reduce the uninsurance rate²²; and

1 Whereas, A public option would have significant leverage during price negotiations with
2 hospitals, pharmaceutical companies, pharmacy benefit managers, and other healthcare
3 providers due to its large size and would likely have lower administrative costs per beneficiary
4 than smaller private plans, leading to lower premiums and cost-sharing for beneficiaries and
5 lower costs to the federal government^{9,21,23,24}; and
6

7 Whereas, A 2021 CBO report on key design considerations for a public option showed that the
8 benchmark premium for insurance plans offered on the ACA Exchanges is closely correlated
9 with the number of insurers participating in the market with more insurers leading to lower
10 premiums, suggesting that the public option, as an additional insurer, would reduce premiums
11 for public and private insurers alike²⁵; and
12

13 Whereas, Though there are concerns that a public option may reduce overall physician
14 reimbursement through lower provider payment rates, CBO estimates of the impacts of
15 Medicare-for-All proposals on physician reimbursement show that lower provider payment rates
16 may be balanced by increased healthcare utilization after the expansion of public insurance
17 programs, leading to small overall changes in physician reimbursement and a net increase in
18 some scenarios^{28,29}; and
19

20 Whereas, Recent studies published by the CBO, JAMA, and AAFP have discussed the inherent
21 tradeoffs between lowering costs through reduced provider reimbursement and developing
22 provider networks attractive enough to convince prospective beneficiaries to enroll in the public
23 option, highlighting how careful design of a public option can maximize benefit to patients and
24 physicians alike³⁰⁻³²; and
25

26 Whereas, The state of Washington created a public option-like program called Cascade Care in
27 2019 that designed overall reimbursement to exceed no more than 160% of Medicare rates with
28 a minimum reimbursement of 135% of Medicare rates for primary care practices, showing how a
29 public option can be designed to reduce costs and expand coverage in ways that do not unduly
30 burden physicians^{33,34}; and
31

32 Whereas, The AMA passed Policy H-165.823 in November 2020, which lays out a variety of
33 criteria that a public option should meet, but does not go so far as to explicitly support a public
34 option; and
35

36 Whereas, H-165.823 already contains provisions to protect physicians and their practices,
37 including a requirement that the public option not tie participation to participation in other public
38 insurance programs, a requirement that contracts with physicians must be subject to meaningful
39 negotiation, and a requirement that reimbursement exceed prevailing Medicare rates and be at
40 levels sufficient to sustain the costs of medical practice; and
41

42 Whereas, Based in large part upon on this policy, the AMA recently sent a letter to Congress
43 regarding a public option, which highlighted the standards codified in H-165.823 while failing to
44 mention the potential benefits or explicitly endorse a public option³⁵; and
45

46 Whereas, multiple physician groups, including the American College of Physicians, American
47 Academy of Family Physicians, American Academy of Pediatrics, American College of
48 Obstetricians and Gynecologists, American Osteopathic Association, American Psychiatric
49 Association, and the Society of General Internal Medicine, have endorsed a public option³⁶⁻³⁸;
50 therefore be it

1 RESOLVED, That our American Medical Association amend Policy H-165.823, "Options to
2 Maximize Coverage under the AMA Proposal for Reform", by addition and deletion to read as
3 follows:
4

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

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

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

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

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

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

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

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

Fiscal Note: Minimal – less than \$1,000

Received: 10/04/22

References:

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RELEVANT AMA POLICY

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

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

- a. The primary goals of establishing a public option are to maximize patient choice of health plan and maximize health plan marketplace competition.
- b. Eligibility for premium tax credit and cost-sharing assistance to purchase the public option is restricted to individuals without access to affordable employer-sponsored coverage that meets standards for minimum value of benefits.
- c. Physician payments under the public option are established through meaningful negotiations and contracts. Physician payments under the public option must be higher than prevailing Medicare rates and at rates sufficient to sustain the costs of medical practice.
- d. Physicians have the freedom to choose whether to participate in the public option. Public option proposals should not require provider participation and/or tie physician participation in Medicare, Medicaid and/or any commercial product to participation in the public option.
- e. The public option is financially self-sustaining and has uniform solvency requirements.
- f. The public option does not receive advantageous government subsidies in comparison to those provided to other health plans.
- g. The public option shall be made available to uninsured individuals who fall into the “coverage gap” in states that do not expand Medicaid – having incomes above Medicaid eligibility limits but below the federal poverty level, which is the lower limit for premium tax credits – at no or nominal cost.

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

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

3. Our AMA: (a) will advocate that any federal approach to cover uninsured individuals who fall into the “coverage gap” in states that do not expand Medicaid--having incomes above Medicaid eligibility limits but below the federal poverty level, which is the lower limit for premium tax credit eligibility--make health insurance coverage available to uninsured individuals who fall into the coverage gap at no or nominal cost, with significant cost-sharing protections; (b) will advocate that any federal approach to cover uninsured individuals who fall into the coverage gap provide states that have already implemented Medicaid expansions with additional incentives to maintain their expansions; (c) supports extending eligibility to purchase Affordable Care Act (ACA) marketplace coverage to undocumented immigrants and Deferred Action for Childhood Arrivals (DACA) recipients, with the guarantee that health plans and ACA marketplaces will not collect and/or report data regarding enrollee immigration status; and (d) recognizes the potential for state and local initiatives to provide coverage to immigrants without regard to immigration status.

Citation: CMS Rep. 1, I-20; Appended: CMS Rep. 3, I-21; Reaffirmation: A-22; Reaffirmed: CMS Rep. 3, A-22; Reaffirmed: Res. 122, A-22

Universal Health Coverage H-165.904

Our AMA: (1) seeks to ensure that federal health system reform include payment for the urgent and emergent treatment of illnesses and injuries of indigent, non-U.S. citizens in the U.S. or its territories; (2) seeks federal legislation that would require the federal government to provide financial support to any individuals, organizations, and institutions providing legally-mandated health care services to foreign nationals and other persons not covered under health system reform; and (3) continues to assign a high priority to the problem of the medically uninsured and underinsured and continues to work toward national consensus on providing access to adequate health care coverage for all Americans

Citation: Sub. Res. 138, A-94; Appended: Sub. Res. 109, I-98; Reaffirmation A-02; Reaffirmation A-07; Reaffirmation I-07; Reaffirmed: Res. 239, A-12; Reaffirmed: CMS Rep. 1, A-22

Evaluating Health System Reform Proposals H-165.888

1. Our AMA will continue its efforts to ensure that health system reform proposals adhere to the following principles:

- A. Physicians maintain primary ethical responsibility to advocate for their patients' interests and needs.
- B. Unfair concentration of market power of payers is detrimental to patients and physicians, if patient freedom of choice or physician ability to select mode of practice is limited or denied. Single-payer systems clearly fall within such a definition and, consequently, should continue to be opposed by the AMA. Reform proposals should balance fairly the market power between payers and physicians or be opposed.
- C. All health system reform proposals should include a valid estimate of implementation cost, based on all health care expenditures to be included in the reform; and supports the concept that all health system reform proposals should identify specifically what means of funding (including employer-mandated funding, general taxation, payroll or value-added taxation) will be used to pay for the reform proposal and what the impact will be.
- D. All physicians participating in managed care plans and medical delivery systems must be able without threat of punitive action to comment on and present their positions on the plan's policies and procedures for medical review, quality assurance, grievance procedures, credentialing criteria, and other financial and administrative matters, including physician representation on the governing board and key committees of the plan.
- E. Any national legislation for health system reform should include sufficient and continuing financial support for inner-city and rural hospitals, community health centers, clinics, special programs for special populations and other essential public health facilities that serve underserved populations that otherwise lack the financial means to pay for their health care.
- F. Health system reform proposals and ultimate legislation should result in adequate resources to enable medical schools and residency programs to produce an adequate supply and appropriate generalist/specialist mix of physicians to deliver patient care in a reformed health care system.
- G. All civilian federal government employees, including Congress and the Administration, should be covered by any health care delivery system passed by Congress and signed by the President.
- H. True health reform is impossible without true tort reform.

2. Our AMA supports health care reform that meets the needs of all Americans including people with injuries, congenital or acquired disabilities, and chronic conditions, and as such values function and its improvement as key outcomes to be specifically included in national health care reform legislation.

3. Our AMA supports health care reform that meets the needs of all Americans including people with mental illness and substance use / addiction disorders and will advocate for the inclusion of full parity for the treatment of mental illness and substance use / addiction disorders in all national health care reform legislation.

4. Our AMA supports health system reform alternatives that are consistent with AMA principles of pluralism, freedom of choice, freedom of practice, and universal access for patients.

Citation: Res. 118, I-91; Res. 102, I-92; BOT Rep. NN, I-92; BOT Rep. S, A-93; Reaffirmed: Res. 135, A-93; Reaffirmed: BOT Reps. 25 and 40, I-93; Reaffirmed in lieu of Res. 714, I-93; Res. 130, I-93; Res. 316, I-93; Sub. Res. 718, I-93; Reaffirmed: CMS Rep. 5, I-93; Res. 124, A-94; Reaffirmed by BOT Rep. 1- I-94; CEJA Rep. 3, A-95; Reaffirmed: BOT Rep. 34, I-95; Reaffirmation A-00; Reaffirmation A-01; Reaffirmed: CMS Rep. 10, A-03; Reaffirmed: CME Rep. 2, A-03; Reaffirmed and Modified: CMS Rep. 5, A-04; Reaffirmed with change in title: CEJA Rep. 2, A-05; Consolidated: CMS Rep. 7, I-05; Reaffirmation I-07; Reaffirmed in lieu of Res. 113, A-08; Reaffirmation A-09; Res. 101, A-09; Sub. Res. 110, A-09; Res. 123, A-09; Reaffirmed in lieu of Res. 120, A-12; Reaffirmation: A-17

Health System Reform Legislation H-165.838

1. Our American Medical Association is committed to working with Congress, the Administration, and other stakeholders to achieve enactment of health system reforms that include the following seven critical components of AMA policy:
 - a. Health insurance coverage for all Americans
 - b. Insurance market reforms that expand choice of affordable coverage and eliminate denials for pre-existing conditions or due to arbitrary caps
 - c. Assurance that health care decisions will remain in the hands of patients and their physicians, not insurance companies or government officials
 - d. Investments and incentives for quality improvement and prevention and wellness initiatives
 - e. Repeal of the Medicare physician payment formula that triggers steep cuts and threaten seniors' access to care
 - f. Implementation of medical liability reforms to reduce the cost of defensive medicine
 - g. Streamline and standardize insurance claims processing requirements to eliminate unnecessary costs and administrative burdens
2. Our American Medical Association advocates that elimination of denials due to pre-existing conditions is understood to include rescission of insurance coverage for reasons not related to fraudulent representation.
3. Our American Medical Association House of Delegates supports AMA leadership in their unwavering and bold efforts to promote AMA policies for health system reform in the United States.
4. Our American Medical Association supports health system reform alternatives that are consistent with AMA policies concerning pluralism, freedom of choice, freedom of practice, and universal access for patients.
5. AMA policy is that insurance coverage options offered in a health insurance exchange be self-supporting, have uniform solvency requirements; not receive special advantages from government subsidies; include payment rates established through meaningful negotiations and contracts; not require provider participation; and not restrict enrollees' access to out-of-network physicians.
6. Our AMA will actively and publicly support the inclusion in health system reform legislation the right of patients and physicians to privately contract, without penalty to patient or physician.
7. Our AMA will actively and publicly oppose the Independent Medicare Commission (or other similar construct), which would take Medicare payment policy out of the hands of Congress and place it under the control of a group of unelected individuals.
8. Our AMA will actively and publicly oppose, in accordance with AMA policy, inclusion of the following provisions in health system reform legislation:
 - a. Reduced payments to physicians for failing to report quality data when there is evidence that widespread operational problems still have not been corrected by the Centers for Medicare and Medicaid Services
 - b. Medicare payment rate cuts mandated by a commission that would create a double-jeopardy situation for physicians who are already subject to an expenditure target and potential payment reductions under the Medicare physician payment system
 - c. Medicare payments cuts for higher utilization with no operational mechanism to assure that the Centers for Medicare and Medicaid Services can report accurate information that is properly attributed and risk-adjusted
 - d. Redistributed Medicare payments among providers based on outcomes, quality, and risk-adjustment measurements that are not scientifically valid, verifiable and accurate
 - e. Medicare payment cuts for all physician services to partially offset bonuses from one specialty to another
 - f. Arbitrary restrictions on physicians who refer Medicare patients to high quality facilities in which they have an ownership interest
9. Our AMA will continue to actively engage grassroots physicians and physicians in training in collaboration with the state medical and national specialty societies to contact their Members of Congress, and that the grassroots message communicate our AMA's position based on AMA policy.
10. Our AMA will use the most effective media event or campaign to outline what physicians and patients need from health system reform.
11. AMA policy is that national health system reform must include replacing the sustainable growth rate (SGR) with a Medicare physician payment system that automatically keeps pace with the cost of running a practice and is backed by a fair, stable funding formula, and that the AMA initiate a "call to action" with the Federation to advance this goal.

12. AMA policy is that creation of a new single payer, government-run health care system is not in the best interest of the country and must not be part of national health system reform.

13. AMA policy is that effective medical liability reform that will significantly lower health care costs by reducing defensive medicine and eliminating unnecessary litigation from the system should be part of any national health system reform.

Citation: Sub. Res. 203, I-09; Reaffirmation A-10; Reaffirmed in lieu of Res. 102, A-10; Reaffirmed in lieu of Res. 228, A-10; Reaffirmed: CMS Rep. 2, I-10; Reaffirmed: Sub. Res. 222, I-10; Reaffirmed: CMS Rep. 9, A-11; Reaffirmation A-11; Reaffirmed: CMS Rep. 6, I-11; Reaffirmed in lieu of Res. 817, I-11; Reaffirmation I-11; Reaffirmation A-12; Reaffirmed in lieu of Res. 108, A-12; Reaffirmed: Res. 239, A-12; Reaffirmed: Sub. Res. 813, I-13; Reaffirmed: CMS Rep. 9, A-14; Reaffirmation A-15; Reaffirmed in lieu of Res. 215, A-15; Reaffirmation: A-17; Reaffirmed in lieu of: Res. 712, A-17; Reaffirmed in lieu of: Res. 805, I-17; Reaffirmed: CMS Rep. 03, A-18; Reaffirmed: CMS Rep. 09, A-19; Reaffirmed: CMS Rep. 3, I-21; Reaffirmation: A-22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 814
(I-22)

Introduced by: American College of Cardiology, American Society of Echocardiography,
American Society of Nuclear Cardiology, Heart Rhythm Society, Society for
Cardiovascular Angiography and Interventions, Society of Cardiovascular
Computed Tomography, Texas

Subject: Socioeconomics of CT Coronary Calcium: Is it Scored or Ignored?

Referred to: Reference Committee J

1 Whereas, A coronary artery calcium score (CACS) measured by computed tomography is a
2 noninvasive, low-radiation diagnostic test that correlates with cardiovascular outcomes¹; and
3

4 Whereas, Screening with CACS can help guide the course of clinical management in the
5 borderline-and intermediate-risk patients with 10-year cardiovascular risk of 5% to
6 20%, particularly those with risk-enhancing factors, e.g., chronic kidney disease, metabolic
7 syndrome, an elevated high sensitivity C-reactive protein, a positive ankle-brachial index, or a
8 positive family history^{2,3} by the American College of Cardiology and American Heart Association
9 2019 Primary Prevention Guidelines; and
10

11 Whereas, CACS is not covered by insurance except in the state of Texas⁴, and the out-of-
12 pocket costs range from \$49-\$1209, which may represent a barrier for patients who may not be
13 able to afford the test, but are likely to derive benefit from the results of the test; and
14

15 Whereas, A low-cost and no-charge CACS strategy has been tested in Cleveland, Ohio⁵,
16 demonstrating a striking increase in CACS utilization in lower income patients, the black
17 population, and women; therefore be it
18

19 RESOLVED, That our American Medical Association seek national and/or state legislation
20 and/or a national coverage determination (NCD) to include coronary artery calcium scoring
21 (CACS) for patients who meet the screening criteria set forth by the American College of
22 Cardiology/American Heart Association 2019 Primary Prevention Guidelines, as a first-dollar
23 covered preventive service, consistent with the current policy in the state of Texas (Directive to
24 Take Action); and be it further
25

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

Fiscal Note: Modest – between \$1,000 - \$5,000

Received: 10/04/22

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 815
(I-22)

Introduced by: Medical Student Section

Subject: Opposition to Debt Litigation Against Patients

Referred to: Reference Committee J

1 Whereas, In 2020, medical debt was \$429 million across the United States, exceeding
2 nonmedical debt by \$39 million¹; and
3

4 Whereas, Medical debt affects a significant portion of the population, with 19% of U.S. families
5 unable to afford paying up-front for medical care in 2017²; and
6

7 Whereas, 26.7% of households with a Black family member had medical debt compared to
8 17.2% of households with a White family member and 9.7% of households with an Asian family
9 member²; and
10

11 Whereas, 31% of households with a family member in poor health had medical debt compared
12 to 14.4% of those with family members in adequate health²; and
13

14 Whereas, 64% of Americans in 2018 delayed or avoided treatment due to cost of medical care³;
15 and
16

17 Whereas, Medical debt is a risk factor for prolonging a period of homelessness, and in a study
18 of 1,600 low income individuals, 27% stated they had housing problems including difficulty
19 qualifying for a mortgage and inability to pay rent or mortgage as a result of their medical
20 debt⁴⁻⁵; and
21

22 Whereas, Individual medical debt is often an insignificant portion of hospital's overall revenue,
23 despite the devastating impacts it has on individuals and families⁶; According to ProPublica this
24 portion can be as little as 0.03%, and the Healthcare Financial Management Association found
25 that in 2018, bad debt (debt unlikely to be paid) consisted of 1-3% of total hospital revenue⁷;
26 and
27

28 Whereas, There is a growing national recognition of the problems associated with medical
29 billing, reflected in the introduced Medical Debt Relief Act of 2021, which primarily aims for
30 increased forgiveness regarding the reporting of medical debt on patient credit, but does not
31 address hospital billing practices⁸; and
32

33 Whereas, An August 2021 study published in JAMA Network Open found that after media
34 coverage of debt litigation against patients in Virginia, Virginia hospitals filed 59% fewer medical
35 debt lawsuits compared to the previous year and 11 hospitals banned the practice altogether,
36 demonstrating that public accountability can reduce this predatory practice⁹; and

Whereas, The American Hospital Association (AHA) Patient Billing Guidelines state that health care organizations have a responsibility to communicate effectively with patients and provide resources for patients wishing to discuss their payments; in the event of a nonpayment, the AHA guidelines recommend giving patients 30 days prior notice of any actions a hospital will take as a result¹⁰; and

Whereas, The AHA Patient Billing Guidelines state that health care organizations working with third-party debt collectors should ensure that the collectors adhere to the Fair Debt Collection Practices Act (FDCPA), which establishes guidelines meant to prevent abusive debt practice against consumers¹⁰; and

Whereas, AMA Policy H-385.963 encourages physicians to ensure no debt collection is sent to a patient without the physician's knowledge and to practice compassion and discretion when sending collection; and

Whereas, Our AMA currently lacks policy addressing the practice of debt litigation directly conducted by health care organizations; therefore be it

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

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

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

Fiscal Note: Minimal - less than \$1,000

Received: 10/05/22

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RELEVANT AMA POLICY

Offsetting the Costs of Providing Uncompensated Care H-160.923

Our AMA: (1) supports the transitional redistribution of disproportionate share hospital (DSH) payments for use in subsidizing private health insurance coverage for the uninsured;(2) supports the use of innovative federal- or state-based projects that are not budget neutral for the purpose of supporting physicians that treat large numbers of uninsured patients, as well as EMTALA-directed care; and (3) encourages public and private sector researchers to utilize data collection methodologies that accurately reflect the amount of uncompensated care (including both bad debt and charity care) provided by physicians.

Citation: CMS Rep. 8, A-05; Reaffirmation A-07; Modified: CMS Rep. 01, A-17

Exclusion of Medical Debt That Has Been Fully Paid or Settled H-373.996

Our AMA supports the principles contained in The Medical Debt Relief Act as drafted and passed by the US House of Representatives to provide relief to the American consumer from a complicated collections process and supports medical debt resolution being portrayed in a positive and productive manner.

Citation: Res. 226, I-10; Reaffirmed: BOT Rep. 04, A-20

Health Plan Payment of Patient Cost-Sharing D-180.979

Our AMA will: (1) support the development of sophisticated information technology systems to help enable physicians and patients to better understand financial obligations; (2) encourage states and other stakeholders to monitor the growth of high deductible health plans and other forms of cost-sharing in health plans to assess the impact of such plans on access to care, health outcomes, medical debt, and provider practice sustainability; (3) advocate for the inclusion of health insurance contract provisions that permit network physicians to collect patient cost-sharing financial obligations (eg, deductibles, co-payments, and co-insurance) at the time of service; and (4) monitor programs wherein health plans and insurers bear the responsibility of collecting patient co-payments and deductibles.

Citation: CMS Rep. 09, A-19;

Physician Review of Accounts Sent for Collection H-385.963

(1) The AMA encourages all physicians and employers of physicians who treat patients to review their accounting/collection policies to ensure that no patient's account is sent to collection without the physician's knowledge. (2) The AMA urges physicians to use compassion and discretion in sending accounts of their patients to collection, especially accounts of patients who are terminally ill, homeless, disabled, impoverished, or have marginal access to medical care.

Citation: (Res. 127, I-92; Reaffirmed: CMS Rep. 10, A-03; Reaffirmed: CMS Rep. 4, A-13)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 816
(I-22)

Introduced by: Medical Student Section

Subject: Medicaid and CHIP Coverage for Glucose Monitoring Devices for Patients with Diabetes

Referred to: Reference Committee J

1 Whereas, Type 1 diabetes mellitus (T1DM) and type 2 diabetes mellitus (T2DM) pose large and
2 steadily increasing health threats for both adults and youth in the United States, with
3 approximately 26.8 million adults and 210,000 youth under the age of 20 currently diagnosed
4 with either disease¹⁻⁶; and

5
6 Whereas, There is increasing evidence for the role of glycemic variability in the development of
7 diabetic complications and mortality, particularly cardiovascular disease, stroke, and kidney
8 disease, which alongside diabetes are four of the top 10 leading causes of death in the U.S.⁷⁻¹²;
9 and

10
11 Whereas, Glycemic variability for both T1DM and T2DM patients overall has been shown to
12 reduce quality of life and increase the burden of diabetes to healthcare systems, which currently
13 stands at over \$1 billion annually¹²⁻¹⁵; and

14
15 Whereas, National trends in U.S. hospitalizations show an increasing number of admissions for
16 hypoglycemia among those with T2DM in recent years, with highest rates among Black
17 Medicare beneficiaries and those older than 75 years old¹⁶; and

18
19 Whereas, Investigators found that frequency of hypoglycemic events can be markedly reduced
20 in individuals with impaired hypoglycemia awareness through use of continuous glucose
21 monitors (CGM) for patients with T1DM, T2DM and gestational diabetes mellitus^{17,18}; and

22
23 Whereas, CGM use has been demonstrated to improve patients' quality of life, reduce fear of
24 hypoglycemia, and provide a sense of empowerment to patients and their caregivers¹⁹⁻²⁷; and

25
26 Whereas, Data show that restrictive access to CGMs in the Medicare and Medicaid populations
27 may have deleterious health, economic, and quality of life consequences^{17,26}; and

28
29 Whereas, Many Medicare beneficiaries are subject to restrictive criteria for eligibility of CGMs,
30 such as documenting four fingerstick glucose tests per day for coverage of CGMs, despite only
31 100 test strips per 3 months being covered for non-insulin dependent diabetics^{17,28,29}; and

32
33 Whereas, As of February 2020, 11 of 36 state Medicaid programs have required similar
34 stringent criteria of individuals needing to document four fingerstick glucose tests per day for
35 coverage of CGMs, and only four states have openly committed to Medicaid covering CGMs in
36 patients with T2DM regardless of durable medical equipment (DME) classification¹⁷; and

37
38 Whereas, CGMs offer a cost-effective alternative to traditional self-monitoring via finger prick at
39 an additional \$653 over a patient's lifetime, translating to \$8898 per quality-adjusted life year

(QALY) gained that is well below the \$100,000 per QALY cost-effectiveness threshold often cited in healthcare economics studies^{30,31}; and

Whereas, Approximately 14% of adults under 65 covered by Medicaid have a form of diabetes³²; and

Whereas, Retrospective analysis of patients prescribed to a professional CGM for T2DM showed no statistically significant increase in total annual costs compared to those who were not prescribed a professional CGM, but did see an improvement in hemoglobin A1c (HbA1c) without intensification of the current treatment regimen^{19,33}; and

Whereas, While long-term cost effectiveness studies have demonstrated CGMs' potential to decrease overall costs for patients with T2DM through elimination of test strips and lancets, a majority of financial benefit is due to lower HbA1c readings and mitigation of direct diabetes related complications such as hospitalizations, emergency room visits, non-diabetes prescription medications, and indirect costs such as hampered productivity, which collectively account for 73.1% of total diabetes care cost^{17,33}; and

Whereas, The lowest-cost option among CGMs, with an out-of-pocket price of less than \$100 for uninsured individuals, are an alternative non-invasive glucose monitor called flash glucose monitoring which provides glucose readings on demand and allows for downloadable glucose data, and use has been found to decrease acute diabetes-related events and all-cause inpatient hospitalizations in patients with T2DM treated with short or rapid acting insulin³⁴⁻³⁶; and

Whereas, Patients with T2DM treated with oral agents are often placed on a basal-bolus regimen of insulin while admitted to the hospital for glucose control, and use of flash glucose monitoring in these patients during admission demonstrated lower average daily glucose and increased detection of hypoglycemia^{37,38}; and

Whereas, CGMs have been able to provide increased insight into nocturnal glucose levels, glucose metabolism during exercise and feeding, and relative impact of medications on ambient glucose than any form of episodic self-monitoring of blood glucose for all patients with diabetes, and CGM users spent significantly less time in hypoglycemic ranges compared to their self-monitoring of blood glucose counterparts^{17,39}; and

Whereas, AMA Directive D-185.983 asks our AMA Board of Trustees to consider a legal challenge, if appropriate, to the authority of the Centers for Medicare & Medicaid Services (CMS) and other health care insurers placing onerous barriers on diabetic patients to procure medically necessary "durable medical equipment and supplies"; and

Whereas, Certain CGMs which require adjunctive therapy are deemed "non-therapeutic" and thus are ineligible to be classified as durable medical equipment (DME) and supplies, despite their ability to influence medical decision making⁴⁰; and

Whereas, CMS Proposal CMS-1739-P includes a section on reclassifying "therapeutic" and "non-therapeutic" CGMs as DME, as access to DME has been associated with better outcomes and significantly lower healthcare spending due to patients' ability to receive care at home, and variations in Medicaid definitions of DME have been linked to variations in geographic healthcare expenditure^{40,41}; and

Whereas, Increased eligibility and access to all glucose monitors, including CGM and flash glucose monitoring, would provide improved, cost-effective health care outcomes for low-income patients with diabetes on Medicaid and Medicare^{19,33-35,37,38}, and

Whereas, Medicaid and public state medical insurance expansions that include CGM devices have been demonstrated to improve glycemic control and reduce disparities in pediatric patients with type 1 diabetes^{42,43}, and

Whereas, Current AMA policy H-330.885 supports coverage of CGM for Medicare patients with insulin-dependent diabetes but does not address Medicaid or CHIP; therefore be it

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

RESOLVED, That our AMA amend AMA Policy H-330.885, "Medicare Coverage of Continuous Glucose Monitoring Devices for Patients with Insulin-Dependent Diabetes," by addition and deletion to read as follows:

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

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

Fiscal Note: Modest – between \$1,000 - \$5,000

Received: 10/12/22

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RELEVANT AMA POLICY

Diabetic Documentation Requirements D-185.983

1. Our AMA Board of Trustees will consider a legal challenge, if appropriate, to the authority of the Centers for Medicare & Medicaid Services (CMS) and other health care insurers placing onerous barriers on diabetic patients to procure medically necessary durable medical equipment and supplies. 2. Our AMA Board of Trustees will consider a legal challenge, if appropriate, to the authority and policy of CMS and other insurers to practice medicine through their diabetes guidelines, and place excessive time and financial burdens without reimbursement on a physician assisting patients seeking reimbursement for supplies needed to treat their diabetes. Res. 730, A-13

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

Our AMA supports efforts to achieve Medicare coverage of continuous glucose monitoring systems for patients with insulin-dependent diabetes. Res. 126, A-14

CMS Required Diabetic Supply Forms H-330.908

Our AMA requests that CMS change its requirement so that physicians need only re-write prescriptions for glucose monitors every twelve months, instead of a six month requirement, for Medicare covered diabetic patients and make the appropriate diagnosis code sufficient for the determination of medical necessity.

Sub Res. 102, A-00; Reaffirmation and Amended: Res. 520, A-02; Modified: CMS Rep. 4, A-12; Reaffirmed: CMS Rep. 1, A-22

Physician Ordering of Durable Medical Equipment and Home Health Services H-330.936

The AMA urges CMS and other payers to require that durable medical equipment and home health and other outpatient medical services be ordered by the physician responsible for the patient's care, with appropriate documentation of medical necessity, before such services are offered to the patient or family; and that suppliers provide to the physician the charge for all durable medical equipment and home health and other outpatient services prior to the time the physician signs the order.

Res. 112, I-96; Reaffirmed by Res. 122, A-97; Amended: CMS Rep. 4, I-97; Reaffirmation: A-99; Reaffirmation: A-04; Reaffirmation: A-08; Reaffirmed: CMS Rep. 01, A-18

Access to Medical Care D-480.991

Our AMA shall work with the Centers for Medicare and Medicaid Services to maximize access to the devices and procedures available to Medicare patients by ensuring reimbursement at least covers the cost of said device or procedure.

Res. 130, A-02; Reaffirmation: A-04; Reaffirmed: CMS Rep. 1, A-14

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 817
(I-22)

Introduced by: Medical Student Section

Subject: Promoting Oral Anticancer Drug Parity

Referred to: Reference Committee J

1 Whereas, Chemotherapy drugs have been traditionally administered intravenously, although the
2 FDA has increasingly approved oral anticancer drugs to reflect not only medical advancement
3 but a growing patient preference^{1,2}; and
4

5 Whereas, Oral drug disparity is found in the disparity between insurance policy medical benefits
6 versus pharmacy benefits, with the former requiring little to no copay for IV chemotherapy and
7 the latter frequently requiring heavy out-of-pocket costs for oral anti-cancer medications^{3,4}; and
8

9 Whereas, For many oral chemotherapeutics, their classification as prescription drug benefits as
10 opposed to medical benefits allows private insurers to impose more expensive monthly copays,
11 sometimes as high as \$2500 compared to \$50 for the IV-administered form of the same drug¹;
12 and
13

14 Whereas, Many oral chemotherapeutics present the only viable option in cancer treatment and
15 have no IV-counterpart⁵; and
16

17 Whereas, Upwards of 40% of all new chemotherapeutics are available solely as oral
18 treatments⁶; and
19

20 Whereas, A portion of patients who cannot afford these oral chemotherapeutics forego taking
21 them, resulting in higher rates of hospitalizations, complications, and increased costs to both the
22 patient and health care system^{2,3,7,8}; and
23

24 Whereas, Despite the inaccessibility of oral chemotherapeutics, studies demonstrate patient-
25 reported preferences for oral administration over intravenous due to convenience, perceived
26 improvement of quality of life, and comfort⁹; and
27

28 Whereas, Higher monthly payments can be associated with a statistically significant higher risk
29 of medication non-adherence²; and
30

31 Whereas, Nonadherence to therapy is the strongest risk factor for cancer recurrence, after
32 which total cost of cancer-related treatment for the patient increases significantly^{2,10}; and
33

34 Whereas, "Oral parity" refers to ensuring equitable costs to patients for orally-administered
35 anticancer drugs as compared to IV-administered anticancer drugs¹¹; and
36

37 Whereas, While some form of oral parity legislation exists in 43 states, many states' policies are
38 unevenly applied such that large, private-sector, multi-state health plans are often excluded^{2,5};
39 and

Whereas, The Cancer Drug Parity Act (originally introduced in the House of Representatives and Senate in 2019, and later re-introduced in 2021) promotes equal coverage of intravenous and oral medications and prohibits insurance companies from making an inequitable distinction between oral and intravenous forms of chemotherapy drugs but has still not been passed in the US Congress⁵; and

Whereas, Coverage requirements for private health insurance companies are regulated by the federal government through the Public Health Service Act (PHSA), the Employee Retirement Income Security Act of 1974 (ERISA), and the Internal Revenue Code (IRC)¹²; and

Whereas, There has been little evidence of increased premiums amongst the 43 states that have enacted oral parity legislation, relative to states without such legislation^{9,13}; and

Whereas, Oral parity is supported by numerous organizations including the American Society of Clinical Oncology (ASCO), the Leukemia and Lymphoma Society, and Susan G. Komen Breast Cancer Foundation^{11,14,15}; and

Whereas, Existing AMA policy H-55.986 supports financial reimbursement of chemotherapy and antibiotic drugs at home via infusion or injection, but does not extend coverage to oral therapies; therefore be it

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

H-55.986 - HOME CHEMOTHERAPY AND ANTIBIOTIC INFUSIONS

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

Fiscal Note: Minimal – less than \$1,000

Received: 10/12/22

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RELEVANT AMA POLICY

Health Plan Coverage Policies for Anti-Nausea Regimens H-55.975

Our AMA advocates: (1) that ethical, cost effective, and compassionate cancer therapy requires the best possible anti-nausea treatment; (2) that no health plan should require a less expensive initial anti-nausea regimen that has been shown to be less than optimally effective compared to other available and approved regimens, thereby preventing patients from receiving the best possible anti-nausea therapy; (3) that all health plans should collaborate with the oncology physician community before changing coverage for anti-nausea therapy; and (4) that clinical coverage decisions for anti-nausea therapy should base considerations of cost effectiveness on the entire cost to the system, including patient co-pays and deductibles for oral anti-nausea agents, the use of oncologists' on-call time for fielding calls late at night when anti-nausea therapy fails, as well as the cost of office visits, emergency room visits, and hospitalizations.

Res. 826, I-10; Reaffirmed: CMS Rep. 01, A-20

Symptomatic and Supportive Care for Patients with Cancer H-55.999

Our AMA recognizes the need to ensure the highest standards of symptomatic, rehabilitative, and supportive care for patients with both cured and advanced cancer. The Association supports clinical research in evaluation of rehabilitative and palliative care procedures for the cancer patient, this to include such areas as pain control, relief of nausea and vomiting, management of complications of surgery, radiation and chemotherapy, appropriate hemotherapy, nutritional support, emotional support, rehabilitation, and the hospice concept. Our AMA actively encourages the implementation of continuing education of the practicing American physician regarding the most effective methodology for meeting the symptomatic, rehabilitative, supportive, and other human needs of the cancer patient.

CSA Rep. H, I-78; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: Sub. Res. 514, I-00; Modified: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 01, A-20

Home Chemotherapy and Antibiotic Infusions H-55.986

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

Citation: Res. 186, I-89; Reaffirmed: Sunset Report and Reaffirmation A-00; Reaffirmed: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 01, A-20; Modified: Res. 508, I-20;

Reducing Prescription Drug Prices D-110.993

Our AMA will (1) continue to meet with the Pharmaceutical Research and Manufacturers of America to engage in effective dialogue that urges the pharmaceutical industry to exercise reasonable restraint in the pricing of drugs; and (2) encourage state medical associations and others that are interested in pharmaceutical bulk purchasing alliances, pharmaceutical assistance and drug discount programs, and other related pharmaceutical pricing legislation, to contact the National Conference of State Legislatures, which maintains a comprehensive database on all such programs and legislation.

CMS Rep. 3, I-04; Modified: CMS Rep. 1, A-14; Reaffirmation A-14; Reaffirmed in lieu of Res. 229, I-14

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 818
(I-22)

Introduced by: American Academy of Pediatrics, Obesity Medicine Association

Subject: Pediatric Obesity Treatment Insurance Coverage

Referred to: Reference Committee J

1 Whereas, Obesity is the most common chronic disease in childhood; and

2
3 Whereas, Untreated pediatric obesity leads to significant morbidity, premature mortality, and an
4 enormous financial burden to society from health care costs and lost productivity; and

5
6 Whereas, Obesity in the pediatric population increases the risk of obesity in adulthood; and

7
8 Whereas, Effective treatment of pediatric obesity requires a comprehensive multi-pronged
9 approach delivered chronically including lifestyle therapy, anti-obesity medications, and
10 metabolic and bariatric surgery; and

11
12 Whereas, Several anti-obesity medications have now been approved by the FDA for use in the
13 pediatric population, thus substantially expanding the options for safe and effective
14 pharmacological options for pediatric obesity treatment; and

15
16 Whereas, Many health insurance plans, public and private, do not adequately cover lifestyle
17 therapy, anti-obesity medications, and metabolic and bariatric surgery, resulting in progressive
18 weight gain, worsening obesity, and weight-related co-morbidities; and

19
20 Whereas, Recent AMA policy D-440.954, Addressing Obesity, establishes the AMA as working
21 to improve national understanding of the obesity epidemic and address gaps in medical obesity
22 education and health disparities, and the lack of insurance coverage for obesity treatment; and

23
24 Whereas, Currently 38% of children in the US are insured by Medicaid and other public health
25 insurance plans; therefore be it

26
27 RESOLVED, That our American Medical Association immediately call for full public health
28 insurance coverage of pediatric evidence-based anti-obesity treatment, including
29 comprehensive life-style therapy, anti-obesity medications and metabolic and bariatric surgery
30 (Directive to Take Action); and be it further

31
32 RESOLVED, That our AMA work with all interested parties to lobby the legislative and executive
33 branches of government to affect public health insurance coverage and payment for the full
34 spectrum of evidence-based pediatric anti-obesity therapy. (Directive to Take Action)

Fiscal Note: Modest – between \$1,000 - \$5,000

Received: 10/13/22

RELEVANT AMA POLICY

Addressing Obesity D-440.954

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

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

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

Citation: BOT Rep. 11, I-06; Reaffirmation A-13; Appended: Sub. Res. 111, A-14; Modified: Sub. Res. 811, I-14; Appended: Res. 201, A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 819
(I-22)

Introduced by: American College of Preventive Medicine

Subject: Advocating for the Implementation of Updated U.S. Preventive Services Task Force Recommendations for Colorectal Cancer Screening Among Primary Care Physicians and Major Payors by the AMA

Referred to: Reference Committee J

Whereas, Colorectal cancer is the third leading cause of cancer death for both men and women, with an estimated 52,980 persons in the US projected to die of colorectal cancer in 2021¹; and

Whereas, There is sufficient evidence to suggest early detection and screening of colorectal cancer can reduce mortality²³⁴⁵; and

Whereas, The incidence of colorectal cancer in adults aged 40 to 49 years has increased by almost 15% from 2000-2002 to 2014-2016; and

Whereas, In 2016, 25.6% of eligible adults in the US had never been screened for colorectal cancer⁶; and

Whereas, The primary barriers to patients not receiving the recommended screenings at age 45-49: lack of physician follow-up, mistrust of medical institutions, and lack of insurance coverage⁷⁸⁹¹⁰; are risk factors modifiable by way of advocacy from Our AMA; and

Whereas, Our AMA supports physician engagement with patients to share decision-making on screening efforts (H-55.981, last modified 2018) and improving prevention via insurance coverage for screening tests (H-330.877, last modified 2018) and encourages appropriate screening (D-55.998, last modified 2013); and

¹ Siegel RL, Miller KD, Fuchs HE, Jemal A. Cancer statistics, 2021. *CA Cancer J Clin*. 2021;71(1):7-33. doi:10.3322/caac.21654

² Etzioni R, Urban N, Ramsey S, et al. The case for early detection. *Nat Rev Cancer* 2003;3:243–52.

³ Lin JS, Perdue LA, Henrikson NB, Bean SI, Blasi PR. Screening for Colorectal Cancer: An Evidence Update for the US Preventive Services Task Force. Evidence Synthesis No. 202. Agency for Healthcare Research and Quality; 2021. AHRQ publication 20-05271-EF-1.

⁴ Lin JS, Perdue LA, Henrikson NB, Bean SI, Blasi PR. Screening for colorectal cancer: updated evidence report and systematic review for the US Preventive Services Task Force. *JAMA*. Published May 18, 2021. doi:10.1001/jama.2021.4417

⁵ Chiu HM, Chen SL, Yen AM, et al. Effectiveness of fecal immunochemical testing in reducing colorectal cancer mortality from the One Million Taiwanese Screening Program. *Cancer*. 2015;121 (18):3221-3229. doi:10.1002/cncr.29462

⁶ Montminy EM, Zhou M, Maniscalco L, et al. Contributions of adenocarcinoma and carcinoid tumors to early-onset colorectal cancer incidence rates in the United States. *Ann Intern Med*. 2021;174 (2):157-166. doi:10.7326/M20-0068

⁷ Azulay R, Valinsky L, Hershkowitz F, Elran E, Lederman N, Kariv R, Braunstein B, Heymann A. Barriers to completing colonoscopy after a positive fecal occult blood test. *Isr J Health Policy Res*. 2021 Feb 11;10(1):11. doi: 10.1186/s13584-021-00444-2. PMID: 33573698; PMCID: PMC7879608.

⁸ Cole H, Thompson HS, White M, Browne R, Trinh-Shevrin C, Braithwaite S, Fiscella K, Boutin-Foster C, Ravenell J. Community-Based, Preclinical Patient Navigation for Colorectal Cancer Screening Among Older Black Men Recruited From Barbershops: The MISTER B Trial. *Am J Public Health*. 2017 Sep;107(9):1433-1440. doi: 10.2105/AJPH.2017.303885. Epub 2017 Jul 20. PMID: 28727540; PMCID: PMC5551599.

⁹ Ho, I. K., Sheldon, T. A., & Botelho, E. (2021). Medical mistrust among women with intersecting marginalized identities: a scoping review. *Ethnicity & health*, 1–19. Advance online publication. <https://doi.org/10.1080/13557858.2021.1990220>

¹⁰ White, P. M., & Itzkowitz, S. H. (2020). Barriers driving racial disparities in colorectal cancer screening in African Americans. *Current Gastroenterology Reports*, 22(8). <https://doi.org/10.1007/s11894-020-00776-0>

1 Whereas, Members of historically excluded and marginalized populations experience worse
2 overall survival for colorectal cancer when controlling for factors such as income and
3 education¹¹, and our AMA Has resolved to support (H-180.994, last modified 2021) efforts to
4 engender health equity; and

5
6 Whereas, No recent policy explicitly supports our AMA engaging with payors, health systems,
7 and other clinician organizations to advocate for the adoption of routine screening for Colorectal
8 Cancer among patients⁴⁵⁻⁴⁹; therefore be it

9
10 RESOLVED, That our American Medical Association advocate that payors, health systems, and
11 clinicians adopt the updated U.S. Preventive Services Task Force Recommendation to initiate
12 routine preventive screening for colorectal cancer at age 45; and to coordinate with like-minded
13 professional organizations to enhance physician education and awareness of this essential
14 recommendation. (Directive to Take Action)

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

Received: 10/13/22

¹¹ Kamath SD, Torrejon N, Wei W, et al. Racial disparities negatively impact outcomes in early-onset colorectal cancer independent of socioeconomic status. *Cancer Medicine*. 2021 Nov;10(21):7542-7550. DOI: 10.1002/cam4.4276. PMID: 34647438; PMCID: PMC8559495.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 820
(I-22)

Introduced by: American College of Rheumatology, American Academy of Allergy,
Asthma & Immunology, American Academy of Dermatology, American
Academy of Neurology, American Academy of Ophthalmology, American
College of Gastroenterology, American Society of Hematology, Association
for Clinical Oncology, North American Neuro-Ophthalmology Society,
American Gastroenterological Association, American Contact Dermatitis
Society, American Society of Dermatopathology, Florida, Iowa, Arizona,
Utah

Subject: Third-Party Pharmacy Benefit Administrators

Referred to: Reference Committee J

1 Whereas, The operations of third-party companies that manage specialty pharmacy benefits are
2 an emerging national issue with significant negative effects on patients and the practice of
3 medicine; and
4

5 Whereas, These entities contract to manage the specialty pharmacy portion of the drug
6 formulary, generally for self-insured entities, and manage formularies, negotiate rebates,
7 process claims, and pay pharmacies for prescriptions, like pharmacy benefit managers (PBMs);
8 and
9

10 Whereas, Although these entities hold themselves out to be something new and different, the
11 only difference from traditional PBMs is that they operate solely in the specialty pharmacy
12 formulary; and
13

14 Whereas, These third-party administrators use heavy-handed tactics with physicians and
15 patients to force the use of preferred prescriptions, with little transparency and opaque
16 practices; and
17

18 Whereas, These entities generally use “proprietary algorithms” to determine the treatments to
19 which a patient will have access, and are forcing patients to change medications with no clear
20 method to override decisions made by the algorithm-- an affront to personalized medical care
21 and to the physician and patient relationship; and
22

23 Whereas, The practices of these third-party companies amount to the practice of medicine. As
24 an example, a common practice is a biologic taper program, overseen by staff of the entity, in
25 which they and not the treating physician make decisions on the dosing and frequency of
26 medication, with no transparency about who is making treating decisions or any data behind the
27 tapering schedule; and
28

29 Whereas, As a result of the Supreme Court decision in *Rutledge v. PCMA*, states can require
30 licensing, registration, and reporting for PBMs that operate in ERISA plans. Even if these
31 entities are contracted directly with employers to manage specialty formularies, states can
32 require licensing, registration, and transparency reporting; and

1 Whereas, Interest in the practices of PBMs has increased at the federal level as well, including
2 federal legislative hearings and a review of PBM business practices by the Federal Trade
3 Commission; and
4

5 Whereas, Because these organizations are newer to the healthcare landscape, they are not
6 bound to PBM-related regulations or laws; therefore be it
7

8 RESOLVED, That our American Medical Association recommend that third-party pharmacy
9 benefit administrators that contract to manage the specialty pharmacy portion of drug
10 formularies be included in existing pharmacy benefit manager (PBM) regulatory frameworks and
11 statutes, and be subject to the same licensing, registration, and transparency reporting
12 requirements (New HOD Policy); and be it further
13

14 RESOLVED, That our AMA advocate that third-party pharmacy benefit administrators be
15 included in future PBM oversight efforts at the state and federal levels. (Directive to Take
16 Action)

Fiscal Note: Modest – between \$1,000 - \$5,000

Received: 10/13/22

RELEVANT AMA POLICY

The Impact of Pharmacy Benefit Managers on Patients and Physicians D-110.987

1. Our AMA supports the active regulation of pharmacy benefit managers (PBMs) under state departments of insurance.
2. Our AMA will develop model state legislation addressing the state regulation of PBMs, which shall include provisions to maximize the number of PBMs under state regulatory oversight.
3. Our AMA supports requiring the application of manufacturer rebates and pharmacy price concessions, including direct and indirect remuneration (DIR) fees, to drug prices at the point-of-sale.
4. Our AMA supports efforts to ensure that PBMs are subject to state and federal laws that prevent discrimination against patients, including those related to discriminatory benefit design and mental health and substance use disorder parity.
5. Our AMA supports improved transparency of PBM operations, including disclosing:
 - Utilization information;
 - Rebate and discount information;
 - Financial incentive information;
 - Pharmacy and therapeutics (P&T) committee information, including records describing why a medication is chosen for or removed in the P&T committee's formulary, whether P&T committee members have a financial or other conflict of interest, and decisions related to tiering, prior authorization and step therapy;
 - Formulary information, specifically information as to whether certain drugs are preferred over others and patient cost-sharing responsibilities, made available to patients and to prescribers at the point-of-care in electronic health records;
 - Methodology and sources utilized to determine drug classification and multiple source generic pricing; and
 - Percentage of sole source contracts awarded annually.
6. Our AMA encourages increased transparency in how DIR fees are determined and calculated.

CMS Rep. 05, A-19Reaffirmed: CMS Rep. 6, I-20

Pharmacy Benefit Managers Impact on Patients D-120.933

Our AMA will: (1) gather more data on the erosion of physician-led medication therapy management in order to assess the impact pharmacy benefit manager (PBM) tactics may have on patient's timely access to medications, patient outcomes, and the physician-patient relationship; (2) examine issues with PBM-related clawbacks and direct and indirect remuneration (DIR) fees to better inform existing advocacy efforts; and (3) request from PBMs, and compile, data on the top twenty-five medication precertification requests and the percent of such requests approved after physician challenge.

Res. 225, A-18

Interference in the Practice of Medicine D-125.997

Our AMA shall initiate action by whatever means to bring a halt to the interference in medical practice by pharmacy benefit managers and others.

Res. 529, A-02Reaffirmation A-10Reaffirmed: CMS Rep. 04, A-16Reaffirmed: Res. 250, A-22

Pharmaceutical Benefits Management Companies H-125.986

Our AMA:

- (1) encourages physicians to report to the Food and Drug Administration's (FDA) MedWatch reporting program any instances of adverse consequences (including therapeutic failures and adverse drug reactions) that have resulted from the switching of therapeutic alternates;
- (2) encourages the Federal Trade Commission (FTC) and the FDA to continue monitoring the relationships between pharmaceutical manufacturers and PBMs, especially with regard to manufacturers' influences on PBM drug formularies and drug product switching programs, and to take enforcement actions as appropriate;
- (3) pursues congressional action to end the inappropriate and unethical use of confidential patient information by pharmacy benefits management companies;
- (4) states that certain actions/activities by pharmacy benefit managers and others constitute the practice of medicine without a license and interfere with appropriate medical care to our patients;
- (5) encourages physicians to routinely review their patient's treatment regimens for appropriateness to ensure that they are based on sound science and represent safe and cost-effective medical care;
- (6) supports efforts to ensure that reimbursement policies established by PBMs are based on medical need; these policies include, but are not limited to, prior authorization, formularies, and tiers for compounded medications; and
- (7) encourages the FTC and FDA to monitor PBMs' policies for potential conflicts of interests and anti-trust violations, and to take appropriate enforcement actions should those policies advantage pharmacies in which the PBM holds an economic interest.

BOT Rep. 9, I-97Appended: Res. 224, I-98Appended: Res. 529, A-02Reaffirmed: Res. 533A-03Reaffirmation I-08Reaffirmation A-10Reaffirmed: Alt. Res. 806, I-17Modified: Res. 242, A-18Reaffirmed: CMS Rep. 08, A-19