

DISCLAIMER

The following is a preliminary report of actions taken by the House of Delegates at its 2025 Interim Meeting and should not be considered final. Only the Official Proceedings of the House of Delegates reflect official policy of the Association.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (I-25)

Final Report of Reference Committee J

Mary Campagnolo, MD MBA, Chair

1 RECOMMENDED FOR ADOPTION

- 2 1. Board of Trustees Report 18 – Published Metrics for Hospitals and Hospital
- 3 Systems
- 4 2. Resolution 802 – Patient Choice of Physician
- 5 3. Resolution 804 – Medicare Advantage Filing Limit
- 6 4. Resolution 809 – Ensuring Patient Safety and Physician Oversight in the
- 7 Integration of Hospital Inpatient Virtual Nursing
- 8 5. Resolution 811 – Non-Medical Switching
- 9 6. Resolution 812 – Discontinue Review Choice Demonstration Project for Inpatient
- 10 Rehabilitation Hospital Admissions
- 11 7. Resolution 814 – Mandate for Insurance Companies to Assist in the Transition of
- 12 Patients to Alternative Participating Physicians Upon Contract Termination
- 13 8. Resolution 821 – Improving Access to Emergency Ophthalmologic Surgical Care
- 14 9. Resolution 828 – Creating a Public Scorecard on Insurer Delays in Care and
- 15 Payment Caused by Prior Authorization
- 16 10. Resolution 829 – Publicize Insurer Financial Gains from Delayed Care and
- 17 Payment Caused by Prior Authorization
- 18 11. Resolution 830 - Preserve Coverage for Peripheral Nerve Blockade in Chronic
- 19 Pain

21 RECOMMENDED FOR ADOPTION AS AMENDED

- 22 12. Council on Medical Service Report 1 – Health Savings Account Reform
- 23 13. Council on Medical Service Report 2 – Telehealth Licensure
- 24 14. Council on Medical Service Report 3 – Payment Models to Sustain Rural
- 25 Hospitals
- 26 15. Council on Medical Service Report 4 – Payment for Biosimilars
- 27 16. Resolution 805 – Shared Medical Appointments
- 28 17. Resolution 806 – Insurance Coverage for Colonoscopy Preparation Cost
- 29 18. *Resolution 807 – Protecting Hospitals and Patients from Inappropriate Denials
- 30 of Inpatient Admissions
- 31 19. Resolution 808 – No Prior Authorization for Inexpensive Medications
- 32 20. Resolution 810 – Opposing Unilateral Downcoding of Physician Services by
- 33 Insurance Companies
- 34 21. Resolution 815 – Mandating Health Insurers to Provide a Real-Time Online Tool
- 35 for Coverage and Payment Policies, Integrated into Electronic Health Records
- 36 (EHRs)

- 1 22. Resolution 816 – Prohibit Arbitrary Time Limits on Preauthorizations
- 2 23. Resolution 817 – Prohibiting Insurers from Denying Payment for Procedures
- 3 Based on Site of Service
- 4 24. Resolution 819 – Update the Status of Virtual Credit Card Policy, EFT Fees, and
- 5 Lack of Enforcement of Administrative Simplification Requirements by CMS*
- 6 25. Resolution 822 – Improving Home or Community-Based Services Waiver Waiting
- 7 List Management
- 8 26. Resolution 823 – Accountability in the Use of Augmented Intelligence for Prior
- 9 Authorization
- 10 27. Resolution 824 – Equitable Payment and Increased Access for In-Office Pediatric
- 11 Lead Screening and Testing
- 12 28. Resolution 825 – Ensuring Coverage for In-Office Point-of-Care (POC) Testing in
- 13 Outpatient Medical Practices
- 14 29. Resolution 826 - Increase National Immunization Rates by Advocating for
- 15 Equitable Vaccine Payments
- 16 30. Resolution 827 – Opposition to Prior Authorization in Medicare Fee-for-Service,
- 17 Burdensome Administrative Requirements

18 **REFER FOR DECISION**

- 21 31. Resolution 820 - Establishing an AMA “First Responder Team” for Real-Time
- 22 Physician Advocacy Against Adverse Insurance Company Actions

23 **RECOMMENDED FOR REAFFIRMATION IN LIEU OF**

- 26 32. Resolution 813 – Increased Regulation of For-Profit Healthcare Insurance
- 27 33. Resolution 818 – Universal Out-of-Network Benefits

RECOMMENDED FOR ADOPTION

1 (1) BOT REPORT 18 – PUBLISHED METRICS FOR
2 HOSPITALS AND HOSPITAL SYSTEMS

3
4 RECOMMENDATION:

5 Your Reference Committee recommends that the
6 Recommendations in Board of Trustees Report 18 be
7 adopted and the remainder of the report be filed.
8

9
10 **HOD ACTION: Board of Trustees Report 18 is adopted and remainder of Report filed.**
11

12
13 The Board of Trustees recommends that the following be adopted and the remainder of
14 the report be filed:
15

16
17 1. Our American Medical Association supports the use of metrics that hospitals and
18 hospital systems can use to improve physicians' experience, engagement, and work
19 environment in a manner accessible to physicians. (New HOD Policy)
20

21 2. That Policy D-215.979, "Published Metrics for Hospitals and Hospital Systems," be
22 rescinded as being accomplished by this report. (Rescind HOD Policy)

23
24 Your Reference Committee heard supportive testimony on Board of Trustees Report 18.
25 Testimony indicated that physician burnout remains alarmingly high and that the report
26 appropriately advances evidence-based, system-level metrics to assess burnout.
27 Therefore, your Reference Committee recommends that the recommendations in Board
28 of Trustees Report 18 be adopted and the remainder of the report be filed.
29

30 (2) RESOLUTION 802 – PATIENT CHOICE OF PHYSICIAN
31

32 RECOMMENDATION:

33
34 Your Reference Committee recommends that
35 Resolution 802 be adopted.
36

37
38 **HOD ACTION: Resolution 802 is adopted.**
39

40
41 RESOLVED, that our American Medical Association continue its support of the patient-
42 physician relationship and the patient's choice of physician by reaffirming existing AMA
43 policies, "Preservation of Physician-Patient Relationships and Promotion of Continuity of
44 Patient Care H-160.901" and "Physician Penalties for Out-of-Network Services H-
45 180.952." (Reaffirm HOD Policy)
46

1 Testimony on Resolution 802 was both in support of reaffirmation and in support of the
2 resolution as written. The resolution itself called for reaffirmation of AMA policy. Either
3 path leads to the same destination, therefore your Reference Committee recommends
4 that Resolution 802 be adopted.

5
6 (3) RESOLUTION 804 – MEDICARE ADVANTAGE FILING
7 LIMIT

8 RECOMMENDATION:

9
10 Your Reference Committee recommends that
11 Resolution 804 be adopted.

14
15 **HOD ACTION: Resolution 804 is adopted.**

16
17 RESOLVED, that our American Medical Association and other stakeholders advocate for
18 and support federal efforts to ensure policy uniformity regarding claim filing time limits
19 between Medicare Advantage plans and traditional Medicare, with a uniform time of one
20 calendar year. (Directive to Take Action)

21
22 Testimony was supportive of adoption of Resolution 804 as written. Several delegations
23 provided testimony in favor of the resolution highlighting that it supports administrative
24 simplification and fairness in Medicare Advantage plans. Testimony agreed on the
25 importance of parity between traditional Medicare and Medicare Advantage and
26 supported standardizing the time limits for filing claims to the 12-month time frame of
27 traditional Medicare. Therefore, your Reference Committee recommends that Resolution
28 804 be adopted.

29
30 (4) RESOLUTION 809 – ENSURING PATIENT SAFETY AND
31 PHYSICIAN OVERSIGHT IN THE INTEGRATION OF
32 HOSPITAL INPATIENT VIRTUAL NURSING

33 RECOMMENDATION:

34
35 Your Reference Committee recommends that
36 Resolution 809 be adopted.

37
38 **HOD ACTION: Resolution 809 is adopted.**

39
40 RESOLVED, that our American Medical Association undertake a comprehensive study
41 of hospital inpatient virtual nursing, including an assessment of its benefits and risks for
42 patient safety and an analysis of guidelines for credentialing, privileging, and
43 documentation standards and any policy gaps related to oversight by the Centers for
44 Medicare & Medicaid Services and The Joint Commission (Directive to Take Action);
45 and be it further

1
2 RESOLVED, that our AMA recognizes that organized medical staffs, as leaders in
3 hospital medicine who have a duty to protect patient safety within their institutions,
4 should work collaboratively to ensure physician-led, high-quality, patient-centered care in
5 the integration of inpatient virtual nursing, (New HOD Policy)

6
7 Your Reference Committee heard supportive testimony on Resolution 809. Testimony
8 noted that this resolution addresses the emerging practice of inpatient virtual nursing,
9 highlights growing concern about the rapid deployment of these systems, and
10 underscores the importance of physician oversight and medical staff involvement in the
11 implementation of these systems. There was a question raised about physicians' role in
12 inpatient virtual nursing but it was clarified that this resolution does not suggest that the
13 AMA overstep into nursing policy but instead this resolution would promote patient-
14 focused, physician-led care. Additional testimony asked that the forthcoming study called
15 for by adoption of Resolution 809 includes a look at the potential bias of these
16 arrangements against low-income individuals, including those covered by Medicaid.
17 Your Reference Committee recommends that Resolution 809 be adopted.

18
19 (5) RESOLUTION 811 – NON-MEDICAL SWITCHING

20
21 RECOMMENDATION:

22
23 Your Reference Committee recommends that
24 Resolution 811 be adopted.

25
26
27 **HOD ACTION: Resolution 811 is adopted.**

28
29
30 RESOLVED, that our American Medical Association opposes the practice of non-
31 medical switching by pharmacy benefit managers and health insurers, except when
32 clinically justified and approved by the prescribing physician (New HOD Policy); and be it
33 further

34
35 RESOLVED, that our American Medical Association study and report back at I-26 on the
36 clinical and economic impact of non-medical switching on patient outcomes, medication
37 adherence, and overall healthcare utilization, and disseminate these findings to
38 policymakers and the public. (Directive to Take Action)

39
40 Testimony on Resolution 811 was universally supportive. Testimony explained the
41 importance of ensuring that physicians, not pharmacy benefit managers or payers, are
42 the ones prescribing drugs to patients. Testimony explained the hurdles that can result
43 from non-medical switching like increased side effects, reduced treatment adherence,
44 and poor health outcomes. An amendment was proffered that would result in monitoring,
45 rather than studying, this topic. However, the vast majority of support was in favor of
46 adopting the resolution as written. Therefore, your Reference Committee recommends
47 Resolution 811 be adopted.

1 (6) RESOLUTION 812 – DISCONTINUE REVIEW CHOICE
2 DEMONSTRATION PROJECT FOR INPATIENT
3 REHABILITATION HOSPITAL ADMISSIONS

4
5 RECOMMENDATION:

6
7 Your Reference Committee recommends that
8 Resolution 812 be adopted.
9

10
11 **HOD ACTION: Resolution 812 is adopted.**
12

13
14 RESOLVED, that our American Medical Association oppose CMS's expansion of the
15 Inpatient Rehabilitation Facility Review Choice Demonstration Project and advocate that
16 the project be immediately discontinued. (Directive to Take Action)

17
18 Testimony on Resolution 812 was supportive of adoption. One delegation expressed
19 that the precedent of discontinuing a Center for Medicare and Medicaid Innovation
20 (CMMI) program could set. However, the authors of the resolution explained that this
21 program is not a CMMI demonstration project and situations of fraud have already been
22 demonstrated in the existing program. The delegation that originally voiced concerns
23 testified that their concerns were dissuaded by the response. Other testimony on this
24 item was strongly supportive and outlined the harm that this program causes. Therefore,
25 your Reference Committee recommends Resolution 812 be adopted.

26
27 (7) RESOLUTION 814 – MANDATE FOR INSURANCE
28 COMPANIES TO ASSIST IN THE TRANSITION OF
29 PATIENTS TO ALTERNATIVE PARTICIPATING
30 PHYSICIANS UPON CONTRACT TERMINATION

31
32 RECOMMENDATION:

33
34 Your Reference Committee recommends that
35 Resolution 814 be adopted.
36

37
38 **HOD ACTION: Resolution 814 is adopted.**
39

40
41 RESOLVED, that our American Medical Association advocate through legislation or
42 regulations that private and public health insurers be mandated on the event of a treating
43 physician terminating participation with that insurer to provide assistance to affected
44 patients in transitioning to other in-network physicians, including providing a list of
45 alternative participating physicians who can continue to provide care to the patient
46 (Directive to Take Action); and be it further

47
48 RESOLVED, that our American Medical Association advocate through legislation or
49 regulations that private and public health insurers be mandated to provide resources to

1 ensure continuity of care for patients who are mid-treatment or require ongoing care with
2 the exiting physician without penalties to the physician, including offering extended
3 benefits or out-of-network coverage when necessary (Directive to Take Action); and be it
4 further

5
6 RESOLVED, that our American Medical Association advocate through legislation or
7 regulations that private and public health insurers be mandated to provide an online
8 payment policy tool that has a uniform interface that works across all insurers and
9 physicians, ensuring consistent and streamlined access to coverage information for
10 physicians and patients. (Directive to Take Action)

11
12 Your Reference Committee heard limited testimony on Resolution 814. This resolution
13 was originally recommended for reaffirmation. However, one delegation provided
14 testimony against reaffirmation and in support of the original resolution. Another
15 delegation provided testimony against reaffirmation and in support of the resolution, but
16 only if it was amended. Testimony stated that it is important for the AMA to advocate on
17 this issue, as many health plans are not assisting patients in transitioning to other in-
18 network physicians when needed. Further testimony questioned the feasibility of the
19 third resolve clause and recommended it be deleted. Your Reference Committee did not
20 find the argument for feasibility compelling and believes the language is important to
21 retain in the resolution. Therefore, your Reference Committee recommends that
22 Resolution 814 be adopted.

23
24 (8) RESOLUTION 821 – IMPROVING ACCESS TO
25 EMERGENCY OPHTHALMOLOGIC SURGICAL CARE

26
27 RECOMMENDATION:

28
29 Your Reference Committee recommends that
30 Resolution 821 be adopted.

31
32 **HOD ACTION: Resolution 821 is adopted.**

33
34
35 RESOLVED, that our American Medical Association supports policies aimed at
36 enhancing access to emergency ophthalmic care—including vitreoretinal surgical
37 services and traumatic open globe injuries— through initiatives such as improved
38 operating room availability, facility reimbursement reforms, and changes to hospital
39 privileging that exclude economic criteria to facilitate timely surgical care (New HOD
40 Policy); and be it further

41
42 RESOLVED, that our AMA advocates to reduce payer barriers, including prior
43 authorization and inadequate Medicaid and Medicare reimbursement, that hinder access
44 to surgical ophthalmologic emergency care including vitreoretinal surgery and traumatic
45 open globe injuries (Directive to Take Action); and be it further

46
47 RESOLVED, that our AMA advocate for reducing geographic and socioeconomic
48 barriers to timely ophthalmologic emergency care—including both surgical vitreoretinal

1 services and traumatic open globe injuries—in alignment with AMA health equity
2 policies, with emphasis on rural and underserved communities. (Directive to Take
3 Action)

4

5 Your Reference Committee heard testimony in strong support of Resolution 821 and the
6 need to ensure timely access to sight-saving emergency ophthalmologic care, including
7 vitreoretinal surgeries and treatment of traumatic open globe injuries. A proffered
8 amendment asked for the addition of a new resolve clause advocating that hospitals
9 maintain 24/7 emergency availability of ophthalmologic care; however, this amendment
10 did not garner sufficient support as the vast majority of testimony strongly supported the
11 resolution as written. Thus, your Reference Committee recommends that Resolution 821
12 be adopted.

13

14 (9) RESOLUTION 828 – CREATING A PUBLIC
15 SCORECARD ON INSURER DELAYS IN CARE AND
16 PAYMENT CAUSED BY PRIOR AUTHORIZATION

17

18 RECOMMENDATION:

19

20 Your Reference Committee recommends that
21 Resolution 828 be adopted.

22

23

24 **HOD ACTION: Resolution 828 is adopted.**

25

26

27 RESOLVED, that our American Medical Association continue to lead the advocacy effort
28 and assist state medical associations with the implementation of timely, non-aggregated
29 public reporting by private and public plans that engage in prior authorization related to
30 the services subject to prior authorization, the number of services approved, denied and
31 overturned on appeal, and the timeframes for responding to requests for authorization
32 and paying physician claims (Directive to Take Action); and be it further

33

34 RESOLVED, that our AMA work with interested organizations in the development and
35 publication of public and private plan scorecards related to prior authorization approvals,
36 denials, appeals, and the timeframes for responding to requests for authorization and
37 processing physician payments to better inform patients, physicians, and purchasers of
38 insurance. (Directive to Take Action)

39

40 Testimony was unanimously supportive of Resolution 828. Testimony indicated that the
41 resolution is an extension of recent Centers for Medicare & Medicaid Services regulation
42 requiring reporting of prior authorization metrics for Medicare Advantage and Exchange
43 plans to private, employer-based, and ERISA-regulated plans. Further, it was suggested
44 that the scorecards outlined by this resolution could provide a broader, more consistent
45 framework for reporting and comparing performance. Due to the entirely supportive
46 testimony, your Reference Committee recommends Resolution 828 be adopted.

1 (10) RESOLUTION 829 – PUBLICIZE INSURER FINANCIAL
2 GAINS FROM DELAYED CARE AND PAYMENT
3 CAUSED BY PRIOR AUTHORIZATION

4
5 RECOMMENDATION:

6 Your Reference Committee recommends that
7 Resolution 829 be adopted.
8

9
10 **HOD ACTION: Resolution 829 is adopted.**
11

12
13
14 RESOLVED, that our American Medical Association support efforts to investigate and
15 publicize the financial benefit and profit to commercial insurers, and Medicare and
16 Medicaid health plans that inappropriately use prior authorization to unnecessarily delay
17 care for patients and payments to physicians. (New HOD Policy)

18
19 Testimony was generally supportive of Resolution 829. Testimony indicated the
20 publication of prior authorization data can inform patients and employers and, potentially,
21 incentivize insurers to improve their practices. One delegation supported the resolution
22 but suggested it may lack definitional clarity, questioned how an investigation of this kind
23 could be operationalized, and encouraged the AMA to proceed in a thoughtful way. Due
24 to the supportive testimony, your Reference Committee recommends Resolution 829 be
25 adopted.

26
27 (11) RESOLUTION 830 – PRESERVE COVERAGE FOR
28 PERIPHERAL NERVE BLOCKADE IN CHRONIC PAIN

29
30 RECOMMENDATION:

31
32 Your Reference Committee recommends that
33 Resolution 830 be adopted.
34

35
36 **HOD ACTION: Resolution 830 is adopted.**
37

38
39 RESOLVED, that our American Medical Association advocate for the withdrawal of the
40 draft Local Coverage Determinations issued by Medicare Administrative Contractors that
41 restrict coverage of peripheral nerve blockade procedures for chronic pain (Directive to
42 Take Action); and be it further

43
44 RESOLVED, that our AMA advocate to the Centers for Medicare & Medicaid Services
45 (CMS) and the Medicare Administrative Contractors to preserve—and, where supported
46 by evidence, expand—coverage of peripheral nerve blockade and all associated
47 therapies (Directive to Take Action); and be it further
48

1 RESOLVED, that our AMA reaffirm and apply existing AMA policy—H-185.931
2 “Workforce and Coverage for Pain Management” and H-120.922 “Improved Access and
3 Coverage to Non-Opioid Modalities to Address Pain”—to oppose efforts that limit the use
4 of peripheral nerve blockade and associated interventional pain procedures as evidence-
5 based treatment options. (Reaffirm HOD Policy)

6
7 Testimony on Resolution 830 was entirely supportive. Testimony explained the
8 importance of peripheral nerve blocks (PNBs) for patients that may not have other pain
9 relief options. Testimony highlighted the importance of PNBs for opioid abuse
10 prevention, in situations when circumstances preclude the use of other medication-
11 based pain relief, and to ensure full spectrum of pain management is offered to patients.
12 One testifier also explained the importance of maintaining coverage of PNBs to facilitate
13 training of the procedures. Therefore, your Reference Committee recommends that
14 Resolution 830 be adopted.

RECOMMENDED FOR ADOPTION AS AMENDED

1 (12) CMS REPORT 1 – HEALTH SAVINGS ACCOUNT
2 REFORM

3
4 RECOMMENDATION A:
5

6 Your Reference Committee recommends that
7 Recommendation 6 in Council on Medical Service Report
8 1 be amended by addition to read as follows:
9

10 6) That our AMA amend Policy H-165.828 by addition and
11 deletion to read as follows:
12

13 HEALTH INSURANCE AFFORDABILITY, H-165.828
14

15 (3) Our AMA (i) encourages the development of
16 demonstration projects to allow individuals eligible for
17 cost-sharing subsidies, who forego these subsidies by
18 enrolling in a bronze plan, to have access to a health
19 savings account (HSA) partially funded by an amount
20 determined to be equivalent to the cost-sharing subsidy;
21 and (ii) supports individual market bronze and silver
22 plans, regardless of actual deductible amount, being
23 treated as HSA-qualified high-deductible health plans,
24 with appropriate guardrails in place (e.g., safe harbor
25 provisions) to ensure low-income enrollees in these plans
26 do not suffer undue financial hardships. (Modify Current
27 HOD Policy)

28
29 RECOMMENDATION B:
30

31 Your Reference Committee recommends that Council
32 on Medical Service Report 1 be amended by addition of
33 a new Recommendation to read as follows:
34

35 Our AMA supports the principle that HSAs are
36 complementary to and do not replace health insurance
37 coverage or other efforts to improve affordability of
38 health insurance such as ACA premium tax credits.
39 (New HOD Policy)

40
41 RECOMMENDATION C:
42

43 Your Reference Committee recommends that the
44 Recommendations in Council on Medical Service Report
45 1 be adopted as amended and the remainder of the report
46 filed.
47

1
2 **HOD ACTION: Council on Medical Service Report 1 is adopted as amended and**
3 **remainder of report filed.**

4
5 **ADOPTED LANGUAGE:**

6
7 **1) That our American Medical Association (AMA) support permitting health**
8 **savings account (HSA) contributions from family members, employers, or**
9 **other designated individuals and not limiting HSA contributions to the owner**
10 **of the high-deductible health plan, provided that annual Internal Revenue**
11 **Service contribution limits are not exceeded.**

12
13 **2) That our AMA support contributions to HSAs by individuals who are Medicare**
14 **enrollees with support for external research and/or demonstration projects to**
15 **determine how best those distributions can be spent, with special**
16 **consideration for low-resource Medicare enrollees.**

17
18 **3) That our AMA amend Policy H-165.852 by addition to read as follows:**

19
20 **HEALTH SAVINGS ACCOUNTS, H-165.852(7)**

21
22 **(7) legislation promoting the establishment and the use of HSAs and allowing**
23 **the tax-free use of such accounts for health care expenses, including health,**
24 **dental, vision, hearing, and long-term care insurance premiums and other costs**
25 **of long-term care, be strongly supported as an integral component of AMA**
26 **efforts to achieve universal access and coverage and freedom of choice in**
27 **health insurance.**

28
29 **4) That our AMA supports external research and/or demonstration projects on the**
30 **feasibility and tax integrity of transferring HSA funds between spouses and**
31 **other family members.**

32
33 **5) That our AMA supports Affordable Care Act (ACA) premium tax credits**
34 **designed to allow individuals to contribute to HSAs through the application of**
35 **unused or residual credit amounts.**

36
37 **6) That our AMA amend Policy H-165.828 by addition and deletion to read as**
38 **follows:**

39
40 **HEALTH INSURANCE AFFORDABILITY, H-165.828 (3)**

41 **(3) Our AMA (i) encourages the development of demonstration projects to allow**
42 **individuals eligible for cost-sharing subsidies, who forego these subsidies by**
43 **enrolling in a bronze plan, to have access to a health savings account (HSA)**
44 **partially funded by an amount determined to be equivalent to the cost-sharing**
45 **subsidy; and (ii) supports individual market bronze and silver plans, regardless**
46 **of actual deductible amount, being treated as HSA-qualified high-deductible**
47 **health plans, with appropriate guardrails in place (e.g., safe harbor provisions)**
48 **to ensure low-income enrollees in these plans do not suffer financial hardships.**

- 1 7) That our AMA supports education on the use of HSAs to Medicare
- 2 beneficiaries and purchasers of ACA marketplace plans, including those
- 3 purchasing bronze plans and how that plan compares to purchasing a silver
- 4 plan with subsidies.
- 5
- 6 8) That our AMA supports the principle that HSAs are complementary to and do
- 7 not replace health insurance coverage or other efforts to improve affordability
- 8 of health insurance such as ACA premium tax credits
- 9
- 10 9) That our AMA reaffirm Policy H-290.972, Health Savings Accounts in the
- 11 Medicaid Program, which outlines several principles for states considering
- 12 offering beneficiaries HSAs.
- 13
- 14 10) That our AMA reaffirm Policy H-165.833, Amend the Patient Protection and
- 15 Affordable Care Act, which states that as part of the AMA's organizational goal
- 16 of amending and improving the Affordable Care Act, the AMA will advocate to
- 17 expand the use of HSAs as a means to provide health insurance.
- 18
- 19 11) That our AMA reaffirm Policy H-385.912, Direct Primary Care, which states that
- 20 the use of a health savings account to access direct primary care (DPC)
- 21 providers and/or to receive care from a direct primary care medical home
- 22 constitutes and bona fide medical expense, and that particular sections of the
- 23 IRS code related to qualified medical expenses should be amended to
- 24 recognize the use of HSA funds for DPC and DPC medical home models as a
- 25 qualified medical expense. Furthermore, H-385.912 states that the AMA will
- 26 seek federal legislation or regulation to amend appropriate sections of the IRS
- 27 code to specify that DPC access or DPC medical homes are not health "plans"
- 28 and that the use of HSA funds to pay for DPC provider services in such setting
- 29 constitutes a qualified medical expense, enabling patients to use HSAs to help
- 30 pay for DPC and to enter DPC periodic-fee agreements without IRS
- 31 interference or penalty.
- 32

33 The following additional resolve language was referred:

34

35 Our AMA advocates for using the expanded Affordable Care Act premium tax

36 credits as a vehicle for improving health insurance affordability rather than

37 converting those subsidies to health savings accounts or other cash savings

38 accounts.

40

41 The Council on Medical Service recommends that the following recommendations be

42 adopted in lieu of Resolution 803-I-24 and the remainder of the report be filed:

43

44 1) That our American Medical Association (AMA) support permitting health savings

45 account (HSA) contributions from family members, employers, or other designated

46 individuals and not limiting HSA contributions to the owner of the high-deductible health

47 plan, provided that annual Internal Revenue Service contribution limits are not

48 exceeded. (New HOD Policy)

1 2) That our AMA support contributions to HSAs by individuals who are Medicare
2 enrollees with support for external research and/or demonstration projects to determine
3 how best those distributions can be spent, with special consideration for low-resource
4 Medicare enrollees. (New HOD Policy)

5
6 3) That our AMA amend Policy H-165.852 by addition to read as follows:

7
8 HEALTH SAVINGS ACCOUNTS, H-165.852
9

10 It is the policy of the AMA that: (7) legislation promoting the establishment and
11 the use of HSAs and allowing the tax-free use of such accounts for health care
12 expenses, including health, dental, vision, hearing, and long-term care insurance
13 premiums and other costs of long-term care, be strongly supported as an integral
14 component of AMA efforts to achieve universal access and coverage and
15 freedom of choice in health insurance. (Modify Current HOD Policy)

16
17 4) That our AMA supports external research and/or demonstration projects on the
18 feasibility and tax integrity of transferring HSA funds between spouses and other family
19 members. (New HOD Policy)

20
21 5) That our AMA supports Affordable Care Act (ACA) premium tax credits designed to
22 allow individuals to contribute to HSAs through the application of unused or residual
23 credit amounts. (New HOD Policy)

24
25 6) That our AMA amend Policy H-165.828 by addition and deletion to read as follows:

26
27 HEALTH INSURANCE AFFORDABILITY, H-165.828
28

29 (3) Our AMA (i) encourages the development of demonstration projects to allow
30 individuals eligible for cost-sharing subsidies, who forego these subsidies by
31 enrolling in a bronze plan, to have access to a health savings account (HSA)
32 partially funded by an amount determined to be equivalent to the cost-sharing
33 subsidy; and (ii) supports individual market bronze and silver plans being treated
34 as HSA-qualified high-deductible health plans. (Modify Current HOD Policy)

35
36 7) That our AMA supports education on the use of HSAs to Medicare beneficiaries and
37 purchasers of ACA marketplace plans, including those purchasing bronze plans and how
38 that plan compares to purchasing a silver plan with subsidies. (New HOD Policy)

39
40 8) That our AMA reaffirm Policy H-290.972, Health Savings Accounts in the Medicaid
41 Program, which outlines several principles for states considering offering beneficiaries
42 HSAs. (Reaffirm HOD Policy)

43
44 9) That our AMA reaffirm Policy H-165.833, Amend the Patient Protection and Affordable
45 Care Act, which states that as part of the AMA's organizational goal of amending and
46 improving the Affordable Care Act, the AMA will advocate to expand the use of HSAs as
47 a means to provide health insurance. (Reaffirm HOD Policy)

48
49 10) That our AMA reaffirm Policy H-385.912, Direct Primary Care, which states that the
use of a health savings account to access direct primary care (DPC) providers and/or to

1 receive care from a direct primary care medical home constitutes and bona fide medical
2 expense, and that particular sections of the IRS code related to qualified medical
3 expenses should be amended to recognize the use of HSA funds for DPC and DPC
4 medical home models as a qualified medical expense. Furthermore, H-385.912 states
5 that the AMA will seek federal legislation or regulation to amend appropriate sections of
6 the IRS code to specify that DPC access or DPC medical homes are not health "plans"
7 and that the use of HSA funds to pay for DPC provider services in such setting
8 constitutes a qualified medical expense, enabling patients to use HSAs to help pay for
9 DPC and to enter DPC periodic-fee agreements without IRS interference or penalty.
10 (Reaffirm HOD Policy)

11
12 Testimony on Council on Medical Service Report 1 was mixed. Several delegations and
13 individuals spoke in favor both of the original recommendations in CMS 1 and in favor of
14 the amended language suggested by the Reference Committee. Additional testimony
15 highlighted concern with recent developments in Congress and within the Administration
16 related to health savings accounts (HSAs) and enhanced ACA premium tax credits. The
17 Council on Medical Service noted that this was not considered during the writing of the
18 report given the timeline of these discussions. Additionally, the Council reiterated that
19 the focus of CMS 1 was directly addressing the referred resolution from I-24.

20
21 In online testimony, there was a question raised regarding the benchmarking of silver
22 level plans if they were to be redefined as HSA eligible high-deductible health plans
23 (HDHP), which the Council addressed. The Council clarified that the recommendations
24 in its report would expand flexibility and usability of HSAs for those wanting that type of
25 health care coverage but would not change eligibility for premium tax credits for others,
26 specifically those tied to the second-lowest cost silver plans. The Council proposed an
27 amendment to Recommendation 6, which the Reference Committee believes addresses
28 the concerns raised. In-person testimony supported this and there was no testimony
29 against these amendments.

30
31 The Reference Committee understands why the recent developments regarding HSAs
32 and ACA premium tax credits were not considered by the Council in their original
33 recommendations and appreciates the concerns that were raised during in-person
34 testimony. There were several amendments offered and your Reference Committee
35 believes an additional recommendation to the original Council recommendations is the
36 best path forward, to preserve the initial work from the Council in addressing the referred
37 resolution while also addressing potential policy changes from Congress and/or the
38 Administration. Your Reference Committee recommends that recommendations in
39 Council on Medical Service Report 1 be adopted as amended and the remainder of the
40 report be filed.

41
42 (13) CMS REPORT 2 – TELEHEALTH LICENSURE

43
44 RECOMMENDATION A:

45
46 Your Reference Committee recommends that
47 Recommendation 1 of Council on Medical Service
48 Report 2 be amended by addition to read as follows:
49

- 1 1. That our AMA amend Policy H-480.969[1] by
2 addition to read:
3 (1) It is the policy of our American Medical Association
4 (AMA) that medical boards of states and territories
5 should require a full and unrestricted license in that
6 state for the practice of telemedicine, unless there are
7 other appropriate state-based licensing methods, with
8 no differentiation by specialty, for physicians who wish
9 to practice telemedicine in that state or territory. This
10 license category should adhere to the following
11 principles:
12 a. Exemption from such a licensure requirement for
13 physician-to-physician consultations.
14 b. Exemption from such a licensure requirement for
15 telemedicine practiced across state lines in the event of
16 an emergent or urgent circumstance, the definition of
17 which for the purposes of telemedicine should show
18 substantial deference to the judgment of the attending
19 and consulting physicians as well as to the views of the
20 patient.
21 c. Allowances, by exemption or other means, for out-of-
22 state physicians providing continuity of care to a
23 patient, where there is an established ongoing
24 relationship and previous in-person visits, for services
25 incident to an ongoing care plan or one that is being
26 modified.
27 d. Exemption from licensure requirements for
28 physicians assessing or screening out-of-state patients
29 for acceptance of a referral to a center for excellence
30 or to a physician with specific expertise in the patient's
31 condition, as selected by the referring physician and
32 patient.
33 e. Exemption from licensure requirements for
34 physicians screening out-of-state patients for
35 acceptance into a clinical trial that meets relevant
36 federal, state, and ethical standards as well as those
37 outlined in AMA policy.
38 f. Exemption from licensure requirements for
39 physicians conducting assessments of out-of-state
40 patients that are required as part of a clinical trial,
41 provided that:
42 1. The trial meets relevant federal, state, and ethical
43 standards as well as those outlined in AMA policy;
44 2. The assessments are not intended to establish or
45 replace care for the patient outside of the context of the
46 trial; and
47 3. Physicians planning to use telehealth identify a
48 physician licensed in the patient's state to address in-
49 person care needs that may arise from the clinical trial.

1 d. Application requirements that are non-burdensome,
2 issued in an expeditious manner, have fees no higher
3 than necessary to cover the reasonable costs of
4 administering this process, and that utilize principles of
5 reciprocity with the licensure requirements of the state
6 in which the physician in question practices. (Modify
7 Current HOD Policy)

8 RECOMMENDATION B:

9 Your Reference Committee recommends that the
10 Recommendations in Council on Medical Service
11 Report 2 be adopted as amended and the remainder
12 of the report be filed.

13 **HOD ACTION: Council on Medical Service Report 2 is adopted as amended and
14 remainder of report filed.**

15 **AMENDED LANGUAGE:**

16 **1. That our AMA amend Policy H-480.969[1] by addition to read:**

17 **(1) It is the policy of our American Medical Association (AMA) that medical boards
18 of states and territories should require a full and unrestricted license in that state
19 for the practice of telemedicine, unless there are other appropriate state-based
20 licensing methods, with no differentiation by specialty, for physicians who wish to
21 practice telemedicine in that state or territory. This license category should
22 adhere to the following principles:**

23 **a. Exemption from such a licensure requirement for physician-to-physician
24 consultations.**

25 **b. Exemption from such a licensure requirement for telemedicine practiced across
26 state lines in the event of an emergent or urgent circumstance, the definition of
27 which for the purposes of telemedicine should show substantial deference to the
28 judgment of the attending and consulting physicians as well as to the views of the
29 patient.**

30 **c. Allowances, by exemption or other means, for out-of-state physicians providing
31 continuity of care to a patient, where there is an established ongoing relationship
32 and previous in-person visits, for services incident to an ongoing care plan or one
33 that is being modified.**

34 **d. Exemption from licensure requirements for physicians assessing or screening
35 out-of-state patients for acceptance of a referral to a center for excellence or to a
36 physician with specific expertise in the patient's condition, as selected by the
37 referring physician and patient.**

38 **e. Exemption from licensure requirements for physicians screening out-of-state
39 patients for acceptance into a clinical trial that meets relevant federal, state, and
40 ethical standards as well as those outlined in AMA policy.**

41 **f. Exemption from licensure requirements for physicians conducting assessments
42 of out-of-state patients that are required as part of a clinical trial, provided that:**

- 1 **1. The trial meets relevant federal, state, and ethical standards as well as
2 those outlined in AMA policy;**
- 3 **2. The assessments are not intended to establish or replace care for the
4 patient outside of the context of the trial; and**
- 5 **3. Physicians planning to use telehealth identify a physician licensed in the
6 patient's state to address in-person care needs that may arise from the
7 clinical trial.**

8 **g. Application requirements that are non-burdensome, issued in an expeditious
9 manner, have fees no higher than necessary to cover the reasonable costs of
10 administering this process, and that utilize principles of reciprocity with the
11 licensure requirements of the state in which the physician in question practices.**

12 **2. That Policies D-480.960 and D-480.964 be reaffirmed.**

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

- 19 **1. That our AMA amend Policy H-480.969[1] by addition to read:**
 - 20 **(1) It is the policy of our American Medical Association (AMA) that medical
21 boards of states and territories should require a full and unrestricted license in
22 that state for the practice of telemedicine, unless there are other appropriate
23 state-based licensing methods, with no differentiation by specialty, for physicians
24 who wish to practice telemedicine in that state or territory. This license category
25 should adhere to the following principles:**
 - 26 **a. Exemption from such a licensure requirement for physician-to-physician
27 consultations.**
 - 28 **b. Exemption from such a licensure requirement for telemedicine practiced
29 across state lines in the event of an emergent or urgent circumstance, the
30 definition of which for the purposes of telemedicine should show substantial
31 deference to the judgment of the attending and consulting physicians as well as
32 to the views of the patient.**
 - 33 **c. Allowances, by exemption or other means, for out-of-state physicians providing
34 continuity of care to a patient, where there is an established ongoing relationship
35 and previous in-person visits, for services incident to an ongoing care plan or one
36 that is being modified.**
 - 37 **d. Exemption from licensure requirements for physicians assessing or screening
38 out-of-state patients for acceptance of a referral to a center for excellence or to a
39 physician with specific expertise in the patient's condition.**
 - 40 **e. Exemption from licensure requirements for physicians screening out-of-state
41 patients for acceptance into a clinical trial that meets relevant federal, state, and
42 ethical standards as well as those outlined in AMA policy.**
 - 43 **f. Exemption from licensure requirements for physicians conducting assessments
44 of out-of-state patients that are required as part of a clinical trial, provided that:**
 - 45 **1. The trial meets relevant federal, state, and ethical standards as well as
46 those outlined in AMA policy;**
 - 47 **2. The assessments are not intended to establish or replace care for the
48 patient outside of the context of the trial; and**

1 3. Physicians planning to use telehealth identify a physician licensed in the
2 patient's state to address in-person care needs that may arise from the
3 clinical trial.

4 d. Application requirements that are non-burdensome, issued in an expeditious
5 manner, have fees no higher than necessary to cover the reasonable costs of
6 administering this process, and that utilize principles of reciprocity with the
7 licensure requirements of the state in which the physician in question practices.
8 (Modify Current HOD Policy)

9
10 2. That our AMA reaffirm Policy D-480.960, which encourages states to allow an out-of-
11 state physician to use telehealth to provide continuity of care to existing patients if there
12 is a pre-existing and ongoing physician-patient relationship and a previous in-person
13 visit, and the care is incident to an existing care plan or one that is being modified.
14 (Reaffirm HOD Policy)

15
16 3. That our AMA reaffirm Policy D-480.964, which encourages states that are not part of
17 the Interstate Medical Licensure Compact (IMLC) to consider joining the Compact;
18 advocates for reduced application and state licensure(s) fees processed through the
19 IMLC; supports state efforts to expand physician licensure recognition across state lines
20 in accordance with the standards and safeguards outlined in AMA policy; and
21 encourages states to pass legislation enhancing patient access to and proper regulation
22 of telehealth services. (Reaffirm HOD Policy)

23
24 Testimony was supportive of Council on Medical Service Report 2 and its
25 recommendations permitting telehealth licensure exceptions for out-of-state complex
26 referrals and clinical trials. An amendment was proffered to add "as selected by the
27 referring physician" to Recommendation 1(1d), citing concerns about patients potentially
28 being solicited for "free second opinions" using telehealth, or an insurer transitioning
29 patients from their treating physicians to groups that have more advantageous contracts
30 with the insurer. Responding to this proposed change, the Council on Medical Service
31 asked that "and patients" be added to the amendment since decisions about complex
32 referrals should ideally be made jointly by physicians and patients. The Council also
33 pointed to existing AMA policy addressing comments on the supervision of
34 nonphysicians using telehealth across state lines (Policy H-160.937) and preserving
35 patient safeguards and a state's liability framework (Policy D-480.960). Your Reference
36 Committee supports the proffered amendment and recommends that the
37 recommendations in Council on Medical Service Report 2 be adopted as amended and
38 the remainder of the report be filed.

39
40 (14) CMS REPORT 3 – PAYMENT MODELS TO SUSTAIN
41 RURAL HOSPITALS

42
43 RECOMMENDATION A:

44
45 Your Reference Committee recommends that
46 Recommendation 2b of Council on Medical Service
47 Report 3 be amended by addition and deletion to read
48 as follows:

1 b. support educating physicians, providers non-
2 physician practitioners, and patients on alternative
3 payment models for rural hospitals. (New HOD Policy)

4
5 RECOMMENDATION B:

6
7 Your Reference Committee recommends that
8 Recommendation 5 of Council on Medical Service
9 Report 3 be amended by addition and deletion to read
10 as follows:

11
12 5. That our AMA amend Policy D-465.998 by addition
13 to read as follows:

14
15 ADDRESSING PAYMENT AND DELIVERY IN
16 RURAL HOSPITALS, D-465.998
17 5. Our AMA supports educating patients, and
18 physicians, and non-physician practitioners on the
19 impact of Medicare Advantage plans on rural hospitals
20 and encourages all payers to provide adequate
21 payment to support the financial stability of rural
22 hospitals. (Modify Current HOD Policy)

23
24 RECOMMENDATION C:

25
26 Your Reference Committee recommends that Council
27 on Medical Service Report 3 be amended by addition of
28 a new Recommendation to read as follows:

29
30 10. That our AMA work to vigorously oppose Medicaid
31 cuts as they significantly impact at-risk rural hospitals.
32 (New HOD Policy)

33
34 RECOMMENDATION D:

35
36 Your Reference Committee recommends that Council
37 on Medical Service Report 3 be amended by addition of
38 a new recommendation to read as follows:

39
40 11. That our AMA reaffirm Policy H-290.951 (Reaffirm
41 HOD Policy)

42
43 RECOMMENDATION E:

44
45 Your Reference Committee recommends that the
46 Recommendations in Council on Medical Service
47 Report 3 be adopted as amended and the remainder of
48 the report filed.

49

1
2 **HOD ACTION: Council on Medical Service Report 3 is adopted as amended and**
3 **remainder of report filed.**

4
5 **ADOPTED LANGUAGE:**

6
7 **1. That our American Medical Association (AMA) supports the following minimum**
8 **standards for alternative payment models to rural hospitals in order to enhance**
9 **their financial sustainability and ensure access to care:**

10 a. **Fixed Cost Payment:** Rural hospitals should be paid an agreed upon and
11 fixed sum delivered on a predictable schedule that is not tied to patient
12 volume.
13 b. **Adequate Payment Rates:** All payers should ensure that payments made
14 for variable services are adequate to cover the full cost of care provision.
15 c. **Patient Cost-Sharing:** Any out-of-pocket payments made by patients
16 should be reasonable and affordable.
17 d. **Accountability and Transparency:** Care delivered should be of high-quality,
18 evidence-based, and part of a physician-led team.
19 e. **Administrative Simplicity:** Models should minimize administrative burdens.

20
21 **2. That our AMA believes that rural hospitals are essential to the communities they**
22 **serve. To ensure that these hospitals have adequate support to remain open and**
23 **financially viable, our AMA will continue to work with interested national medical**
24 **specialty societies and state medical associations to:**

25 a. support and monitor novel payment models for rural hospitals and
26 encourage uniform reporting; and
27 b. support educating patients, physicians, and non-physician practitioners on
28 alternative payment models for rural hospitals.

29
30 **3. That our AMA supports that funds allocated for rural hospitals be used to**
31 **enhance or maintain rural health care.**

32
33 **4. That our AMA work to vigorously oppose Medicaid cuts as they significantly**
34 **impact at-risk rural hospitals.**

35
36 **5. Policy D-465.999 be amended to read:**

37
38 **Our AMA: (1) will call on the Centers for Medicare & Medicaid Services to support**
39 **individual states in their development of rural health networks; (2) support the**
40 **reintroduction of the state-designated Critical Access Hospital (CAH) "necessary**
41 **provider" designation; and (3) will pursue steps to require the federal government**
42 **to fully fund its obligations under the Medicare Rural Hospital Flexibility Program.**

43
44 **6. Policy D-465.998 be amended by addition of a new 5 to read:**

45 **5. Our AMA supports educating patients and physicians on the impact of Medicare**
46 **Advantage plans on rural hospitals and encourages all payers to provide**
47 **adequate payment to support the financial stability of rural hospitals.**

48
49 **6. That Policies H-465.994, H-465.982, H-290.951, and H-465.997 be reaffirmed.**

1
2 **7. That the second clause of Policy D-190.969 be rescinded.**
3

4
5 The Council on Medical Service recommends that the following be adopted and the
6 remainder of the report be filed:
7

8 1. That our American Medical Association (AMA) supports the following minimum
9 standards for alternative payment models to rural hospitals in order to enhance their
10 financial sustainability and ensure access to care:

- 11 a. Fixed Cost Payment: Rural hospitals should be paid an agreed upon and fixed
12 sum delivered on a predictable schedule that is not tied to patient volume.
- 13 b. Adequate Payment Rates: All payers should ensure that payments made for
14 variable services are adequate to cover the full cost of care provision.
- 15 c. Patient Cost-Sharing: Any out-of-pocket payments made by patients should be
16 reasonable and affordable.
- 17 d. Accountability and Transparency: Care delivered should be of high-quality,
18 evidence-based, and part of a physician-led team.
- 19 e. Administrative Simplicity: Models should minimize administrative burdens. (New
20 HOD Policy)

21
22 2. That our AMA believes that rural hospitals are essential to the communities they serve.
23 To ensure that these hospitals have adequate support to remain open and financially
24 viable, our AMA will continue to work with interested national medical specialty societies
25 and state medical associations to:

- 26 c. support and monitor novel payment models for rural hospitals and encourage
27 uniform reporting; and
- 28 d. support educating physicians, providers, and patients on alternative payment
29 models for rural hospitals. (New HOD Policy)

30
31 3. That our AMA supports that funds allocated for rural hospitals be used to enhance or
32 maintain rural health care. (New HOD Policy)

33
34 4. That our AMA amend Policy D-465.999 by addition and deletion to read as follows:
35 CRITICAL ACCESS HOSPITAL NECESSARY PROVIDER DESIGNATION, D-465.999
36 Our AMA: (1) will call on the Centers for Medicare & Medicaid Services to support
37 individual states in their development of rural health networks; (2) ~~opposes the~~
38 ~~elimination~~support the reintroduction of the state-designated Critical Access Hospital
39 (CAH) "necessary provider" designation; and (3) will pursue steps to require the federal
40 government to fully fund its obligations under the Medicare Rural Hospital Flexibility
41 Program. (Modify Current HOD Policy)

42
43 5. That our AMA amend Policy D-465.998 by addition to read as follows:
44 ADDRESSING PAYMENT AND DELIVERY IN RURAL HOSPITALS, D-465.998
45 5. Our AMA supports educating patients and physicians on the impact of Medicare
46 Advantage plans on rural hospitals and encourages all payers to provide adequate
47 payment to support the financial stability of rural hospitals. (Modify Current HOD Policy)

48
49 6. That our AMA reaffirm Policy H-465.994 which outlines support for continued work with
50 relevant and interested stakeholders to research, report, and improve rural health

1 through strategies including telemedicine and innovative workforce strategies. (Reaffirm
2 HOD Policy)

3
4 7. That our AMA reaffirm Policy H-465.982 which encourages states, and ensures AMA
5 support, to support efforts related to managed care in rural settings. (Reaffirm HOD
6 Policy)

7
8 8. That our AMA reaffirm Policy H-465.997 which outlines support for local and federal
9 efforts to improve rural health with initiatives that are holistic and community-based.
10 (Reaffirm HOD Policy)

11
12 9. That the second clause of Policy D-190.969 be rescinded as it is accomplished by this
13 report. (Rescind AMA Policy)

14
15 Testimony on Council on Medical Service Report 3 was supportive. Testimony echoed
16 the concerns for rural hospitals that are outlined in the report and emphasized the
17 importance of ensuring their survival. Additionally, testimony explained the importance of
18 ensuring that the impact of recent federal legislation on rural hospitals is mitigated as
19 much as possible. An amendment was proposed to add physician practices to the
20 recommendations, however as explained by the authors, your Reference Committee
21 believes this is out of the scope of the current report which focused exclusively on rural
22 hospitals.

23
24 A second minor amendment was suggested by a delegation, and supported by the
25 Council, to change “providers” to “non-physician practitioners” in the second
26 recommendation. Your Reference Committee agrees that this language switch is
27 important and recommends the amendment. To ensure language is consistent
28 throughout policy, your Reference Committee also recommends mirroring language in
29 the fifth recommendation of the report to include “non-physician practitioners.”

30
31 Finally, an amendment was proffered to add a new 10th recommendation outlining AMA
32 efforts to oppose cuts to Medicaid as the cuts will likely impact rural hospitals
33 significantly. The Council pointed out that there is existing AMA policy and a Board
34 report on this topic. However, your Reference Committee believes that the addition of
35 the proffered new recommendation strengthens the report’s recommendations and
36 therefore supports its inclusion. Additionally, your Reference Committee agreed with the
37 Council testimony that existing policy should be reaffirmed as new recommendation 11.
38 Therefore, your Reference Committee recommends that recommendations in Council on
39 Medical Service Report 3 be adopted as amended and the remainder of the report filed.

40
41 (15) CMS REPORT 4 – PAYMENT FOR BIOSIMILARS

42
43 RECOMMENDATION A:

44
45 Your Reference Committee recommends that
46 Recommendation 2 of Council on Medical Service Report
47 4 be amended by addition to read as follows:
48

1 2. That our AMA encourages public and private payers to implement
2 comprehensive payment structures that allow for fair and timely payment for
3 biologic/biosimilar drugs that:
4 a. Maintain patient access to biologic/biosimilar drugs prescribed by their
5 physician consistent with AMA Policy H-100.940;
6 b. Account for physician/practice administrative and acquisition costs, including
7 but not limited to, obtaining, storing, and administering the drug through a
8 payment rate that covers these costs;
9 c. Incentivize the use of biosimilars when safe, clinically appropriate, and agreed
10 upon by the patient and physician; and
11 d. Ensure that patient out-of-pocket costs are affordable. (New HOD Policy)

12 RECOMMENDATION B:

13 Your Reference Committee recommends that the
14 Recommendations in Council on Medical Service Report 4
15 be adopted as amended and the remainder of the report
16 be filed.

21 **HOD ACTION: Council on Medical Service Report 4 is adopted as amended and**
22 **remainder of report filed.**

24 ADOPTED LANGUAGE:

26 1. **That our American Medical Association (AMA) supports the revision of the**
27 **Average Sales Price (ASP) calculation of biologic/biosimilar drugs to more**
28 **accurately represent the cost of drugs for the physician practice. (New HOD**
29 **Policy)**

31 2. **That our AMA encourages public and private payers to implement**
32 **comprehensive payment structures that allow for fair and timely payment for**
33 **biologic/biosimilar drugs that:**

34 a. Maintain patient access to biologic/biosimilar drugs prescribed by their
35 physician consistent with AMA Policy H-100.940;
36 b. Account for physician/practice administrative and acquisition costs,
37 including but not limited to, obtaining, storing, and administering the drug
38 through a payment rate that covers these costs;
39 c. Incentivize the use of biosimilars when safe, clinically appropriate, and
40 agreed upon by the patient and physician; and
41 d. Ensure that patient out-of-pocket costs are affordable. (New HOD Policy)

43 3. **That Policies H-100.940, H-110.959, H-125.972, D-110.987 be reaffirmed.**

45
46 The Council on Medical Service recommends that the following be adopted in lieu of
47 Resolution 103-A-25, and the remainder of the report be filed:
48

1. That our American Medical Association (AMA) supports the revision of the Average
2 Sales Price (ASP) calculation of biologic/biosimilar drugs to more accurately represent
3 the cost of drugs for the physician practice. (New HOD Policy)
- 4
5. That our AMA encourages public and private payers to implement comprehensive
6 payment structures that allow for fair and timely payment for biologic/biosimilar drugs
7 that:
 - 8 a. Maintain patient access to biologic/biosimilar drugs prescribed by their physician;
 - 9 b. Account for physician/practice administrative and acquisition costs, including but
10 not limited to, obtaining, storing, and administering the drug;
 - 11 c. Incentivize the use of biosimilars when safe, clinically appropriate, and agreed
12 upon by the patient and physician; and
 - 13 d. Ensure that patient out-of-pocket costs are affordable. (New HOD Policy)
- 14
15. That our AMA supports calculating the ASP for biologic/biosimilar drugs under
16 Medicare Part B as the average price paid for a reference biologic and its
17 interchangeable biosimilars adjusted by the market share of each product while ensuring
18 payment is adequate to maintain the financial viability of physician practices. (New HOD
19 Policy)
- 20
21. That our AMA reaffirm Policy H-100.940, which supports incentivizing the use of
22 biosimilars when appropriate, eliminating acquisition costs/reimbursement disparities,
23 and patient education. (Reaffirm HOD Policy)
- 24
25. That our AMA reaffirm Policy H-110.959, which opposes drug payment methodologies
26 that result in physicians being paid less than cost of the drug and related clinical
27 services. (Reaffirm HOD Policy)
- 28
29. That our AMA reaffirm Policy H-125.972, which supports the education of physicians
30 on biosimilars and their involved processes as well as encourages data collection and
31 evaluation by the Food & Drug Administration. (Reaffirm HOD Policy)
- 32
33. That our AMA reaffirm Policy D-110.987, which presents guidelines supportive of the
34 regulation of pharmacy benefit managers in a manner that encourages transparency.
35 (Reaffirm HOD Policy)

37 Testimony on Council on Medical Service Report 4 was mixed, but generally supportive
38 of the report's intent. Testimony from some delegations voiced support for the report
39 recommendations as written explaining they offered realistic and incremental steps that
40 would help patients and physicians in the short and long term. Additionally, supportive
41 testimony outlined the importance of not only looking forward to new payment models
42 but to also addressing the current payment methodology, Average Sales Price (ASP)
43 calculations. Some delegations offered support with some amendments to the
44 recommendations that would outline AMA support for flat rate payment methodologies
45 and broaden the Council recommended calculation revision. Other testimony from
46 delegations and individuals outlined opposition to the ASP calculation generally and
47 suggested the removal of recommendations referencing this price calculation. The
48 Council acknowledged that while the ASP calculation is not perfect, it is the current
49 payment model and therefore revisions should be advocated for. The authors explained
50 that the recommendation offered covers the intent of the original referred resolution and

1 goes further. The Council expressed concern that the addition of a flat payment rate to
2 the second recommendation could harm future advocacy efforts by limiting support to
3 only flat payment methodology and not other innovative and helpful methods. To
4 address the concerns regarding Recommendation 3, the Council explained that the
5 suggested alternative calculation supports increases in biosimilar market competition,
6 supports physician transition to lower cost biosimilars when appropriate, and could lead
7 to brand-name biologic manufacturers being forced to reduce prices in order to maintain
8 market share. Additionally, the Council explained that Recommendations 1 and 3 work
9 to improve the current ASP model and Recommendation 2 aims to support future
10 alternative payment models that meet the set criteria. Finally, the Council reiterated that
11 language has been included throughout the recommendations to ensure that all payment
12 models are sufficient to sustain practices and include fair payment rates.
13

14 In-person testimony on Council on Medical Service Report 4 was generally supportive of
15 removing the reference to “flat payment” rates. Testifiers explained that this language
16 could be harmful to physicians/practices and block their full payment. Additionally,
17 testimony was unified in deletion of the new Recommendation 3 offered in the
18 Preliminary Report. Therefore, your Reference Committee recommends the removal of
19 the new Recommendation 3 and the reference to “flat payment” in Recommendation 2B.
20 Testimony related to the deletion of the third original recommendation was mixed. Some
21 testimony explained that the specificity of the calculation was important and would help
22 physicians and patients in accessing lower-cost medications when appropriate.
23 However, other testifiers voiced that the original third recommendation was too
24 prescriptive and supported its removal as is recommended in the Preliminary Report.
25 Your Reference Committee felt testimony supported the retention of the *original* third
26 recommendation and therefore recommends that the *original* third recommendation be
27 retained. Therefore, your Reference Committee recommends that the recommendations
28 in Council on Medical Service Report 4 be adopted as amended and the remainder of
29 the report be filed.
30

31 (16) RESOLUTION 805 – SHARED MEDICAL
32 APPOINTMENTS
33

34 RECOMMENDATION A:
35

36 Your Reference Committee recommends that the first
37 resolve of Resolution 805 be amended by addition and
38 deletion to read as follows:
39

40 RESOLVED, that our American Medical
41 Association recognizes Shared Medical Appointments,
42 ~~also known as~~ and/or Group Medical Visits, as an
43 effective model of care delivery (New HOD Policy);
44 and be it further
45

46 RECOMMENDATION B:
47

48 Your Reference Committee recommends that the
49 second resolve of Resolution 805 be amended by
50 addition and deletion to read as follows:

1
2 RESOLVED, that our AMA advocate to hospitals and
3 health systems that they support physicians and other
4 clinicians who desire to host Shared Medical
5 Appointments, ~~also known as~~ and/or Group Medical
6 Visits (Directive to Take Action); and be it further
7
8

9
10 RECOMMENDATION C:
11
12

13
14 Your Reference Committee recommends that the third
15 resolve of Resolution 805 be addition and deletion to
16 read as follows:
17
18

19 RESOLVED, that our AMA advocate ~~to Medicare,~~
20 ~~Medicaid, private insurers, and other appropriate~~
21 ~~indemnity organizations, for payment of in-person or~~
22 ~~telehealth Shared Medical Appointments, also known~~
23 ~~as and/or Group Medical Visits, utilizing CPT codes~~
24 ~~and AMA-CPT coding guidance~~ commensurate with
25 ~~standard Evaluation and Management billing codes~~
26 ~~(i.e., 99212-99215) based on Medical Decision~~
27 ~~Making criteria or the time spent in the delivery of~~
28 ~~individualized care, with individual assessments~~
29 ~~occurring either within the group setting or in~~
30 ~~private.~~ (Directive to Take Action)
31
32

33 RECOMMENDATION D:
34
35

36 Your Reference Committee recommends that
37 Resolution 805 be adopted as amended.
38
39

40 **HOD ACTION: Resolution 805 is amended.**
41
42

43 **ADOPTED LANGUAGE:**
44
45

- 46 1. **RESOLVED, that our American Medical Association recognizes Shared Medical**
47 **Appointments and/or Group Medical Visits, as an effective model of care**
48 **delivery.**
- 49 2. **RESOLVED, that our AMA advocate to hospitals and health systems that**
50 **they support physicians and other clinicians who desire to host Shared**
51 **Medical Appointments-and/or Group Medical Visits.**
- 52 3. **RESOLVED, that our AMA advocate for payment of in-person or telehealth**
53 **Shared Medical Appointments and/or Group Medical Visits, utilizing CPT codes**
54 **and AMA-CPT coding guidance.**

1 RESOLVED, that our American Medical Association recognizes Shared Medical
2 Appointments, also known as Group Medical Visits, as an effective model of care
3 delivery (New HOD Policy); and be it further
4

5 RESOLVED, that our AMA advocate to hospitals and health systems that they support
6 physicians and other clinicians who desire to host Shared Medical Appointments, also
7 known as Group Medical Visits (Directive to Take Action); and be it further
8

9 RESOLVED, that our AMA advocate to Medicare, Medicaid, private insurers, and other
10 appropriate indemnity organizations, for payment of in-person or telehealth Shared
11 Medical Appointments, also known as Group Medical Visits, commensurate with
12 standard Evaluation and Management billing codes (i.e., 99212-99215) based on
13 Medical Decision Making criteria or the time spent in the delivery of individualized care,
14 with individual assessments occurring either within the group setting or in private.
15 (Directive to Take Action)

16
17 Testimony on Resolution 805 was supportive, with some testimony offering amendments
18 in line with the intent of the resolution. Testimony explained the importance and personal
19 success of shared medical appointments for physicians who utilize them. While still
20 supportive of the idea of the resolution, an amendment to the third resolve clause was
21 offered by a CPT expert outlining the importance of ensuring that the HOD and CPT
22 maintain an appropriate distance. Both the Council on Medical Service and the authors
23 of the resolution supported this amendment. Additionally, an amendment was proffered
24 to simplify the language and remove the use of the term "group medical appointments" in
25 order to limit confusion. The authors of this resolution suggested that maintaining group
26 medical appointments by adding "and/or" both reduces confusion and maintains the
27 original intent of the resolution. Your Reference Committee was convinced that the
28 combination of these amendments maintains the integrity of the original Resolution while
29 clarifying its language. Therefore, your Reference Committee recommends that
30 Resolution 805 be adopted as amended.

31
32 (17) RESOLUTION 806 – INSURANCE COVERAGE FOR
33 COLONOSCOPY PREPARATION COST

34
35 RECOMMENDATION A:

36
37 Your Reference Committee recommends that
38 Resolution 806 be amended by addition and deletion
39 to read as follows:

40
41 RESOLVED, that our American Medical Association
42 advocates ~~for a federal mandate to include full~~
43 ~~coverage of that all health insurance plans~~
44 ~~cover colonoscopy preparation costs without cost-~~
45 ~~sharing as part of colorectal cancer screenings the~~
46 ~~Affordable Care Act's preventative care~~
47 ~~requirements, ensuring that all Americans have~~
48 ~~access to necessary, cost-free preventative~~
49 ~~measures for colorectal cancer.~~

1 RECOMMENDATION B:
2

3 Your Reference Committee recommends that
4 Resolution 806 be adopted as amended.
5

6
7 **HOD ACTION: Resolution 806 is amended.**
8

9 **ADOPTED LANGUAGE:**
10

11 **RESOLVED**, that our American Medical Association advocates that all health
12 insurance plans cover colonoscopy preparation costs without cost-sharing as
13 part of colorectal cancer screenings, ensuring that all Americans have access to
14 necessary, cost-free preventative measures for colorectal cancer.
15

16
17 **RESOLVED**, that our American Medical Association advocates for a federal mandate to
18 include full coverage of colonoscopy preparation costs as part of the Affordable Care
19 Act's preventative care requirements, ensuring that all Americans have access to
20 necessary, cost-free preventative measures for colorectal cancer. (Directive to Take
21 Action)
22

23 Testimony supported the intent of Resolution 806 to ensure that colonoscopy
24 preparation kits are accessible without cost-sharing. An amendment was proffered to
25 broaden the resolution's scope to advocate that all health plans, including public plans
26 such as Medicare that are not covered under ACA preventive screenings requirements,
27 cover these kits without cost-sharing. Because the sponsoring delegation testified in
28 support of this amendment, your Reference Committee recommends that Resolution
29 806 be adopted as amended.
30

31 (18) **RESOLUTION 807 – PROTECTING HOSPITALS AND
32 PATIENTS FROM INAPPROPRIATE DENIALS OF
33 INPATIENT ADMISSIONS**
34

35 **RECOMMENDATION A:**
36

37 Your Reference Committee recommends that
38 Resolution 807 be amended by addition and deletion
39 to read as follows:
40

41 **RESOLVED**, that our American Medical Association
42 assert advocate that if an insurance company denies
43 "full admission" status for a patient being hospitalized,
44 that the insurance company must provide the ability to
45 revert the status to observation so to protect the patient
46 and the hospital and patient are protected from total
47 denial of payment. (New HOD Policy)

1 RECOMMENDATION B:
2

3 Your Reference Committee recommends that
4 Resolution 807 be adopted as amended.
5

6
7 **HOD ACTION: Resolution 807 is amended.**

8
9 **ADOPTED LANGUAGE:**

10
11 **RESOLVED**, that our American Medical Association advocate that if an insurance
12 company denies “full admission” status for a patient being hospitalized, that the
13 insurance company must provide the ability to revert the status to observation to
14 protect the patient and the hospital from total denial of payment.
15

16
17 **RESOLVED**, that our American Medical Association assert that if an insurance company
18 denies “full admission” status for a patient being hospitalized, that the insurance
19 company must provide the ability to revert the status to observation so the hospital and
20 patient are protected from total denial. (New HOD Policy)

21
22 Your Reference Committee heard mixed testimony on Resolution 807. While some
23 testimony supported reaffirmation of Policy H-320.943 in lieu of the resolution, the
24 sponsoring delegation explained that the resolution addresses what happens at the time
25 an insurer denies “full admission” status, whereas Policy H-320.943 advocates against
26 retrospective denials. Additional testimony supported the resolution, with one commenter
27 suggesting that “hospital” be deleted from the resolve so that the focus is on protecting
28 patients. However, testimony also argued against deleting “hospital” because protecting
29 hospitals from denials will also help patients. Testimony also suggested use of the term
30 “advocate” instead of “assert.” Your Reference Committee also suggests editorial
31 changes to at the end of the resolve and recommends that Resolution 807 be adopted
32 as amended.

33
34 (19) **RESOLUTION 808 – NO PRIOR AUTHORIZATION FOR**
35 **INEXPENSIVE MEDICATIONS**

36
37 RECOMMENDATION A:
38

39 Your Reference Committee recommends that the first
40 resolve of Resolution 808 be deleted.
41

42 ~~RESOLVED~~, that our American Medical Association
43 identify through the Council on Medical Services or
44 other professional content experts a cost threshold
45 below which medical services and medications should
46 not require prior authorization (Directive to Take
47 Action); and be it further

1 RECOMMENDATION B:
2

3 Recommendation B: Your Reference Committee
4 recommends that Resolution 808 be adopted as
5 amended.

6

7 **HOD ACTION: Resolution 808 is amended.**

8

9

10 **ADOPTED LANGUAGE:**

11

12 **RESOLVED, that our American Medical Association advocate that low-cost**
13 **medications and procedures should not require prior authorization.**

14

15 RESOLVED, that our American Medical Association identify through the Council on
16 Medical Services or other professional content experts a cost threshold below which
17 medical services and medications should not require prior authorization (Directive to
18 Take Action); and be it further

19

20 RESOLVED, that our American Medical Association advocate that low-cost medications
21 and procedures should not require prior authorization. (Directive to Take Action)

22

23 Testimony on Resolution 808 was generally supportive of the resolution's intent but
24 differed recommended execution. Some testimony suggested that this resolution should
25 be adopted as written due to the excessive burdens and harms that come at the cost of
26 prior authorization. While agreeing with the harms of prior authorization, other testimony
27 voiced concerns about the feasibility and practicality of defining "low cost" in this context.
28 Additionally, testimony from the Council on Medical Service explained concern with the
29 appropriateness of developing a set threshold as it may indicate approval for prior
30 authorization if the cost is above the set threshold. A number of amendments were
31 suggested. One amendment suggested the development of a Coding and Procedural
32 Terminology® Code (CPT®) for prior authorization. Other testimony explained that this is
33 not appropriate as it violates the separation between CPT® and the AMA House of
34 Delegates and violates existing AMA policy. The Council proffered the deletion of the
35 first resolve and adoption of the second resolve, which was supported. In the hearing it
36 was suggested that existing AMA policy be amended in lieu of this resolution, however
37 this is not in order due to the policy not being addressed in the original resolution.
38 Additionally, other in-person testimony echoed concerns voiced online related to the cost
39 threshold in the first resolve and the support for the second resolve. Therefore, your
40 Reference Committee recommends that Resolution 808 be adopted as amended.

1 (20) RESOLUTION 810 – OPPOSING UNILATERAL
2 DOWNCODING OF PHYSICIAN SERVICES BY
3 INSURANCE COMPANIES
4

5 RECOMMENDATION A:

6 Your Reference Committee recommends that
7 resolve one and two be deleted:
8 ~~RESOLVED, that our American Medical~~
9 ~~Association vigorously oppose unilateral~~
10 ~~downcoding of evaluation and management~~
11 ~~(E/M) services by insurance companies,~~
12 ~~including but not limited to Cigna's "Evaluation~~
13 ~~and Management Coding Accuracy (R49)"~~
14 ~~program and Aetna's "Claim and Code Review~~
15 ~~Program (CCRP)" (New HOD Policy); and be it~~
16 ~~further~~

17
18 ~~RESOLVED, that our AMA advocate the insurers~~
19 ~~adhere to AMA CPT® and E/M guidelines as the~~
20 ~~nationally recognized standard for coding and~~
21 ~~reimbursement, without unilateral~~
22 ~~reinterpretation (Directive to Take Action); and~~
23 ~~be it further~~

24 RECOMMENDATION B:

25 Your Reference Committee recommends that
26 resolve three of Resolution 810 be amended by
27 addition and deletion to read as follows:
28

29
30 RESOLVED, that our AMA work with state
31 medical associations, specialty societies, and
32 regulatory authorities to challenge these payer-
33 initiated downcoding policies through regulatory,
34 legislative, and when appropriate, legal channels
35 (Directive to Take Action); and be it further
36

37 RECOMMENDATION C:

38 Your Reference Committee recommends the
39 addition of a new resolved clause to read as
40 follows:
41

42 RESOLVED, That Policy D-320.972 be
43 reaffirmed.
44

45 RECOMMENDATION D:

46 Your Reference Committee recommends Resolution
47 810 be adopted as amended.
48

1
2 **HOD ACTION: Resolution 810 is amended.**
3
4

5 **ADOPTED LANGUAGE:**
6
7

8 **RESOLVED**, that our AMA work with state medical associations, specialty
9 societies, and regulatory authorities to challenge payer-initiated downcoding
10 policies through regulatory, legislative, and when appropriate, legal channels.
11
12

13 **RESOLVED**, that our AMA report back on payer downcoding practices, their
14 effects on physicians and patients, and strategies for collective advocacy at the
15 2026 Interim Meeting.
16
17

18 **RESOLVED**, that our AMA will develop and disseminate guidance and educational
19 materials for physicians regarding insurer downcoding and recoding practices,
20 including how to document, appeal, and report inappropriate payer conduct to
21 regulators and AMA advocacy channels.
22

23 **RESOLVED**, That Policy D-320.972 be reaffirmed.
24
25

26 **RESOLVED**, that our American Medical Association vigorously oppose unilateral
27 downcoding of evaluation and management (E/M) services by insurance companies,
28 including but not limited to Cigna's "Evaluation and Management Coding Accuracy
29 (R49)" program and Aetna's "Claim and Code Review Program (CCRP)" (New HOD
30 Policy); and be it further
31

32 **RESOLVED**, that our AMA advocate the insurers adhere to AMA CPT® and E/M
33 guidelines as the nationally recognized standard for coding and reimbursement, without
34 unilateral reinterpretation (Directive to Take Action); and be it further
35

36 **RESOLVED**, that our AMA work with state medical associations, specialty societies, and
37 regulatory authorities to challenge these payer policies through regulatory, legislative,
38 and when appropriate, legal channels (Directive to Take Action); and be it further
39

40 **RESOLVED**, that our AMA report back on payer downcoding practices, their effects on
41 physicians and patients, and strategies for collective advocacy at the 2026 Annual
42 Meeting. (Directive to Take Action)
43

44 Testimony on Resolution 810 was fully supportive of the intent, but some testimony
45 indicated that the first three resolve clauses are already covered in existing AMA policy
46 D-320.972. However, other testimony disagreed and voiced that the language is unique
47 enough to be its own policy. Testimony explained the challenge of dealing with these
48 downcoding rulings from payers and how important it is for the AMA to advocate on this
49 issue. Your Reference Committee reviewed existing policy and agreed that the first two
resolves of this resolution are encompassed in current policy. However, your Reference
Committee agreed with Council on Medical Service testimony that the third resolve is
worded in a manner that is stronger and more specific. Your Reference Committee did
have concerns that the original third resolve does not stand on its own and therefore

1 offers an editorial amendment. Finally, testimony was in agreement regarding the
2 importance of the fourth resolve. Therefore, your Reference Committee recommends
3 that Policy D-320.972 be reaffirmed in lieu of the resolves 1 and 2, and resolves 3 and 4
4 of Resolution 810 be adopted as amended.

5
6 (21) RESOLUTION 815 – MANDATING HEALTH INSURERS
7 TO PROVIDE A REAL-TIME ONLINE TOOL FOR
8 COVERAGE AND PAYMENT POLICIES, INTEGRATED
9 INTO ELECTRONIC HEALTH RECORDS (EHRS)

10
11 RECOMMENDATION A:

12
13 Your Reference Committee recommends that the
14 second resolve of Resolution 815 be amended by
15 addition and deletion to read as follows:

16
17 RESOLVED, that our AMA advocates that the
18 online payment policy tool must include detailed,
19 accurate, and up-to-date information regarding
20 covered services, co-pays, deductibles, and
21 payment policies for specific procedures, and that
22 insurers honor the coverage and payment
23 determination provided at the time of approval
24 ~~this tool be binding on the insurers for the~~
25 ~~purposes of determining payment for~~
26 ~~claims.~~ (Directive to Take Action)

27
28 RECOMMENDATION B:

29
30 Your Reference Committee recommends that
31 Resolution 815 be adopted as amended.

32
33 HOD ACTION: Resolution 815 is amended.

34
35 ADOPTED LANGUAGE:

36
37 RESOLVED, that our American Medical Association shall advocate for legislation
38 or regulations requiring all health insurers in every State to provide a real-time
39 online tool for physicians and patients to determine coverage and payment
40 policies for medical procedures, treatments, and services at the time of suggested
41 procedures.

42
43 RESOLVED, that our AMA advocates that the online payment policy tool must
44 include detailed, accurate, and up-to-date information regarding covered services,
45 co-pays, deductibles, and payment policies for specific procedures, and that
46 insurers honor the coverage and payment determination provided at the time of
47 approval.

1 **RESOLVED**, that our AMA advocate that the online payment policy tool must be a
2 uniform interface that works across all insurers and physicians, ensuring
3 consistent and streamlined access to coverage information for physicians and
4 patients.

5
6
7 RESOLVED, that our American Medical Association shall advocate for legislation or
8 regulations requiring all health insurers in every State to provide a real-time online tool
9 for physicians and patients to determine coverage and payment policies for medical
10 procedures, treatments, and services at the time of suggested procedures (Directive to
11 Take Action); and be it further

12
13 RESOLVED, that our AMA advocates that the online payment policy tool must include
14 detailed, accurate, and up-to-date information regarding covered services, co-pays,
15 deductibles, and payment policies for specific procedures, and that this tool be binding
16 on the insurers for the purposes of determining payment for claims (Directive to Take
17 Action); and be it further

18
19 RESOLVED, that our AMA advocate that the online payment policy tool must be a
20 uniform interface that works across all insurers and physicians, ensuring consistent and
21 streamlined access to coverage information for physicians and patients. (Directive to
22 Take Action)

23
24 Testimony was supportive of Resolution 815 and the need for health plans to make real-
25 time coverage and payment information available to physicians and patients as part of
26 the electronic health record. However, concerns were raised about the second resolve
27 and whether the information provided by such tools should be binding on insurers since
28 deductible and copay information is only accurate for a point in time. However, testimony
29 in the hearing was supportive of the second resolve as written. Your Reference
30 Committee suggests clarifying in the second resolve that our AMA will advocate that
31 insurers honor the coverage and payment determination provided at the time of the
32 approval. We recommend that Resolution 815 be adopted as amended.

33
34 (22) **RESOLUTION 816 – PROHIBIT ARBITRARY TIME
35 LIMITS ON PREAUTHORIZATIONS**

36
37 **RECOMMENDATION A:**

38
39 Your Reference Committee recommends that the
40 second resolve of Resolution 816 be amended by
41 addition to read as follows:

42
43 RESOLVED, that our AMA seek similar changes in
44 Federal legislation and policies to prohibit Medicare
45 Advantage, Medicaid, Veterans Affairs Community
46 Care, and Employee Retirement Income Security
47 Act of 1974 (ERISA) plans from establishing time
48 limits on preauthorizations for care of less than one
49 year.

1 RECOMMENDATION B:
2

3 Your Reference Committee recommends that
4 Resolution 816 be adopted as amended.
5

6
7 **HOD ACTION: Resolution 816 is amended.**
8

9 **ADOPTED LANGUAGE:**
10

11 **RESOLVED**, that our American Medical Association (AMA) advocate for changes
12 in State legislation and Division of Financial Services policy to prohibit health
13 insurers in any State, including Medicaid plans, from establishing time limits on
14 duration of preauthorization for care of less than one year
15

16 **RESOLVED**, that our AMA seek similar changes in Federal legislation and policies
17 to prohibit Medicare Advantage, Medicaid, Veterans Affairs Community Care, and
18 Employee Retirement Income Securement Act of 1974 (ERISA) plans from
19 establishing time limits on preauthorizations for care of less than one year.
20

21
22 **RESOLVED**, that our American Medical Association advocate for changes in State
23 legislation and Division of Financial Services policy to prohibit health insurers in any
24 State, including Medicaid plans, from establishing time limits on duration of
25 preauthorization for care of less than one year (Directive to Take Action); and be it
26 further
27

28 **RESOLVED**, that our AMA seek similar changes in Federal legislation and policies to
29 prohibit Medicare Advantage, Medicaid, and Employee Retirement Income Securement
30 Act of 1974 (ERISA) plans from establishing time limits on preauthorizations for care of
31 less than one year. (Directive to Take Action)
32

33 Testimony was supportive of Resolution 816. Testimony indicated that frequent prior
34 authorization requirements impose unnecessary administrative burden on physicians
35 and delay patient care and suggested that Resolution 816 advances the shared goals of
36 reducing administrative waste, protecting continuity of care, and restoring physician
37 authority in clinical decision-making. One delegation proffered an amendment to expand
38 the second resolve to include Veterans Affairs (VA) Community Care, noting that VA
39 limits on pre-authorization for services are routinely set at 90 days. Several delegations
40 expressed strong support for the inclusion of Veterans Affairs Community Care;
41 therefore, your Reference Committee recommends Resolution 816 be adopted as
42 amended.

1 (23) RESOLUTION 817 – PROHIBITING INSURERS FROM
2 DENYING PAYMENT FOR PROCEDURES BASED ON
3 SITE OF SERVICE

4
5 RECOMMENDATION A:

6
7 Your Reference Committee recommends that
8 Resolution 817 be amended by addition and deletion to
9 read as follows:

10
11 RESOLVED, that our American Medical Association
12 ~~advocates for legislation or regulation that to prohibit~~
13 ~~insurers in all States from denying payment for a~~
14 ~~procedure based solely on the site of service in which it~~
15 ~~was performed, provided that the procedure is medically~~
16 ~~necessary and can be safely performed in that location.~~
17 (Directive to Take Action)

18
19 RECOMMENDATION B:

20
21 Your Reference Committee recommends that
22 Resolution 817 be adopted as amended.

23
24 HOD ACTION: Resolution 817 is amended.

25
26 ADOPTED LANGUAGE:

27
28 RESOLVED, that our American Medical Association advocate to prohibit insurers
29 from denying or reducing payment for a procedure based solely on the site of
30 service in which was performed, provided that the procedure is medically
31 necessary and can safely be performed in that location.

32
33 RESOLVED, that our American Medical Association advocates for legislation or
34 regulation that prohibit insurers in all States from denying payment for a procedure
35 based on the site of service in which it was performed, provided that the procedure is
36 medically necessary. (Directive to Take Action)

37
38
39 Testimony was supportive of Resolution 817 and also included suggestions for
40 amendments and one call for referral. Several comments supported amending the
41 resolve to account for patient safety. Amendments also suggested deleting “legislation or
42 regulation” and “in all states” to broaden the resolution’s scope to include federal
43 advocacy and advocacy with insurers. An additional amendment requested the addition
44 of “solely” before site of service. Your Reference Committee believes that amendments
45 addressing payment for travel costs and selective contracting may be beyond the
46 resolution’s scope and focus on the site of service and does not recommend those
47 changes. One commenter asked that “or reducing” be added after “denying;” however,
48 your Reference Committee did not hear additional support for this change. Your
49 Reference Committee recommends that Resolution 817 be adopted as amended.

1 (24) RESOLUTION 819 – UPDATE THE STATUS OF
2 VIRTUAL CREDIT CARD POLICY, EFT FEES, AND LACK
3 OF ENFORCEMENT OF ADMINISTRATIVE
4 SIMPLIFICATION REQUIREMENTS BY CMS

5
6 RECOMMENDATION A:

7
8 Your Reference Committee recommends that
9 Resolution 819 be amended by addition and deletion to
10 read as follows:

11
12 RESOLVED, that our American Medical Association
13 report at the Annual 2027 2026 Meeting on the
14 progress of, and action items for implementation of AMA
15 Policies D-190.970, H-190.955, and D-190.968.
16 (Directive to Take Action)

17
18 RECOMMENDATION B:

19
20 Your Reference Committee recommends that
21 Resolution 819 be adopted as amended.

22
23 **HOD ACTION: Resolution 819 is amended.**

24
25 **ADOPTED LANGUAGE:**

26
27 **RESOLVED, that our American Medical Association report at the
28 Annual 2026 Meeting on the progress of, and action items for implementation of
29 AMA Policies D-190.970, H-190.955, and D-190.968. (Directive to Take Action)**

30
31
32 RESOLVED, that our American Medical Association report at the Annual 2027 Meeting
33 on the progress of implementation of AMA Policies D-190.970, H-190.955, and D-
34 190.968. (Directive to Take Action)

35
36
37 Online testimony was limited and supportive of Resolution 819. Testimony indicated that
38 despite the efforts of the AMA, the financial burden of virtual credit cards and EFT fees
39 have not abated and require action by the AMA, national medical specialty societies, and
40 physicians. The author proffered an amendment asking the AMA to provide a progress
41 report one year earlier than originally requested. This amendment was supported during
42 in-person testimony, along with a request for “action items” to be added to the resolution.
43 Additional testimony supported the amendment, recognizing its time-sensitive nature,
44 and recommended adoption of the resolution as amended. Your Reference Committee
45 recommends that Resolution 819 be adopted as amended.

1 (25) RESOLUTION 822 – IMPROVING HOME OR
2 COMMUNITY-BASED SERVICES WAIVER WAITING
3 LIST MANAGEMENT

4
5 RECOMMENDATION A:

6
7 Your Reference Committee recommends that
8 Resolution 822 be amended by addition to read as
9 follows:

10
11 RESOLVED, that our American Medical Association
12 support automatic eligibility screening for home or
13 community-based services (HCBS) waivers for
14 individuals who may be eligible, including older adults
15 and people with disabilities. (New HOD Policy)

16
17 RECOMMENDATION B:

18
19 Your Reference Committee recommends that
20 Resolution 822 be adopted as amended.

21
22 **HOD ACTION: Resolution 822 is amended.**

23
24 **ADOPTED LANGUAGE:**

25
26 **RESOLVED, that our American Medical Association support automatic eligibility**
27 **screening for home or community-based services (HCBS) waivers for individuals**
28 **who may be eligible, including older adults and people with disabilities.**

29
30
31 RESOLVED, that our American Medical Association support automatic eligibility
32 screening for home or community-based services (HCBS) waivers. (New HOD Policy)

33
34 Your Reference Committee heard testimony that was supportive of Resolution 822 and
35 the use of automatic eligibility screening for Medicaid home and community-based
36 services to reduce extensive wait lists. A delegation requested that older adults and
37 people with disabilities be included in the resolve clause, therefore your Reference
38 Committee recommends that Resolution 822 be adopted as amended.

39
40 (26) RESOLUTION 823 – ACCOUNTABILITY IN THE USE OF
41 AUGMENTED INTELLIGENCE FOR PRIOR
42 AUTHORIZATION

43
44 RECOMMENDATION A:

45
46 Your Reference Committee recommends that the first
47 resolve, subclause 2 of Resolution 823 be amended by
48 addition and deletion to read as follows:

1 RESOLVED, that our American Medical Association will
2 amend policy D-480.956, "Use of Augmented Intelligence
3 for Prior Authorization," by addition and deletion to read as
4 follows:

5 Our American Medical Association will work with
6 stakeholders advocates to advocate for legislative and/or
7 regulatory action for greater regulatory oversight of related
8 to the use of augmented intelligence for review of patient
9 claims and prior authorization requests, including whether
10 insurers and/or contracted third parties are using a
11 thorough and fair process that:

12 1) is based on accurate and up-to-date clinical criteria
13 derived from national medical specialty
14 societies' evidence-based guidelines and peer-reviewed
15 clinical literature.

16 2) includes reviews by ~~doctors-physicians~~ and other health
17 care professionals who are not incentivized to deny care
18 and with expertise for the service under review.

19 3) ~~requires such reviews include human examination of~~
20 ~~patient records prior to a care denial~~

21 3) provides for transparency and accountability over the
22 use of augmented intelligence for all medical service
23 denials, to include a direct review of patient records by a
24 qualified clinician.

25 4) requires direct review of the patient record by a qualified
26 clinician of all medications flagged for denial by augmented
27 intelligence platforms that were previously approved by
28 payers.

29 5) provides robust appeals processes and guardrails to
30 prevent algorithmic discrimination and ensure equitable
31 access to care.

32 RECOMMENDATION B:

33 Your Reference Committee recommends that Resolution
34 823 be adopted as amended.

1
2 **HOD ACTION: Resolution 823 is amended.**
3
4

5 **ADOPTED LANGUAGE:**
6
7

8 **1. Policy D-480.956 is amended to read as follows:**
9
10

11 Our American Medical Association will work with stakeholders to advocate for
12 legislative and/or regulatory action for greater regulatory oversight related to the
13 use of augmented intelligence for review of patient claims and prior authorization
14 requests, including whether insurers and/or contracted third parties are using a
15 thorough and fair process that:

16 1) is based on accurate and up-to-date clinical criteria derived from
17 national medical specialty societies' evidence-based guidelines and peer-
18 reviewed clinical literature.

19 2) includes reviews by physicians and other health care professionals who
20 are not incentivized to deny care and with expertise for the service under
21 review.

22 3) provides for transparency and accountability over the use of augmented
23 intelligence for all medical service denials, to include a direct review of
24 patient records by a qualified clinician.

25 4) requires direct review of the patient record by a qualified clinician of all
26 medications flagged for denial by augmented intelligence platforms that
27 were previously approved by payers.

28 5) provides robust appeals processes and guardrails to prevent algorithmic
29 discrimination and ensure equitable access to care.

30 **2. RESOLVED, that our AMA will report on actions taken by the 2026 Annual**
31 **Meeting of the AMA House of Delegates.**

32
33 RESOLVED, that our American Medical Association will amend policy D-480.956, "Use
34 of Augmented Intelligence for Prior Authorization," by addition and deletion to read as
35 follows:

36
37 Our American Medical Association will work with stakeholders advocates to
38 advocate for legislative and/or regulatory action for greater regulatory oversight
39 ef related to the use of augmented intelligence for review of patient claims and
40 prior authorization requests, including whether insurers and/or contracted third
41 parties are using a thorough and fair process that:

42 1) is based on accurate and up-to-date clinical criteria derived from national
43 medical specialty societies' evidence-based guidelines and peer-reviewed clinical
44 literature.

1 2) includes reviews by doctors and other health care professionals who are not
2 incentivized to deny care and with expertise for the service under review.
3 ~~requires such reviews include human examination of patient records prior to a~~
4 ~~care denial~~
5 ~~3) provides for transparency and accountability over the use of augmented~~
6 ~~intelligence for all medical service denials, to include a direct review of patient~~
7 ~~records by a qualified clinician.~~
8 ~~4) requires direct review of the patient record by a qualified clinician of all~~
9 ~~medications flagged for denial by augmented intelligence platforms that were~~
10 ~~previously approved by payers.~~
11 ~~5) provides robust appeals processes and guardrails to prevent algorithmic~~
12 ~~discrimination and ensure equitable access to care. (Modify Current HOD Policy);~~
13 ~~and be it further~~

14
15 RESOLVED, that our AMA will report on actions taken by the 2026 Annual Meeting of
16 the AMA House of Delegates. (Directive to Take Action)

17
18 Testimony was unanimously supportive of Resolution 823. Testimony indicated that the
19 resolution enhances existing augmented intelligence (AI) policy by providing clear
20 guidance for the use of oversight before the denial of care and will go far to protect
21 patients and relieve the burden of prior authorization. One delegation proffered a minor
22 amendment to subclause 2 of the first resolve, replacing the word “doctors” with
23 “physicians,” to more accurately reflect a licensed medical doctor. This amendment was
24 supported by several delegations. A second amendment proffered by an individual to
25 include a detailed explanation of prior authorization denials did not receive any additional
26 supportive testimony.

27
28 During in-person testimony, several delegations supported the original language of the
29 resolution, stating that it improved and enhanced AMA AI policy. Due to the supportive
30 testimony, your Reference Committee recommends that the Resolution be adopted as
31 amended.

32
33 (27) RESOLUTION 824 – EQUITABLE PAYMENT AND
34 INCREASED ACCESS FOR IN-OFFICE PEDIATRIC
35 LEAD SCREENING AND TESTING

36
37 RECOMMENDATION A:

38
39 Your Reference Committee recommends that the
40 third resolve of Resolution 824 be deleted.

41
42 ~~RESOLVED, That our AMA advocate for increased~~
43 ~~accountability among insurers to ensure that~~
44 ~~physicians do not face inappropriate disciplinary~~
45 ~~action, or decreased financial incentives or other~~
46 ~~payment, due to lab orders for lead screening that go~~
47 ~~unfilled for reasons outside the physician’s control.~~
48 (Directive to Take Action)

1 RECOMMENDATION B:
2

3 Your Reference Committee recommends that
4 Resolution 824 be adopted as amended.
5

6 **HOD ACTION: Resolution 824 is amended.**
7

8 **ADOPTED LANGUAGE:**
9

10 **RESOLVED**, that our American Medical Association advocate for all public and
11 private payers for equitable payment rates for in-office pediatric lead screening
12 and testing to cover time, supplies, training, and administrative costs, including
13 both point-of-care and other methods.
14

15 **RESOLVED**, that our AMA support federal and state policies to reduce barriers to
16 improve access to lead screening and testing by incentivizing completion of such
17 services in physician offices.
18

20 **RESOLVED**, that our American Medical Association advocate for all public and private
21 payers for equitable payment rates for in-office pediatric lead screening and testing to
22 cover time, supplies, training, and administrative costs, including both point-of-care and
23 other methods (Directive to Take Action); and be it further
24

25 **RESOLVED**, that our AMA support federal and state policies to reduce barriers to
26 improve access to lead screening and testing by incentivizing completion of such
27 services in physician offices (New HOD Policy); and be it further
28

30 **RESOLVED**, that our AMA advocate for increased accountability among insurers to
31 ensure that physicians do not face inappropriate disciplinary action, or decreased
32 financial incentives or other payment, due to lab orders for lead screening that go
33 unfulfilled for reasons outside the physician's control. (Directive to Take Action)
34

35 Your Reference Committee heard testimony in support of Resolution 824. One
36 delegation provided testimony in support of the resolution as written and one delegation
37 provided testimony in support of the first two resolve clauses and recommended the third
38 resolve clause be deleted. Testimony stated that the language used in the third resolve
39 clause, specifically the phrase "decreased financial incentives" is too broad and would
40 lead the AMA to opposing pay-for-performance programs that incentivize lead screening.
41 Furthermore, AMA Policy H-450.947 outlines the principles and guidelines for pay-for-
42 performance programs and opposes initiatives that do not adhere to this policy, so there
43 is no need to create standalone policy specifically regarding lead screening. Your
44 Reference Committee agrees and recommends that Resolution 824 be adopted as
45 amended.

1 (28) RESOLUTION 825 – ENSURING COVERAGE FOR IN-
2 OFFICE POINT-OF-CARE (POC) TESTING IN
3 OUTPATIENT MEDICAL PRACTICES

4
5 RECOMMENDATION A:

6
7 Recommendation: Your Reference Committee
8 recommends that the first resolve of Resolution 825 be
9 amended by addition and deletion to read as follows:

10
11 RESOLVED, that our American Medical Association
12 advocate for recognition, coverage, and adequate
13 payment by all public and private payers to provide
14 coverage and adequate payment for basic POC for
15 laboratory testing, when it is appropriately performed in
16 physician offices and urgent/emergency care settings,
17 to ensure timely and equitable access to
18 diagnostic services for their patients. (Directive to Take
19 Action). and be it further

20
21 RECOMMENDATION B:

22
23 Your Reference Committee recommends that the
24 second resolve of Resolution 825 be deleted.

25
26 RESOLVED, that the AMA advocates for the
27 recognition of physician offices as the appropriate
28 setting for POC testing to ensure timely and equitable
29 access to diagnostic services for their patients.
30 (Directive to Take Action)

31
32 RECOMMENDATION C:

33
34 Your Reference Committee recommends that
35 Resolution 825 be adopted as amended.

36
37 HOD ACTION: Resolution 825 is amended.

38
39 ADOPTED LANGUAGE:

40
41 RESOLVED, that our American Medical Association advocate for recognition,
42 coverage, and adequate payment by all public and private payers for laboratory
43 testing, when it is appropriately performed in physician offices and
44 urgent/emergency care settings, to ensure timely and equitable access to
45 diagnostic services for their patients.

1 RESOLVED, that our American Medical Association advocate for all public and private
2 payers to provide coverage and adequate payment for basic POC testing, when
3 performed in physician offices and urgent care settings (Directive to Take Action); and
4 be it further

5
6 RESOLVED, that the AMA advocates for the recognition of physician offices as
7 the appropriate setting for POC testing to ensure timely and equitable access to
8 diagnostic services for their patients. (Directive to Take Action)

9
10 Testimony on Resolution 825 was entirely supportive of the intent but split regarding
11 proffered amendments. Testimony agreed that it is important to ensure that point-of-care
12 testing is both available to patients and covered by payers. Further testimony explained
13 how crucial this testing is to not only patient treatment, but also public health, prevention
14 of unnecessary emergency visits, and controlling chronic diseases. One delegation
15 proffered an amendment to remove ambiguous language, ensure terminology matches
16 best practices, and that the resolution does not conflict with current laboratory services
17 requirements. This amendment was supported by other delegations. Additionally,
18 another delegation suggested that the language could be modified to include point-of-
19 care testing in emergency departments. Your Reference Committee was persuaded by
20 testimony outlining the importance of matching language with industry standards and
21 ensuring that point-of-care testing is covered regardless of location and felt that the
22 second resolve clause was duplicative with the proffered amendments incorporated in
23 the first resolve clause. Therefore, your Reference Committee recommends that
24 Resolution 825 be adopted as amended.

25
26 (29) RESOLUTION 826 – INCREASE NATIONAL
27 IMMUNIZATION RATES BY ADVOCATING FOR
28 EQUITABLE VACCINE PAYMENTS

29
30 RECOMMENDATION A:

31
32 Your Reference Committee recommends that
33 Resolution 826 be amended by addition and deletion to
34 read as follows:

35
36 RESOLVED, that our American Medical Association
37 supports the establishment of national standards for
38 immunization payment rates that ensure physicians
39 are ~~reimbursed at no less than 125% of the CDC~~
40 ~~private sector vaccine price paid at the full cost of~~
41 ~~vaccine procurement and administration.~~

42
43 RECOMMENDATION B:

44
45 Your Reference Committee recommends that
46 Resolution 826 be adopted as amended.

1
2 **HOD ACTION: Resolution 826 is amended.**
3
4

5
ADOPTED LANGUAGE:
6

7 **RESOLVED**, that our American Medical Association supports the establishment of
8 national standards for immunization payment rates that ensure physicians are paid
9 at the full cost of vaccine procurement and administration.

10
11 **RESOLVED**, that our American Medical Association supports the establishment of
12 national standards for immunization payment rates that ensure physicians are
13 reimbursed at no less than 125% of the CDC private sector vaccine price. (New HOD
14 Policy)

15
16 Testimony on Resolution 826 was entirely supportive of the resolution's intent but
17 indicated concern with the original wording. All testimony supported the idea that
18 physicians should be paid fairly for vaccines, but there was concern that the referenced
19 price may not be the most accessible to all physicians. Additionally, there was concern
20 that specifying a certain percentage payment rate could backfire should the reference
21 price be too low to adequately cover costs. The Council on Medical Service and a
22 delegation offered similar amendments to both make the resolution more inclusive and
23 ensure that payment rates are not tied to a specific percentage. These amendments
24 were supported by other delegations and seem to address the concerns voiced in
25 testimony and your Reference Committee believes a hybrid of the two proffered
26 amendment captures the full breadth of online testimony. A delegation proffered an
27 alternative amendment in person, however other in-person testimony voiced significant
28 concerns with associating payment to a minimum rate. Additionally, there was concern
29 that the new amended language did not address costs like administration and
30 acquisition. Testimony supported the language offered in the Preliminary Report that
31 procurement, or the obtaining of goods, services, and works, and acquisition adequately
32 cover costs associated with physicians providing vaccine services. Therefore, your
33 Reference Committee recommends that Resolution 826 be adopted as amended.

34
35 (30) **RESOLUTION 827 – OPPOSITION TO PRIOR
36 AUTHORIZATION IN MEDICARE FEE-FOR-SERVICE,
37 BURDENSOME ADMINISTRATIVE REQUIREMENTS**

38
39 **RECOMMENDATION A:**

40
41 Your Reference Committee recommends that the first
42 resolve of Resolution 827 be referred for decision.

43
44 **RECOMMENDATION B:**

45
46 Your Reference Committee recommends that the
47 second resolve of Resolution 827 be deleted.

48

1 ~~RESOLVED, that our AMA will advocate against the~~
2 ~~implementation of the WISER Model and any similar~~
3 ~~programs that impose new PA requirements in~~
4 ~~Medicare FFS, while continuing its efforts to educate~~
5 ~~Congress, the Centers for Medicare & Medicaid~~
6 ~~Services, and the public on the harms of PA to both~~
7 ~~patients and physicians, leveraging data from its own~~
8 ~~surveys and the experiences of its members (Directive~~
9 ~~to Take Action); and be it further~~

10
11 RECOMMENDATION C:

12
13 Your Reference Committee recommends the addition of
14 a new second resolve of Resolution 827 to read as
15 follows:

16
17 RESOLVED, that our AMA will work with the Centers
18 for Medicare & Medicaid Services to establish
19 provisions that are in accordance with AMA principles
20 and reform goals for prior authorization to protect
21 patients, physicians, and non-physician providers
22 including robust guardrails in any demonstration project
23 implementing prior authorization in Medicare fee for
24 service, such as the WISER Model; and be it further

25
26 RECOMMENDATION D:

27
28 Your Reference Committee recommends that the third
29 resolve of Resolution 827 be amended by deletion to
30 read as follows:

31
32 RESOLVED, that our AMA will continue to advocate
33 for a legislative and regulatory framework that
34 streamlines administrative processes, prioritizes
35 patient access to timely care, and replaces
36 burdensome prior authorization with clinically-sound
37 alternatives, such as the adoption of "gold card"
38 programs for high-performing providers and the
39 greater use of evidence-based clinical guidelines.
40 (Directive to Take Action)

41
42 RECOMMENDATION E:

43
44 Your Reference Committee recommends that
45 Resolution 827 be adopted as amended.

1
2 **HOD ACTION: Resolve 1 of Resolution 827 is Referred for Decision and Resolve 2**
3 **and 3 of Resolution 827 is amended.**

4
5 **LANGUAGE REFERRED FOR DECISION:**

6
7 **RESOLVED**, that our American Medical Association opposes the use of prior
8 authorization (PA) and pre-payment review in Medicare Fee-for-Service (FFS),
9 including the proposed Wasteful and Inappropriate Service Reduction (WISeR)
10 Model which would implement a technology-enabled review system (including
11 augmented intelligence/artificial intelligence) (New HOD Policy); and be it further

12
13 **ADOPTED LANGUAGE:**

14
15 **RESOLVED**, that our AMA will work with the Centers for Medicare & Medicaid
16 Services to establish provisions that are in accordance with AMA principles and
17 reform goals for prior authorization to protect patients, physicians, and non-
18 physician providers including robust guardrails in any demonstration project
19 implementing prior authorization in Medicare fee for service, such as the WISeR
20 Model.

21
22 **RESOLVED**, that our AMA will continue to advocate for a legislative and
23 regulatory framework that streamlines administrative processes, prioritizes
24 patient access to timely care, and replaces burdensome prior authorization with
25 clinically-sound alternatives, such as the greater use of evidence-based clinical
26 guidelines.

27
28
29
30 **RESOLVED**, that our American Medical Association opposes the use of prior
31 authorization (PA) and pre-payment review in Medicare Fee-for-Service (FFS), including
32 the proposed Wasteful and Inappropriate Service Reduction (WISeR) Model which
33 would implement a technology-enabled review system (including augmented
34 intelligence/artificial intelligence) (New HOD Policy); and be it further

35
36 **RESOLVED**, that our AMA will advocate against the implementation of the WISeR
37 Model and any similar programs that impose new PA requirements in Medicare FFS,
38 while continuing its efforts to educate Congress, the Centers for Medicare & Medicaid
39 Services, and the public on the harms of PA to both patients and physicians, leveraging
40 data from its own surveys and the experiences of its members (Directive to Take Action);
41 and be it further

42
43 **RESOLVED**, that our AMA will continue to advocate for a legislative and regulatory
44 framework that streamlines administrative processes, prioritizes patient access to timely
45 care, and replaces burdensome PA with clinically-sound alternatives, such as the
46 adoption of "gold card" programs for high-performing providers and the greater use of
47 evidence-based clinical guidelines. (Directive to Take Action)

1 Online testimony was largely supportive of Resolution 827. Two delegations testified in
2 opposition to the resolution, alternatively supporting collaborative engagement with
3 Centers for Medicare & Medicaid Innovation and advocacy for scalable, clinically guided
4 prior authorization (PA) reform across all Medicare programs. However, nine delegations
5 strongly supported the resolution as written, noting that technology-enabled review
6 systems will impose an additional administrative hurdle in an already opaque and
7 inconsistent PA process.

8
9 During the in-person hearing, the author proffered amendments to a new second resolve
10 and amendments to the third resolve with language supporting the establishment of
11 principles and guardrails to allow the AMA the opportunity to improve the model. The
12 Board of Trustees testified in support of these amendments but recommended the first
13 resolve be referred for decision. While the Board expressed support of the intent of the
14 resolution, there was concern that outright opposition to the WISeR model would make it
15 difficult to continue AMA advocacy efforts. The Council on Medical Service, Council on
16 Legislation, and several delegations agreed with the Board, recommending that the first
17 resolve be referred for decision, the new second resolve be adopted, and the third
18 resolve be adopted as amended. Due to the preponderance of testimony, your
19 Reference Committee recommends that the first resolve be referred for decision and the
20 second and third resolves be adopted as amended.

RECOMMENDED FOR REFERRAL FOR DECISION

1 (31) RESOLUTION 820 – ESTABLISHING AN AMA “FIRST
2 RESPONDER TEAM” FOR REAL-TIME PHYSICIAN
3 ADVOCACY AGAINST ADVERSE INSURANCE
4 COMPANY ACTIONS

5 RECOMMENDATION:
6 Your Reference Committee recommends that
7 Resolution 820 be referred for decision.
8

10 **HOD ACTION: Resolution 820 is referred for decision.**
11

13 RESOLVED, that our American Medical Association establish a “first responder team for
14 physician advocacy against adverse insurance company actions” to provide urgent
15 liaison services and advocacy representation for individual physicians and their practices
16 when they are confronted with what appears to be predatory harassment, systematic
17 obstruction, or punitive changes including, but not limited to:

18 • sudden increased in claim denials,
19 • arbitrarily onerous documentation requirements,
20 • mid-treatment coverage interruptions

22 (Directive to Take Action); and be it further

24 RESOLVED, that an AMA “first responder team for physician advocacy against adverse
25 insurance company actions” be a pilot program for the first two years of operation that
26 will develop ongoing protocols to prioritize future cases brought to them, catalog them,
27 and then report back to the House of Delegates annually (Directive to Take Action); and
28 be it further

30 RESOLVED, that an AMA “first responder team for physician advocacy against adverse
31 insurance company actions” will coordinate relevant information and strategy with other
32 existing AMA programs already engaged in implementing existing AMA policy protecting
33 the rights of physicians and their practices from insurance company behaviors. (Directive
34 to Take Action)

36 Testimony on Resolution 820 was mixed. Several delegations supported the original
37 language, suggesting that the AMA currently lacks a mechanism for providing physician
38 advocacy against adverse insurance company actions. The Board of Trustees
39 recommended that the resolution be referred for decision, as coordination and careful
40 consideration is a critical component in the development of a “First Responder Team.”
41 Testimony included that some states have similar ongoing programs which could be
42 used as models for future AMA efforts. Testimony supported the Board’s
43 recommendations. Therefore, your Reference Committee recommends that Resolution
44 820 be referred for decision.

RECOMMENDED FOR REAFFIRMATION IN LIEU OF

(32) RESOLUTION 813 – INCREASED REGULATION OF FOR-PROFIT HEALTHCARE INSURANCE

RECOMMENDATION:

Your Reference Committee recommends that Policies D-160.907, H-180.947, D-160.906, D-160.908, and H-160.884 be reaffirmed in lieu of Resolution 813.

HOD ACTION: Policies D-160.907, H-180.947, D-160.906, D-160.908, and H-160.884 be reaffirmed in lieu of Resolution 813.

RESOLVED, that our American Medical Association promote public awareness of the harms of for-profit vertical integration of health insurance systems (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for a comprehensive review by the legislature of current regulations and increased regulatory oversight and increased resources for the monitoring of State Medicaid and Managed Medicare for-profit health plans, including vertical integration. (Directive to Take Action)

Your Reference Committee recommends that the policies listed above be reaffirmed in lieu of Resolution 813. The authors testified that the novelty of this resolution was the “public awareness” aspect and urged the AMA to act. One additional delegation provided testimony against reaffirmation and in support of the resolution as written, although the Reference Committee notes many of the points raised in these comments seem to expand beyond the scope of the resolve clauses of this resolution. The Council on Medical Service provided testimony in support of reaffirmation, highlighting several recent Council reports and additional policies that address consolidation and the corporate practice of medicine broadly. Furthermore, the Council stated concerns with the original language, questioning the feasibility of the second resolve clause as well as why only for-profit insurers were called out in the first resolve clause. To address the authors concern about public awareness, your Reference Committee would like to highlight the AMA Policy Research Perspective titled: Competition in Health Insurance: A comprehensive study of U.S. markets. Your Reference Committee agrees that there is sufficient AMA policy that addresses the request of this resolution and thus recommends that Policies D-160.907, H-180.947, D-160.906, D-160.908, and H-160.884 be reaffirmed in lieu of Resolution 813.

HEALTH SYSTEM CONSOLIDATION. D-160.907

1. Our American Medical Association will assess and report annually on nationwide health system and hospital consolidation, as well as payer consolidation, to assist policymakers and the federal government.

1 2. Our AMA annual report on nationwide hospital
2 consolidation will be modeled after the "Competition in health
3 insurance: A comprehensive study of U.S. Markets" in its
4 comprehensiveness to include for example data an analyses
5 as:
6 a. A review of the current level of hospital and/or health
7 system consolidation at the level of all metropolitan statistical
8 areas, state, and national markets.
9 b. A list of all mergers and acquisition transactions valued
10 above a set threshold amount resulting in hospital and/or
11 health system consolidation.
12 c. Analyses of how each transaction has changed or is
13 expected to change the level of competition in the affected
14 service and geographic markets.
15 d. Analyses of healthcare costs and prices have changes in
16 affected markets after a large consolidation transaction has
17 taken place.
18 3. Our AMA will report the initial findings of this study to the
19 House of Delegates by Annual 2024.
20 4. Our AMA will report the findings of this study to its
21 members and stakeholders, including policymakers and
22 legislators, to inform future healthcare policy.
23 (Res. 727, A-23)

24
25 MAINTAINING FREEDOM OF CHOICE WITH INSURANCE
26 PRODUCTS, H-180.947
27 Our AMA opposes consolidation in the health insurance
28 industry that may result in anticompetitive markets.
29 (Sub Res. 202, I-15; Reaffirmed: BOT Rep. 09, A-25)

30
31 STRENGTHENING EFFORTS AGAINST HORIZONTAL &
32 VERTICAL CONSOLIDATION, D-160.906
33 Our American Medical Association advocates to adequately
34 resource competition policy authorities such as the Federal
35 Trade Commission (FTC) and Department of Justice Antitrust
36 Division to perform oversight of health care markets.
37 (Res. 813, I-23)

38
39 VERTICAL CONSOLIDATION IN HEALTH CARE –
40 MARKETS OR MONOPOLIES, D-160.908
41 Our American Medical Association advocates against
42 anticompetitive business practices that have the potential to
43 adversely affect the physician patient relationship, to result in
44 higher costs or decreased quality of care, or are not in the
45 best interest of patients, the public and/or physicians.
46

47
48 Our AMA supports efforts to increase transparency, review,
49 and enforcement of laws with respect to vertical mergers that
50 have the potential to negatively impact the health care
 industry.

1 Our AMA will work with all appropriate stakeholders to create
2 model legislation to prohibit anticompetitive business
3 practices within the health care sector.

4 (Res. 723, A-23)

5 **STRENGTHENING EFFORTS AGAINST HORIZONTAL &
6 VERTICAL CONSOLIDATION, H-160.884**

7 1. Our American Medical Association opposes not-for-profit
8 firm immunity from FTC competition policy enforcement in the
9 health care sector.
10 2. Our AMA supports appropriate transaction value
11 thresholds, including cumulative transaction values, for
12 merger reporting in health care sectors to ensure that vertical
13 acquisitions in health care do not evade antitrust scrutiny.
14 3. Our AMA supports health care-specific advocacy efforts
15 that will strengthen antitrust enforcement in the health care
16 sector through multiple mechanisms.

17 (Res. 813, I-23)

18
19 (33) **RESOLUTION 818 – UNIVERSAL OUT-OF-NETWORK
20 BENEFITS**

21 **RECOMMENDATION:**

22
23 Your Reference Committee recommends that AMA
24 Policies H-285.904, H-285.907, D-285.958, D-
25 285.963, H-165.838, H-180.952, and H-285.908 be
26 reaffirmed in lieu of Resolution 818.

27
28 **HOD ACTION: Policies H-285.904, H-285.907, D-285.958, D-285.963, H-165.838, H-
29 180.952, and H-285.908 reaffirmed in lieu of Resolution 818.**

30
31 **RESOLVED**, that our American Medical Association will advocate for federal and state
32 laws that requires all private insurers to offer health insurance plans with out-of-network
33 benefits. (Directive to Take Action)

34
35 Testimony on Resolution 818 was mixed. Your Reference Committee heard some
36 support for reaffirmation of the AMA's network adequacy and out-of-network care
37 policies in lieu of the resolution. Other commenters supported the resolution as written,
38 with one supporter simultaneously citing the AMA's policy on out-of-network care. A
39 concern was raised regarding the inconsistency of Resolution 818 with AMA policy on
40 patient choice of insurance, which generally includes Health Maintenance Organization
41 (HMO) options that by definition have closed networks, and the perception that adoption
42 would suggest that the AMA believes HMOs should no longer exist. Your Reference
43 Committee points to existing AMA policy that opposes the denial of coverage and/or
44 payment for services that is based solely on the network participation of the ordering
45 physician (Policies H-285.907, D-285.958, and D-285.963); states that insurance options
46 offered in an exchange must not restrict enrollees' access to out-of-network physicians
47
48
49
50

1 (H-165.838[5]); opposes any penalties implemented by insurance companies against
2 physicians when patients independently choose to obtain out-of-network services (Policy
3 H-180.952); supports requiring insurers to indemnify patients for any covered medical
4 expenses provided by out-of-network providers incurred over the copay and deductibles
5 that would apply to in-network providers (Policy H-285.908); and supports other
6 principles for out-of-network care, including that patients must not be financially
7 penalized for receiving unanticipated care from an out-of-network provider, insurers must
8 meet appropriate network adequacy standards that include adequate patient access to
9 care, and minimum coverage standards should pay out-of-network providers at the usual
10 and customary out-of-network charges for services. (Policy H-285.904). Your Reference
11 Committee believes that these policies address the concerns raised about out-of-
12 network care and recommends that they be reaffirmed in lieu of Resolution 818.

OUT-OF-NETWORK CARE H-285.904

1. Our American Medical Association adopts the following principles related to unanticipated out-of-network care:
 - a. Patients must not be financially penalized for receiving unanticipated care from an out-of-network provider.
 - b. Insurers must meet appropriate network adequacy standards that include adequate patient access to care, including access to hospital-based physician specialties. State regulators should enforce such standards through active regulation of health insurance company plans.
 - c. Insurers must be transparent and proactive in informing enrollees about all deductibles, copayments and other out-of-pocket costs that enrollees may incur.
 - d. Prior to scheduled procedures, insurers must provide enrollees with reasonable and timely access to in-network physicians.
 - e. Patients who are seeking emergency care should be protected under the "prudent layperson" legal standard as established in state and federal law, without regard to prior authorization or retrospective denial for services after emergency care is rendered.
 - f. Out-of-network payments must not be based on a contrived percentage of the Medicare rate or rates determined by the insurance company.
 - g. Minimum coverage standards for unanticipated out-of-network services should be identified. Minimum coverage standards should pay out-of-network providers at the usual and customary out-of-network charges for services, with the definition of usual and customary based upon a percentile of all out-of-network charges for the particular health care service performed by a provider in the same or similar specialty and provided in the same geographical area as reported by a benchmarking database. Such a benchmarking database must be independently recognized and verifiable, completely

1 transparent, independent of the control of either payers or
2 providers and maintained by a non-profit organization. The
3 non-profit organization shall not be affiliated with an insurer, a
4 municipal cooperative health benefit plan or health
5 management organization.
6 h. Independent Dispute Resolution (IDR) should be allowed in
7 all circumstances as an option or alternative to come to
8 payment resolution between insurers and physicians.
9 2. Our AMA will advocate for the principles delineated in Policy
10 H-285.904 for all health plans, including ERISA plans.
11 3. Our AMA will advocate that any legislation addressing
12 surprise out of network medical bills use an independent, non-
13 conflicted database of commercial charges.

14
15 OUT OF NETWORK RESTRICTIONS OF PHYSICIANS H-
16 285.907

17 Our American Medical Association opposes the denial of
18 payment for a medically necessary prescription of a drug or
19 service covered by the policy based solely on the network
20 participation of the duly licensed physician ordering it.

21
22 PATIENT ACCESS TO COVERED BENEFITS ORDERED BY
23 OUT-OF-NETWORK PHYSICIANS D-285.958

24 1. Our American Medical Association will develop model
25 legislation to protect patients managed by out-of-network
26 physicians by prohibiting insurance plans from denying
27 payment for covered services, including imaging, laboratory
28 testing, referrals, medications, and other medically-necessary
29 services for patients under their commercial insurance, based
30 solely on the network participation of the ordering physician
31 while preserving evidence based high quality care and
32 healthcare affordability.
33 2. Our AMA will collaborate with other physician organizations
34 to develop resources, toolkits, and education to support out-of-
35 network care models.

36
37 OUT OF NETWORK COVERAGE DENIALS FOR PHYSICIAN
38 PRESCRIPTIONS AND ORDERED SERVICES D-285.963

39 Our American Medical Association will pursue regulation or
40 legislation to prohibit any insurer from writing individual or
41 group policies which deny or unreasonably delay coverage of
42 medically necessary prescription drugs or services based on
43 network distinctions of the licensed health care provider
44 ordering the drug or service.

45
46 HEALTH SYSTEM REFORM LEGISLATION H-165.838

47 ...5. AMA policy is that insurance coverage options offered in
48 a health insurance exchange be self-supporting, have uniform
49 solvency requirements; not receive special advantages from

1 government subsidies; include payment rates established
2 through meaningful negotiations and contracts; not require
3 provider participation; and not restrict enrollees' access to out-
4 of-network physicians.

5
6 PHYSICIAN PENALTIES FOR OUT-OF-NETWORK
7 SERVICES H-180.952

8 Our AMA vehemently opposes any penalties implemented by
9 insurance companies against physicians when patients
10 independently choose to obtain out-of-network services.

11
12 NETWORK ADEQUACY H-285.908

13 1. Our AMA supports state regulators as the primary enforcer
14 of network adequacy requirements.
15 2. Our AMA supports requiring that provider terminations
16 without cause be done prior to the enrollment period, thereby
17 allowing enrollees to have continued access throughout the
18 coverage year to the network they reasonably relied upon
19 when purchasing the product. Physicians may be added to the
20 network at any time.

21 3. Our AMA supports requiring health insurers to submit and
22 make publicly available, at least quarterly, reports to state
23 regulators that provide data on several measures of network
24 adequacy, including the number and type of providers that
25 have joined or left the network; the number and type of
26 specialists and subspecialists that have left or joined the
27 network; the number and types of providers who have filed an
28 in network claim within the calendar year; total number of
29 claims by provider type made on an out-of-network basis; data
30 that indicate the provision of Essential Health Benefits; and
31 consumer complaints received.

32 4. Our AMA supports requiring health insurers to indemnify
33 patients for any covered medical expenses provided by out-of-
34 network providers incurred over the co-payments and
35 deductibles that would apply to in-network providers, in the
36 case that a provider network is deemed inadequate by the
37 health plan or appropriate regulatory authorities.

38 5. Our AMA advocates for regulation and legislation to require
39 that out-of-network expenses count toward a participant's
40 annual deductibles and out-of-pocket maximums when a
41 patient is enrolled in a plan with out-of-network benefits, or
42 forced to go out-of-network due to network inadequacies.

43 6. Our AMA supports fair and equitable compensation to out-
44 of-network providers in the event that a provider network is
45 deemed inadequate by the health plan or appropriate
46 regulatory authorities.

47 7. Our AMA supports health insurers paying out-of-network
48 physicians fairly and equitably for emergency and out-of-
49 network bills in a hospital. AMA policy is that any legislation
50 which addresses this issue should assure that insurer payment

1 for such care be based upon a number of factors, including the
2 physicians' usual charge, the usual and customary charge for
3 such service, the circumstances of the care and the expertise
4 of the particular physician.

5 8. Our AMA provides assistance upon request to state medical
6 associations in support of state legislative and regulatory
7 efforts, and disseminate relevant model state legislation, to
8 ensure physicians and patients have access to adequate and
9 fair appeals processes in the event that they are harmed by
10 inadequate networks.

11 9. Our AMA supports the development of a mechanism by
12 which health insurance enrollees are able to file formal
13 complaints about network adequacy with appropriate
14 regulatory authorities.

15 10. Our AMA advocates for legislation that prohibits health
16 insurers from falsely advertising that enrollees in their plans
17 have access to physicians of their choosing if the health
18 insurer's network is limited.

19 11. Our AMA advocates that health plans should be required
20 to document to regulators that they have met requisite
21 standards of network adequacy including hospital-based
22 physician specialties (i.e. radiology, pathology, emergency
23 medicine, anesthesiologists and hospitalists) at in-network
24 facilities, and ensure in-network adequacy is both timely and
25 geographically accessible.

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

1 Madam Speaker, this concludes the report of Reference Committee J. I would like to
2 thank Teresa Girolami, MD, Patricia Kolowich, MD, Mary LaPlante, MD, Michele Nedelka,
3 MD, Daniel Pfeifle, MD, and Laurel Ries, MD.

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