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

RECOMMENDED FOR ADOPTION

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

RECOMMENDED FOR ADOPTION AS AMENDED

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

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

REFER FOR DECISION

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

RECOMMENDED FOR REAFFIRMATION IN LIEU OF

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

RECOMMENDED FOR ADOPTION

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

RECOMMENDATION:

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

HOD ACTION: Board of Trustees Report 18 is adopted and remainder of Report filed.

The Board of Trustees recommends that the following be adopted and the remainder of the report be filed:

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

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

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

(2) RESOLUTION 802 – PATIENT CHOICE OF PHYSICIAN

RECOMMENDATION:

Your Reference Committee recommends that Resolution 802 be adopted.

HOD ACTION: Resolution 802 is adopted.

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

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

(3) RESOLUTION 804 – MEDICARE ADVANTAGE FILING LIMIT

RECOMMENDATION:

Your Reference Committee recommends that Resolution 804 be adopted.

HOD ACTION: Resolution 804 is adopted.

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

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

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

RECOMMENDATION:

Your Reference Committee recommends that Resolution 809 be adopted.

HOD ACTION: Resolution 809 is adopted.

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

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

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

(5) RESOLUTION 811 – NON-MEDICAL SWITCHING

RECOMMENDATION:

Your Reference Committee recommends that Resolution 811 be adopted.

HOD ACTION: Resolution 811 is adopted.

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

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

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

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

RECOMMENDATION:

Your Reference Committee recommends that Resolution 812 be adopted.

HOD ACTION: Resolution 812 is adopted.

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

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

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

RECOMMENDATION:

Your Reference Committee recommends that Resolution 814 be adopted.

HOD ACTION: Resolution 814 is adopted.

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

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

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

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

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

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

RECOMMENDATION:

Your Reference Committee recommends that Resolution 821 be adopted.

HOD ACTION: Resolution 821 is adopted.

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

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

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

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

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

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

RECOMMENDATION:

Your Reference Committee recommends that Resolution 828 be adopted.

HOD ACTION: Resolution 828 is adopted.

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

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

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

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

RECOMMENDATION:

Your Reference Committee recommends that Resolution 829 be adopted.

HOD ACTION: Resolution 829 is adopted.

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

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

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

RECOMMENDATION:

Your Reference Committee recommends that Resolution 830 be adopted.

HOD ACTION: Resolution 830 is adopted.

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

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

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

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

RECOMMENDED FOR ADOPTION AS AMENDED

(12) CMS REPORT 1 – HEALTH SAVINGS ACCOUNT REFORM

RECOMMENDATION A:

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

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

HEALTH INSURANCE AFFORDABILITY, H-165.828

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

RECOMMENDATION B:

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

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

RECOMMENDATION C:

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

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

ADOPTED LANGUAGE:

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

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

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

   HEALTH SAVINGS ACCOUNTS, H-165.852(7)

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

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

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

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

   HEALTH INSURANCE AFFORDABILITY, H-165.828 (3)
   (3) Our AMA (i) encourages the development of demonstration projects to allow individuals eligible for cost-sharing subsidies, who forego these subsidies by enrolling in a bronze plan, to have access to a health savings account (HSA) partially funded by an amount determined to be equivalent to the cost-sharing subsidy; and (ii) supports individual market bronze and silver plans, regardless of actual deductible amount, being treated as HSA-qualified high-deductible health plans, with appropriate guardrails in place (e.g., safe harbor provisions) to ensure low-income enrollees in these plans do not suffer financial hardships.

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

8) That our AMA supports the principle that HSAs are complementary to and do not replace health insurance coverage or other efforts to improve affordability of health insurance such as ACA premium tax credits

9) That our AMA reaffirm Policy H-290.972, Health Savings Accounts in the Medicaid Program, which outlines several principles for states considering offering beneficiaries HSAs.

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

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

The following additional resolve language was <u>referred</u>:

Our AMA advocates for using the expanded Affordable Care Act premium tax credits as a vehicle for improving health insurance affordability rather than converting those subsidies to health savings accounts or other cash savings accounts.

The Council on Medical Service recommends that the following recommendations be adopted in lieu of Resolution 803-I-24 and the remainder of the report be filed:

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

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

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

HEALTH SAVINGS ACCOUNTS, H-165.852

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

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

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

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

HEALTH INSURANCE AFFORDABILITY, H-165.828

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

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

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

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

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

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

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

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

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

(13) CMS REPORT 2 – TELEHEALTH LICENSURE

RECOMMENDATION A:

Your Reference Committee recommends that Recommendation 1 of Council on Medical Service Report 2 be <u>amended by addition</u> to read as follows:

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

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

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

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

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

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

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

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

1.The trial meets relevant federal, state, and ethical standards as well as those outlined in AMA policy;

2.The assessments are not intended to establish or replace care for the patient outside of the context of the trial; and

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

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

RECOMMENDATION B:

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

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

AMENDED LANGUAGE:

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

(1) It is the policy of our American Medical Association (AMA) that medical boards of states and territories should require a full and unrestricted license in that state for the practice of telemedicine, unless there are other appropriate state-based licensing methods, with no differentiation by specialty, for physicians who wish to practice telemedicine in that state or territory. This license category should adhere to the following principles:
a. Exemption from such a licensure requirement for physician-to-physician consultations.
b. Exemption from such a licensure requirement for telemedicine practiced across state lines in the event of an emergent or urgent circumstance, the definition of which for the purposes of telemedicine should show substantial deference to the judgment of the attending and consulting physicians as well as to the views of the patient.
c. Allowances, by exemption or other means, for out-of-state physicians providing continuity of care to a patient, where there is an established ongoing relationship and previous in-person visits, for services incident to an ongoing care plan or one that is being modified.
d. Exemption from licensure requirements for physicians assessing or screening out-of-state patients for acceptance of a referral to a center for excellence or to a physician with specific expertise in the patient's condition, as selected by the referring physician and patient.
e. Exemption from licensure requirements for physicians screening out-of-state patients for acceptance into a clinical trial that meets relevant federal, state, and ethical standards as well as those outlined in AMA policy.
f. Exemption from licensure requirements for physicians conducting assessments of out-of-state patients that are required as part of a clinical trial, provided that:

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

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

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

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

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

(1) It is the policy of our American Medical Association (AMA) that medical boards of states and territories should require a full and unrestricted license in that state for the practice of telemedicine, unless there are other appropriate state-based licensing methods, with no differentiation by specialty, for physicians who wish to practice telemedicine in that state or territory. This license category should adhere to the following principles:
a. Exemption from such a licensure requirement for physician-to-physician consultations.
b. Exemption from such a licensure requirement for telemedicine practiced across state lines in the event of an emergent or urgent circumstance, the definition of which for the purposes of telemedicine should show substantial deference to the judgment of the attending and consulting physicians as well as to the views of the patient.
c. Allowances, by exemption or other means, for out-of-state physicians providing continuity of care to a patient, where there is an established ongoing relationship and previous in-person visits, for services incident to an ongoing care plan or one that is being modified.
d. Exemption from licensure requirements for physicians assessing or screening out-of-state patients for acceptance of a referral to a center for excellence or to a physician with specific expertise in the patient's condition.
e. Exemption from licensure requirements for physicians screening out-of-state patients for acceptance into a clinical trial that meets relevant federal, state, and ethical standards as well as those outlined in AMA policy.
f. Exemption from licensure requirements for physicians conducting assessments of out-of-state patients that are required as part of a clinical trial, provided that:
1.The trial meets relevant federal, state, and ethical standards as well as those outlined in AMA policy;
2.The assessments are not intended to establish or replace care for the patient outside of the context of the trial; and

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

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

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

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

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

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

RECOMMENDATION A:

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

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

RECOMMENDATION B:

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

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

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

RECOMMENDATION C:

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

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

RECOMMENDATION D:

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

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

RECOMMENDATION E:

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

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

ADOPTED LANGUAGE:

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

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

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

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

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

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

5. Policy D-465.999 be amended to read:

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

6. Policy D-465.998 be amended by addition of a new 5 to read:
5. Our AMA supports educating patients and physicians on the impact of Medicare Advantage plans on rural hospitals and encourages all payers to provide adequate payment to support the financial stability of rural hospitals.

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

7. That the second clause of Policy D-190.969 be rescinded.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(15) CMS REPORT 4 – PAYMENT FOR BIOSIMILARS

RECOMMENDATION A:

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

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

RECOMMENDATION B:

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

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

ADOPTED LANGUAGE:

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

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

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

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

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

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

a. Maintain patient access to biologic/biosimilar drugs prescribed by their physician;
b. Account for physician/practice administrative and acquisition costs, including but not limited to, obtaining, storing, and administering the drug;
c. Incentivize the use of biosimilars when safe, clinically appropriate, and agreed upon by the patient and physician; and
d. Ensure that patient out-of-pocket costs are affordable. (New HOD Policy)

3.That our AMA supports calculating the ASP for biologic/biosimilar drugs under Medicare Part B as the average price paid for a reference biologic and its interchangeable biosimilars adjusted by the market share of each product while ensuring payment is adequate to maintain the financial viability of physician practices. (New HOD Policy)

4. That our AMA reaffirm Policy H-100.940, which supports incentivizing the use of biosimilars when appropriate, eliminating acquisition costs/reimbursement disparities, and patient education. (Reaffirm HOD Policy)

5. That our AMA reaffirm Policy H-110.959, which opposes drug payment methodologies that result in physicians being paid less than cost of the drug and related clinical services. (Reaffirm HOD Policy)

6. That our AMA reaffirm Policy H-125.972, which supports the education of physicians on biosimilars and their involved processes as well as encourages data collection and evaluation by the Food & Drug Administration. (Reaffirm HOD Policy)

7. That our AMA reaffirm Policy D-110.987, which presents guidelines supportive of the regulation of pharmacy benefit managers in a manner that encourages transparency. (Reaffirm HOD Policy)

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

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

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

(16) RESOLUTION 805 – SHARED MEDICAL APPOINTMENTS

RECOMMENDATION A:

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

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

RECOMMENDATION B:

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

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

RECOMMENDATION C:

Your Reference Committee recommends that the third resolve of Resolution 805 be addition and deletion to read as follows:

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

RECOMMENDATION D:

Your Reference Committee recommends that Resolution 805 be adopted as amended.

HOD ACTION: Resolution 805 is amended.

ADOPTED LANGUAGE:

1. **RESOLVED, that our American Medical Association recognizes Shared Medical Appointments and/or Group Medical Visits, as an effective model of care delivery.**

2. **RESOLVED, that our AMA advocate to hospitals and health systems that they support physicians and other clinicians who desire to host Shared Medical Appointments and/or Group Medical Visits.**

3. **RESOLVED, that our AMA advocate for payment of in-person or telehealth Shared Medical Appointments and/or Group Medical Visits, utilizing CPT codes and AMA-CPT coding guidance.**

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

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

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

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

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

RECOMMENDATION A:

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

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

RECOMMENDATION B:

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

HOD ACTION: Resolution 806 is amended.

ADOPTED LANGUAGE:

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

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

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

(18) RESOLUTION 807 – PROTECTING HOSPITALS AND PATIENTS FROM INAPPROPRIATE DENIALS OF INPATIENT ADMISSIONS

RECOMMENDATION A:

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

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

RECOMMENDATION B:

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

HOD ACTION: Resolution 807 is amended.

ADOPTED LANGUAGE:

RESOLVED, that our American Medical Association advocate that if an insurance company denies "full admission" status for a patient being hospitalized, that the insurance company must provide the ability to revert the status to observation to protect the patient and the hospital from total denial of payment.

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

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

(19) RESOLUTION 808 – NO PRIOR AUTHORIZATION FOR INEXPENSIVE MEDICATIONS

RECOMMENDATION A:

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

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

RECOMMENDATION B:

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

HOD ACTION: Resolution 808 is amended.

ADOPTED LANGUAGE:

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

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

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

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

(20) RESOLUTION 810 – OPPOSING UNILATERAL DOWNCODING OF PHYSICIAN SERVICES BY INSURANCE COMPANIES

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

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

RECOMMENDATION B:

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

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

RECOMMENDATION C:

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

RESOLVED, That Policy D-320.972 be reaffirmed.

RECOMMENDATION D:

Your Reference Committee recommends Resolution 810 be adopted as amended.

HOD ACTION: Resolution 810 is amended.

ADOPTED LANGUAGE:

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

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

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

RESOLVED, That Policy D-320.972 be reaffirmed.

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

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

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

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

Testimony on Resolution 810 was fully supportive of the intent, but some testimony indicated that the first three resolve clauses are already covered in existing AMA policy D-320.972. However, other testimony disagreed and voiced that the language is unique enough to be its own policy. Testimony explained the challenge of dealing with these downcoding rulings from payers and how important it is for the AMA to advocate on this 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

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

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

RECOMMENDATION A:

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

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

RECOMMENDATION B:

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

HOD ACTION: Resolution 815 is amended.

ADOPTED LANGUAGE:

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

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

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

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

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

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

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

(22) RESOLUTION 816 – PROHIBIT ARBITRARY TIME LIMITS ON PREAUTHORIZATIONS

RECOMMENDATION A:

Your Reference Committee recommends that the second resolve of Resolution 816 be <u>amended by addition</u> to read as follows:

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

RECOMMENDATION B:

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

HOD ACTION: Resolution 816 is amended.

ADOPTED LANGUAGE:

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

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

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

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

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

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

RECOMMENDATION A:

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

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

RECOMMENDATION B:

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

HOD ACTION: Resolution 817 is amended.

ADOPTED LANGUAGE:

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

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

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

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

RECOMMENDATION A:

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

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

RECOMMENDATION B:

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

HOD ACTION: Resolution 819 is amended.

ADOPTED LANGUAGE:

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

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

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

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

RECOMMENDATION A:

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

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

RECOMMENDATION B:

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

HOD ACTION: Resolution 822 is amended.

ADOPTED LANGUAGE:

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

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

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

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

RECOMMENDATION A:

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

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

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

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

2) includes reviews by ~~doctors~~ physicians and other health care professionals who are not 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 care denial~~

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

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

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

RECOMMENDATION B:

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

HOD ACTION: Resolution 823 is amended.

ADOPTED LANGUAGE:

1.Policy D-480.956 is amended to read as follows:

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

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

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

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

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

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

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

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

Our American Medical Association will work with stakeholders ~~advocates~~ to advocate for legislative and/or regulatory action for greater regulatory oversight ~~of~~ related to the use of augmented intelligence for review of patient claims and prior authorization requests, including whether insurers and/or contracted third parties are using a thorough and fair process that:
1) is based on accurate and up-to-date clinical criteria derived from national medical specialty societies' evidence-based guidelines and peer-reviewed clinical literature.

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

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

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

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

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

RECOMMENDATION A:

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

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

RECOMMENDATION B:

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

HOD ACTION: Resolution 824 is amended.

ADOPTED LANGUAGE:

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

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

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

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

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

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

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

RECOMMENDATION A:

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

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

RECOMMENDATION B:

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

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

RECOMMENDATION C:

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

HOD ACTION: Resolution 825 is amended.

ADOPTED LANGUAGE:

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

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

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

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

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

RECOMMENDATION A:

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

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

RECOMMENDATION B:

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

HOD ACTION: Resolution 826 is amended.

ADOPTED LANGUAGE:

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

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

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

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

RECOMMENDATION A:

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

RECOMMENDATION B:

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

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

RECOMMENDATION C:

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

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

RECOMMENDATION D:

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

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

RECOMMENDATION E:

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

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

LANGUAGE REFERRED FOR DECISION:

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

ADOPTED LANGUAGE:

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

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

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

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

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

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

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

RECOMMENDED FOR REFERRAL FOR DECISION

(31) RESOLUTION 820 – ESTABLISHING AN AMA "FIRST RESPONDER TEAM" FOR REAL-TIME PHYSICIAN ADVOCACY AGAINST ADVERSE INSURANCE COMPANY ACTIONS

RECOMMENDATION:
Your Reference Committee recommends that Resolution 820 be referred for decision.

HOD ACTION: Resolution 820 is referred for decision.

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

- sudden increased in claim denials,
- arbitrarily onerous documentation requirements,
- mid-treatment coverage interruptions

(Directive to Take Action); and be it further

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

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

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

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

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

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

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

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

Our AMA will work with all appropriate stakeholders to create model legislation to prohibit anticompetitive business practices within the health care sector.
(Res. 723, A-23)
STRENGTHENING EFFORTS AGAINST HORIZONTAL & VERTICAL CONSOLIDATION, H-160.884
1. Our American Medical Association opposes not-for-profit firm immunity from FTC competition policy enforcement in the health care sector.
2. Our AMA supports appropriate transaction value thresholds, including cumulative transaction values, for merger reporting in health care sectors to ensure that vertical acquisitions in health care do not evade antitrust scrutiny.
3. Our AMA supports health care-specific advocacy efforts that will strengthen antitrust enforcement in the health care sector through multiple mechanisms.
(Res. 813, I-23)

(33) RESOLUTION 818 – UNIVERSAL OUT-OF-NETWORK BENEFITS

RECOMMENDATION:

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

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

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

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

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

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

OUT OF NETWORK RESTRICTIONS OF PHYSICIANS H-285.907
Our American Medical Association opposes the denial of payment for a medically necessary prescription of a drug or service covered by the policy based solely on the network participation of the duly licensed physician ordering it.

PATIENT ACCESS TO COVERED BENEFITS ORDERED BY OUT-OF-NETWORK PHYSICIANS D-285.958
1.Our American Medical Association will develop model legislation to protect patients managed by out-of-network physicians by prohibiting insurance plans from denying payment for covered services, including imaging, laboratory testing, referrals, medications, and other medically-necessary services for patients under their commercial insurance, based solely on the network participation of the ordering physician while preserving evidence based high quality care and healthcare affordability.
2.Our AMA will collaborate with other physician organizations to develop resources, toolkits, and education to support out-of-network care models.

OUT OF NETWORK COVERAGE DENIALS FOR PHYSICIAN PRESCRIPTIONS AND ORDERED SERVICES D-285.963
Our American Medical Association will pursue regulation or legislation to prohibit any insurer from writing individual or group policies which deny or unreasonably delay coverage of medically necessary prescription drugs or services based on network distinctions of the licensed health care provider ordering the drug or service.

HEALTH SYSTEM REFORM LEGISLATION H-165.838
…5. AMA policy is that insurance coverage options offered in a health insurance exchange be self-supporting, have uniform solvency requirements; not receive special advantages from

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

PHYSICIAN PENALTIES FOR OUT-OF-NETWORK SERVICES H-180.952
Our AMA vehemently opposes any penalties implemented by insurance companies against physicians when patients independently choose to obtain out-of-network services.

NETWORK ADEQUACY H-285.908
1. Our AMA supports state regulators as the primary enforcer of network adequacy requirements.
2. Our AMA supports requiring that provider terminations without cause be done prior to the enrollment period, thereby allowing enrollees to have continued access throughout the coverage year to the network they reasonably relied upon when purchasing the product. Physicians may be added to the network at any time.
3. Our AMA supports requiring health insurers to submit and make publicly available, at least quarterly, reports to state regulators that provide data on several measures of network adequacy, including the number and type of providers that have joined or left the network; the number and type of specialists and subspecialists that have left or joined the network; the number and types of providers who have filed an in network claim within the calendar year; total number of claims by provider type made on an out-of-network basis; data that indicate the provision of Essential Health Benefits; and consumer complaints received.
4. Our AMA supports requiring health insurers to indemnify patients for any covered medical expenses provided by out-of-network providers incurred over the co-payments and deductibles that would apply to in-network providers, in the case that a provider network is deemed inadequate by the health plan or appropriate regulatory authorities.
5. Our AMA advocates for regulation and legislation to require that out-of-network expenses count toward a participant's annual deductibles and out-of-pocket maximums when a patient is enrolled in a plan with out-of-network benefits, or forced to go out-of-network due to network inadequacies.
6. Our AMA supports fair and equitable compensation to out-of-network providers in the event that a provider network is deemed inadequate by the health plan or appropriate regulatory authorities.
7. Our AMA supports health insurers paying out-of-network physicians fairly and equitably for emergency and out-of-network bills in a hospital. AMA policy is that any legislation which addresses this issue should assure that insurer payment

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

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

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

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

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

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

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

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