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REPORT 1 OF THE COUNCIL ON MEDICAL SERVICE (NOV-21)
End-of-Life Care
(Resolution 101-Nov-20)
(Reference Committee A)

EXECUTIVE SUMMARY

Referred Resolution 101-Nov-20, “End of Life Care Payment,” raised concerns regarding patients who may benefit from custodial nursing care at the end of their lives but are prohibited under current Medicare rules from electing skilled nursing facility (SNF) and hospice benefits at the same time for the same condition. Except under very limited circumstances, Medicare’s hospice benefit does not pay for room and board for its enrollees in nursing, skilled nursing, or assisted living facilities. People who pay out of pocket for stays at these facilities may elect hospice if qualified, and if there is an agreement between the facility and a hospice. However, patients using Medicare’s SNF benefit post-hospitalization typically cannot elect hospice under current program rules. Research has suggested that of the large numbers of Medicare patients enrolled in the SNF benefit at the end of their lives, many would have elected hospice if they had not needed room and board coverage.

In line with polls showing that most people would prefer to die at home, most Medicare hospice services are provided at patients’ residences. The Council recognizes that there is an ongoing need for supportive care and assistance with activities of daily living services among many end-of-life patients and the importance of discharging these patients to appropriate settings—preferably where the patient resides—with necessary, affordable supports. The Council believes that hospice is well-suited to provide supportive care services as part of routine home care, as needed (since it already does so), and that the provision of such services as determined by patient need may improve quality of life and prevent utilization of higher intensity care. Accordingly, the Council recommends supporting Medicare coverage of and payment for supportive care services, including assistance with activities of daily living, as needed, under the hospice benefit.

The Council believes the costs and benefits of care models incorporating elements of SNF and hospice are worthy of further study and recommends support for study and pilot testing by the Centers for Medicare & Medicaid Services of care models that allow concurrent use of Medicare’s hospice and SNF benefits. Because the Council expects that many Medicare patients will continue to be discharged to SNFs in the last months of life, it also recommends supporting increased access to palliative care services in that setting.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 1-N-21

Subject: End-of-Life Care
(Resolution 101-Nov-20)

Presented by: Asa C. Lockhart, MD, MBA, Chair

Referred to: Reference Committee A

1 At the November 2020 Special Meeting, the House of Delegates referred Resolution 101, “End of
2 Life Care Payment,” which was sponsored by the New York Delegation. Resolution 101-Nov-20
3 directed the American Medical Association (AMA) to petition the Centers for Medicare &
4 Medicaid Services (CMS) to allow hospice patients to cover the cost of housing (room and board)
5 as a patient in a nursing home or assisted living facility, and to advocate that patients be allowed to
6 use their skilled nursing home benefit while receiving hospice services. The Board of Trustees
7 assigned this item to the Council on Medical Service for a report back to the House of Delegates.
8 This report provides overviews of Medicare’s hospice and skilled nursing benefits, differentiates
9 between hospice and palliative care, summarizes AMA policy and makes policy recommendations.

10
11 BACKGROUND

12
13 Except under very limited circumstances, Medicare’s hospice benefit does not pay for room and
14 board for its enrollees including those in nursing, skilled nursing, or assisted living facilities, where
15 many Medicare enrollees spend the end of their lives. People who pay out of pocket for stays at
16 these facilities may elect hospice if qualified, and if there is an agreement between the facility and a
17 hospice.¹ Medicaid pays for room and board for its dually eligible enrollees who qualify for
18 hospice if the facility has an agreement with a hospice. However, patients using Medicare’s skilled
19 nursing facility (SNF) benefit post-hospitalization typically cannot elect hospice under current
20 program rules. An exception would be for patients enrolled in hospice who need skilled care for a
21 condition unrelated to their terminal illness. For example, if a cancer patient in hospice falls and
22 breaks a hip, Medicare may pay for care in a SNF that the patient needs to recover from the hip
23 injury.²

24
25 Post-acute care services, including skilled nursing and rehabilitation, are commonly used by
26 Medicare patients in the last months of life. Nearly one quarter of hospitalized Medicare patients
27 are discharged from a hospital to a facility, usually a SNF, for post-acute care.³ Because Medicare
28 typically does not pay for concurrent coverage of hospice services and SNF care, some patients
29 who could benefit from hospice instead elect Medicare’s SNF benefit so that their room and board
30 costs are paid for. It is a common challenge at hospital discharge to find post-acute placements for
31 seriously ill patients who may have limited life expectancies, require more care and assistance than
32 can be provided at home, and cannot afford the costs of nursing care or stays at a long-term care
33 facility out of pocket. Because Medicare covers room and board under the SNF benefit, this can
34 become the preferred option for patients deemed eligible for the benefit, even though SNFs are
35 designed to provide rehabilitative, not palliative, care and some SNF services may not be consistent
36 with appropriate end-of-life care.

1 A frequently cited study from 2012 found that one-third of Medicare patients received SNF care
2 during the last six months of life and nine percent died in a SNF, many within 30 days of
3 admission.⁴ More recent Centers for Disease Control and Prevention data reveal that, in 2016,
4 nearly 30 percent of decedents 65 and over died at home, 28 percent died in the hospital, another
5 25 percent died in a facility that provides patient care (e.g., a nursing home, SNF, or long-term care
6 facility), and 8.5 percent died in a hospice facility.⁵ Research has suggested that of the large
7 numbers of patients enrolled in the SNF benefit at the end of their lives, many would have elected
8 hospice if they had not needed room and board coverage.⁶ A 2018 *Health Affairs* blog describes
9 this conundrum as follows:

10
11 Either you get to receive restorative care in a nursing facility or end-of-life care at home.
12 Unfortunately, this approach fails to meet the needs of real-world patients and families. If our
13 current model persists, we will continue to cause patients and families to fall into a gap at some
14 of the most tender moments in their family life cycle.⁷

15
16 Patients at the end of life who are too sick to benefit from skilled care, but are unable to return
17 home, often remain hospitalized until death because there is no appropriate, affordable community
18 placement available. Patients who need around-the-clock nursing care often end up in nursing
19 facilities, including SNFs. Some Medicare enrollees cycle between hospital stays and nursing
20 facilities in the last months of life, even when rehabilitation is unlikely to be successful. Many end-
21 of-life patients remain at home with family members who become responsible for providing the
22 care they need, including assistance with activities of daily living (ADL) services.

23 24 *Medicare's Skilled Nursing Facility Benefit*

25
26 Covered SNF services include post-hospital extended care services for which benefits are provided
27 under Medicare Part A and include nursing care; bed and board in connection with furnishing of
28 such nursing care; physical or occupational therapy and/or speech-language pathology services;
29 medical social services; drugs, biologicals, supplies, appliances, and equipment; and other services
30 necessary to the health of the patients.⁸ Medicare does not cover SNF services for patients who
31 only need custodial services (e.g., assistance with ADL such as bathing and dressing) but not
32 skilled nursing benefits.

33
34 Medicare will cover skilled nursing under the SNF benefit if patients have a qualifying three-day
35 hospital stay and documented daily skilled care needs, although CMS waived SNF three-day stay
36 and discharge requirements during the public health emergency so that hospitals could focus on
37 COVID-19 care. Care in a SNF is generally covered if it is documented that the patient requires
38 daily skilled services that must be performed by or under the supervision of a professional and can
39 only be provided to an inpatient at a SNF. Services must be reasonable and necessary for the
40 treatment of a patient's illness or injury and consistent with the individual's medical needs and
41 medical practice standards. According to the Medicare benefits manual, coverage does not depend
42 on the patient's potential for improvement from the nursing care and/or therapy, but rather on the
43 patient's need for skilled care.⁹ Nonetheless, patients need to be able to participate in daily therapy
44 services to be eligible for the SNF benefit and some seriously ill patients receiving hospice care
45 cannot do so.

46
47 Medicare will cover up to 100 days of SNF care but only pays 100 percent of the costs for the first
48 20 days. At day 21, patients must begin paying a copay (\$185.50 per day in 2021) through day 100
49 of a covered stay.¹⁰ SNF services are costly; in 2019, Medicare's median payment per day was
50 \$498 and its median payment per stay was \$18,559. Medicare spending on SNF services in 2019—
51 when almost 1.5 million Medicare patients used the SNF benefit—was \$27.8 billion.¹¹ In addition

1 to providing post-acute care, most SNFs are also certified to provide long-term care (nursing home
 2 care) that is not covered by Medicare.

3
 4 *Medicare’s Hospice Benefit*

5
 6 More than 1.6 million Medicare patients received hospice services in 2019 at a total cost of \$20.9
 7 billion.¹² Medicare spending on hospice has increased substantially in recent years and was \$15.1
 8 billion in 2014, a figure cited by the Council in its most recent report on the program ([Council on
 9 Medical Service Report 4-I-16, Concurrent Hospice and Curative Care](#)). The literature on hospice
 10 costs to the Medicare program has been mixed, with some studies showing cost savings among
 11 hospice patients who are in the last one or two months of life. A MedPAC-commissioned analysis
 12 suggests that hospice produces savings for some patients, including cancer patients, but has not
 13 decreased net Medicare spending.¹³

14
 15 The hospice benefit was introduced to the Medicare program in 1983 to provide a range of
 16 palliative and support services provided primarily in the home. To be eligible to elect hospice care
 17 under Medicare, patients must be certified as having a life expectancy of six months or less if the
 18 terminal illness runs its normal course; patients can be recertified for additional periods if they
 19 remain terminal.¹⁴ Room and board costs in a nursing facility are not covered unless the patient
 20 qualifies for a short inpatient hospice or a respite stay. Covered hospice services include nursing
 21 care, medical social services, physician services, counseling and bereavement services, medical
 22 equipment and supplies (including prescription drugs), and other services included in a patient’s
 23 individualized care plan. Skilled therapy services, such as physical, speech and occupational
 24 therapy are covered if they are deemed reasonable and necessary to manage symptoms or help
 25 maintain patient functioning. Under the supervision of a hospice nurse, hospice aides may provide
 26 personal care and some homemaker services that are deemed necessary to maintain a safe and
 27 sanitary environment in areas of the home used by the patient.¹⁵

28
 29 Medicare pays for hospice care using per diem payment categories encompassing four levels of
 30 care: (1) routine home care, for which Medicare pays \$199 per day for the first 60 days and \$157
 31 per day thereafter; (2) general inpatient care, paid \$1,046 per day; (3) continuous home care, paid
 32 at a rate of \$60 per hour; and (4) inpatient respite care, for which Medicare pays \$461 per day
 33 (payment rates are for fiscal year 2021).¹⁶ General inpatient care is provided around the clock in an
 34 inpatient facility (e.g., a hospice inpatient unit or SNF), usually for pain or symptom control which
 35 cannot be managed in other settings. It is intended to be short-term and, once symptoms stabilize,
 36 patients may be returned to their residences. Continuous home care consists mainly of nursing care
 37 provided on a continuous basis; this level of care is available only during brief periods of crisis and
 38 as needed to maintain the patient at home.¹⁷ Inpatient respite care is provided in an approved
 39 facility on a short-term basis for respite. Service intensity add-on payments are made when hospice
 40 provides direct patient care by a registered nurse or social worker during patients’ last seven days
 41 of life.

42
 43 When Congress established Medicare’s hospice benefit, it established two caps on payments to
 44 hospices—known as the inpatient cap and the aggregate cap—to ensure that hospice costs do not
 45 exceed the costs of conventional care. The inpatient cap limits the share of general and respite
 46 inpatient days that a hospice can provide to 20 percent of its total patient care days. Although this
 47 cap is rarely exceeded, the aggregate cap, which limits total aggregate payments any individual
 48 hospice can receive in a year (\$30,684 in 2021), is exceeded by an estimated 16 percent of all
 49 hospices.¹⁸

1 Hospice use among Medicare enrollees has been incrementally increasing in recent years, such that
 2 51.6 percent of enrollees who died in 2019 had used hospice services, up from 25 percent in
 3 2000.¹⁹ In 2018, a majority of hospice care days were provided at private residences, followed by
 4 assisted living facilities and nursing facilities, including SNFs.²⁰ Most care provided by hospice is
 5 routine home care, which accounted for 98 percent of Medicare-covered hospice days in 2019²¹
 6 and is in line with polls showing that seven in ten people would prefer to die at home.²² Hospices
 7 vary and, even within the routine home level of care, the frequency and type of hospice visits and
 8 type and intensity of services may differ by patient and across hospices. While more people are
 9 turning to hospice at the end of life, families and the caregivers they hire provide much of the care
 10 and assistance with ADL services that home hospice patients often require.

11
 12 *Palliative Care*

13
 14 Palliative medicine focuses on reducing suffering, improving a patient’s quality of life, and
 15 supporting patients with serious illness and their families. Palliative care can be provided alongside
 16 other medical treatments regardless of whether the patient can be cured and can be initiated early in
 17 one’s disease course. Hospice is a type of palliative care for people who likely have six or fewer
 18 months to live and are willing to forego curative treatments for their terminal illness. Not all
 19 palliative care is hospice, although hospice care is always palliative.

20
 21 The philosophies underlying hospice and palliative care are similar; however, care location, timing
 22 and eligibility often differ. At its core, palliative care is designed to assess, prevent and manage
 23 physical and psychological symptoms, address spiritual concerns, and focus on communications
 24 that establish patient goals of care and assist patients with medical decision-making about treatment
 25 options. Whereas hospice care is most commonly provided to patients in their homes, long-term
 26 care facilities, or wherever patients reside, non-hospice palliative care is frequently provided in
 27 hospitals or community settings such as cancer centers, clinics and nursing homes. Patients can
 28 receive palliative care while continuing curative treatment at any stage of their illnesses, and many
 29 studies have shown that early palliative care interventions improve quality of life and increase
 30 patient and family satisfaction. As suggested by Policy H-85.951, it is important for physicians to
 31 be familiar with hospice and palliative care resources and their benefit structures, as well as clinical
 32 practice guidelines developed by national medical specialty societies, and to refer seriously ill
 33 patients accordingly.

34
 35 *Medicare Advantage Plans and Hospice*

36
 37 Traditional Medicare has historically covered services related to a terminal illness under the
 38 hospice benefit even for patients enrolled in Medicare Advantage (MA) plans, meaning that fee-
 39 for-service Medicare has generally been responsible for coverage of most services while the MA
 40 plan is responsible for certain supplemental benefits. In 2021, CMS began testing the inclusion of
 41 hospice within the MA benefits package through the hospice component of the Value-Based
 42 Insurance Design (VBID) Model.²³ MA plans participating in the demonstration are permitted to
 43 offer palliative care as well as supplemental benefits such as meals, transportation, and in-home
 44 supports. The demonstration has started small; for example, Humana is offering the hospice benefit
 45 to enrollees in a handful of metropolitan areas. Humana’s benefit allows transitional concurrent
 46 care and offers in-home respite care.²⁴

47
 48 *Disparities in End-of-Life Care*

49
 50 Despite increases in the use of both hospice and palliative services in this country, racial disparities
 51 in end-of-life care persist, and communities of color remain underserved. Black and Latino people

1 are more likely to die in a hospital and be treated more intensively at the end of life than Whites.²⁵
2 Black Americans are less likely to utilize hospice than Whites and have more emergency
3 department visits and hospitalizations in the last six months of life.²⁶ While some have posited that
4 differences in trust of health systems and patient preferences contribute to existing disparities,²⁷
5 more research and efforts to understand and reduce these disparities, and address cultural
6 competence in end-of-life care, are needed.

7
8 RELEVANT AMA POLICY

9
10 The AMA has long supported the goals of hospice and palliative care. Policy H-70.915 supports
11 improved payments for health care practices caring for dying patients and encourages research into
12 the needs of dying patients and how they could be better served by the health care system. Policy
13 H-85.951, which was established through Council Report 4-I-16, (1) supports continued study and
14 pilot testing by CMS of a variety of models for providing and paying for concurrent hospice,
15 palliative and curative care; (2) encourages CMS to identify ways to optimize patient access to
16 palliative care, and to provide appropriate coverage and payment for these services; and (3)
17 encourages physicians to be familiar with local hospice and palliative care resources and their
18 benefit structures and to refer seriously ill patients accordingly.

19
20 Policy H-85.966 maintains that the use of hospice should provide the patient and family with
21 appropriate support, but not preclude or prevent the use of appropriate palliative therapies to
22 continue to treat the underlying disease. Policy H-85.955 approves of the physician-directed
23 hospice concept to enable the terminally ill to die in a more homelike environment; supports
24 changes to the Medicaid program to allow provision of concurrent life-prolonging and palliative
25 care; and supports broadening eligibility beyond six-month prognoses under Medicaid and
26 Medicare hospice benefits. Policy D-155.995 supports greater evaluation of the use of disease
27 management, case management, pay-for-performance, and end-of-life care programs for high-cost
28 patients.

29
30 The AMA also has substantial policy on long-term care (LTC), including the financing of long-
31 term services and supports (Policy H-280.945). Policy H-280.991 states that programs to finance
32 LTC should cover needed services in a timely, coordinated manner in the least restrictive setting
33 appropriate to the health care needs of the individual, and coordinate benefits across different LTC
34 financing programs. Policy H-210.994 similarly supports the provision of LTC services in the least
35 restrictive setting by affirming support of home health care as an alternative to nursing home or
36 institutional care.

37
38 Policy H-290.982 supports: increasing public and private investments in home and community-
39 based care, such as adult day care, assisted living facilities, congregate living facilities, and respite
40 care; allowing states to use long-term care eligibility criteria that distinguish between persons who
41 can be served in a home or community-based setting and those who can only be served safely and
42 cost-effectively in a nursing facility; buy-ins for home and community-based care for persons with
43 incomes and assets above Medicaid eligibility limits; and providing grants to states to develop new
44 LTC infrastructures and to encourage expansion of LTC financing to middle-income families who
45 need assistance.

46
47 Policy D-280.985 directs the AMA to work to identify additional mechanisms by which patients'
48 out-of-pocket costs for SNF care can be fairly covered. Under Policy H-280.947, the AMA
49 continues to advocate for elimination of the three-day stay rule and requirements related to
50 inpatient hospitalization as a prerequisite before Medicare patients are eligible for SNF or LTC
51 placement.

1 DISCUSSION

2
 3 The 2015 Institute of Medicine (IOM) report, *Dying in America*, found that “significant problems
 4 remain in providing end-of-life care for Americans that is high quality and compassionate and
 5 preserves their choice while being affordable and sustainable.”²⁸ The IOM report further
 6 highlighted the need for policy changes to support high-quality end-of-life care by stating:

7
 8 A major reorientation and restructuring of Medicare, Medicaid, and other health care delivery
 9 programs is needed to craft a system of care designed to ensure quality and address the central
 10 needs of all people nearing the end of life and their families. Current financial incentives and a
 11 lack of more appropriate alternatives drive a reliance on the riskiest and most costly care
 12 settings. These incentives should be changed, and positive alternatives should be further
 13 developed.

14
 15 In addition, many of the most urgent needs of these patients and their families are not medical
 16 per se and require the design and implementation of affordable support service programs that
 17 rigorously target the highest-risk patients and families, and tailor services to specific family
 18 needs as they evolve over time.²⁹

19
 20 The sentiment of the IOM report is relevant to the concerns raised by referred Resolution
 21 101-Nov-20 regarding end-of-life care, for patients who may benefit from custodial nursing care
 22 but are prohibited under current rules from electing Medicare’s SNF and hospice benefits at the
 23 same time for the same condition. The Council’s work on long-term services and supports and
 24 home and community-based services has highlighted the challenges of caring for our aging
 25 population and identifying affordable and politically viable solutions that meet the care needs of
 26 many seniors. Council on Medical Service Report 4, which is also being considered at this meeting,
 27 recommends new AMA policy on the hospital at home model, which we believe could benefit
 28 some patients at the end of life.

29
 30 Medicare’s hospice benefit helps large numbers of patients and families, but it does not cover room
 31 and board for more than a small number of enrollees who qualify for short-term inpatient hospice,
 32 or a brief respite stay. Continuous home care that includes nursing and supportive care in one’s
 33 residence is allowable under Medicare’s hospice benefit but only during brief periods of crisis.
 34 Although routine home care makes up 98 percent of Medicare-covered hospice days, it is critical
 35 that general inpatient care, continuous home care, and respite inpatient care are available to hospice
 36 patients as their conditions change and their needs evolve.

37
 38 The Council recognizes the ongoing need for custodial or continuous care, and ADL services,
 39 among many end-of-life patients and the importance of discharging these patients to appropriate
 40 settings—preferably where the patient resides—with necessary, affordable supports. The Council
 41 believes that hospice is well-suited to provide supportive care services as part of routine home care,
 42 as needed (since it already does so), and that the provision of such services as determined by
 43 patient need may improve quality of life and prevent utilization of higher intensity care.
 44 Accordingly, the Council recommends supporting Medicare coverage of and payment for
 45 supportive care services, including assistance with activities of daily living, as needed, under the
 46 hospice benefit.

47
 48 The Council recognizes that a new room and board coverage benefit for hospice enrollees could
 49 significantly add to the costs of Medicare, a program already making headlines for its trust fund
 50 sustainability issues. The Council further recognizes that Medicare’s SNF and hospice benefits
 51 were not designed to work in tandem and differ in many respects, including their mission and

1 goals, eligibility criteria, and duration of allowable services. SNFs are intended to provide
2 rehabilitative—not palliative—services, some of which may not be needed at the end of life.
3 Despite these differences, some similar services are provided by both SNFs and hospices, including
4 skilled nursing, nursing aides, equipment, supplies and prescription drugs. A concurrent model
5 would need to be carefully designed to prevent duplication of services, ensure administrative
6 coordination and proper payment, and address site-neutral care. Although the Council does not
7 recommend concurrent hospice and SNF care under the Medicare program, we believe the costs
8 and benefits of care models incorporating elements of SNF and hospice are worthy of further study,
9 especially given that COVID-19 may have impacted location preferences of hospice services.
10 Accordingly, the Council recommends support for study and pilot testing by CMS of care models
11 that allow concurrent use of Medicare’s hospice and SNF benefits.

12
13 Because of financial incentives and coverage gaps within Medicare, the Council expects that many
14 patients will continue to be discharged to SNFs in the last months of life, and some will die there,
15 especially as the elderly population grows and the SNF benefit continues to be utilized for its room
16 and board coverage. Consistent with AMA policy supportive of coverage and payment for
17 palliative care, the Council recommends supporting increased access to palliative care services by
18 Medicare patients in SNF. Finally, the Council acknowledges the breadth of existing AMA policy
19 on hospice, palliative, and end-of-life care, and recommends reaffirmation of Policies H-85.966
20 and H-70.915.

21
22 **RECOMMENDATIONS**

23
24 The Council on Medical Service recommends that the following be adopted in lieu of Resolution
25 101-Nov-20, and that the remainder of the report be filed:

- 26
27 1. That our American Medical Association (AMA) support Medicare coverage of and appropriate
28 payment for supportive care services, including assistance with activities of daily living, as
29 needed, under Medicare’s hospice benefit. (New HOD Policy)
30
31 2. That our AMA support study and pilot testing by the Centers for Medicare & Medicaid
32 Services of care models that allow concurrent use of Medicare’s hospice and skilled nursing
33 facility (SNF) benefits for the same condition. (New HOD Policy)
34
35 3. That our AMA support increased access to palliative care services by Medicare patients in
36 skilled nursing facilities. (New HOD Policy)
37
38 4. That our AMA reaffirm Policy H-85.966, which maintains that hospice care should provide the
39 patient and family with appropriate physical and emotional support, but not preclude the use of
40 appropriate palliative therapies to continue to treat underlying disease. (Reaffirm HOD Policy)
41
42 5. That our AMA reaffirm Policy H-70.915, which recognizes the importance of palliative care,
43 encourages the education of health professionals and the public in caring for dying patients,
44 and supports improved payment for health care practices that are important to good care of the
45 dying patient. (Reaffirm HOD Policy)

Fiscal Note: Less than \$500.

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REPORT 3 OF THE COUNCIL ON MEDICAL SERVICE (NOV-21)
Covering the Remaining Uninsured
(Resolution 123-J-21)
(Reference Committee A)

EXECUTIVE SUMMARY

With the enactment of the most recent COVID-19 relief bill, the American Rescue Plan Act of 2021 (ARPA), into law, the coverage dynamics in the US have shifted. The Council analyzed the remaining uninsured post-ARPA to assess whether new American Medical Association (AMA) policy is needed targeting select segments of the remaining uninsured. After reviewing AMA policy as well as health reform legislation and regulation at the state and federal levels, the Council sees an opportunity to further maximize coverage rates and improve affordability under the AMA proposal for reform by either amending existing policy, or establishing new policy, impacting the uninsured ineligible for Affordable Care Act (ACA) financial assistance due to falling into the coverage gap, immigration status, or having an “affordable” offer of employer coverage.

The Council is highly concerned about the more than two million uninsured who fall into ACA’s coverage gap. With policy alternatives emerging to cover this segment of the uninsured, ranging from making them eligible for premium tax credits and cost-sharing reductions to purchase marketplace coverage, to establishing a standalone federal Medicaid-like program or other public option, the Council recommends new policy to advocate that any approach to cover the uninsured who fall into the coverage gap ensure this population has access to affordable, quality coverage, and protect against current expansion states from dropping their Medicaid expansions.

Addressing the uninsured ineligible for ACA financial assistance due to immigration status, Policy H-290.983 already enables the AMA to advocate in support of removing the five-year waiting period for lawfully present immigrants to enroll in Medicaid/Children’s Health Insurance Program. However, additional policy is needed not only to provide a coverage option via unsubsidized ACA marketplace coverage for undocumented immigrants and Deferred Action for Childhood Arrivals recipients, but also recognize state and local efforts to provide coverage to immigrants regardless of immigration status.

The Council believes that additional policy options must be pursued to make coverage more affordable to individuals and families offered an “affordable” employer-sponsored plan which, in reality, is actually not affordable to them. To do so, the Council recommends the amendment of Policy H-165.828, to open the door to eligibility for premium tax credits and cost-sharing reductions to those facing an employer plan premium that is above the maximum affordability threshold applied to subsidized ACA marketplace plans. In addition, the Council recommends the amendment of the policy to enable the AMA to support additional solutions to fix ACA’s “family glitch,” to ensure that more families of workers are able to become eligible for subsidized ACA marketplace coverage.

The Council recognizes there is strong interest in the House of Delegates in how best to cover the population ages 60-64. In assessing the options available to cover the uninsured ages 60 to 64, the Council finds that the AMA proposal for reform, as well as the recommendations of this report, are preferable to other options, including lowering the Medicare eligibility age to 60. The AMA proposal for reform, as well as the recommendations of this report, strongly target each segment of the uninsured population ages 60 to 64, without causing health system disruptions.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 3-N-21

Subject: Covering the Remaining Uninsured
(Resolution 123-J-21)

Presented by: Asa Lockhart, MD, MBA, Chair

Referred to: Reference Committee A

1 With the enactment of the most recent COVID-19 relief bill, the American Rescue Plan Act of
2 2021 (ARPA), into law, the coverage dynamics in the US have shifted. The nation has witnessed
3 record enrollment in Affordable Care Act (ACA) coverage, via coverage offered on ACA
4 marketplaces and under the Medicaid expansion, as well as through the Special Open Enrollment
5 Period that recently ended. Resulting from the ARPA, a significant proportion of the uninsured is
6 now eligible for ACA financial assistance, either in the form of premium tax credits to purchase
7 marketplace coverage, or Medicaid. However, some segments of the uninsured population continue
8 to be left behind, with potential negative effects on their health outcomes and financial security, as
9 well as systemwide impacts resulting from how their care is provided and financed. After
10 reviewing American Medical Association (AMA) policy as well as health reform legislation and
11 regulation at the state and federal levels, the Council concluded that new and innovative AMA
12 policy is needed targeting select segments of the uninsured population.

13
14 Subsequently, at the June 2021 Special Meeting of the House of Delegates, Resolution 123,
15 Medicare Eligibility at Age 60, was referred. Introduced by the Medical Student Section,
16 Resolution 123 asked that our AMA advocate that the eligibility threshold to receive Medicare as a
17 federal entitlement be lowered from age 65 to age 60. The Board of Trustees assigned this item to
18 the Council on Medical Service for a report back to the House of Delegates.

19
20 This report provides background on the ACA improvements included in the ARPA; outlines the
21 AMA proposal for reform; analyzes the need for new AMA policy to improve the coverage rates
22 for each segment of the post-ARPA uninsured; examines the uninsured population ages 60 to 64
23 and evaluates potential pathways to increase coverage to this population, including lowering the
24 Medicare eligibility age; and presents policy recommendations.

25 26 BUILDING UPON THE ACA: THE AMERICAN RESCUE PLAN ACT

27
28 The ARPA represents the largest coverage expansion since the ACA. Under the ACA, eligible
29 individuals and families with incomes between 100 and 400 percent of the federal poverty level
30 (FPL) (between 133 and 400 percent FPL in Medicaid expansion states) have been provided with
31 refundable and advanceable premium credits that are inversely related to income to purchase
32 coverage on health insurance exchanges. However, consistent with Policy H-165.824, the ARPA
33 eliminated ACA's subsidy "cliff" for 2021 and 2022. As a result, individuals and families with
34 incomes above 400 percent FPL (\$51,040 for an individual and \$104,800 for a family of four based
35 on 2020 federal poverty guidelines) are eligible for premium tax credit assistance. Individuals
36 eligible for premium tax credits include individuals who are offered an employer plan that does not

1 have an actuarial value of at least 60 percent (i.e., 60 percent of benefit costs covered) or if the
2 employee share of the premium exceeds 9.83 percent of income in 2021.

3
4 Also consistent with Policy H-165.824, ARPA increased the generosity of premium tax credits for
5 two years, lowering the cap on the percentage of income individuals are required to pay for
6 premiums of the benchmark (second-lowest-cost silver) plan. Premiums of the second-lowest-cost
7 silver plan for individuals with incomes at and above 400 percent FPL are capped at 8.5 percent of
8 their income. Notably, resulting from the changes, eligible individuals and families with incomes
9 between 100 and 150 percent of the federal poverty level (133 percent and 150 percent FPL in
10 Medicaid expansion states) now qualify for zero-premium silver plans, effective until the end of
11 2022. In addition, individuals receiving unemployment compensation who qualify for exchange
12 coverage are eligible for a zero-premium silver plan in 2021.

13
14 Individuals and families with incomes between 100 and 250 percent FPL (between 133 and 250
15 percent FPL in Medicaid expansion states) also qualify for cost-sharing subsidies if they select a
16 silver plan, which reduces their deductibles, out-of-pocket maximums, copayments and other cost-
17 sharing amounts. The only change ARPA made to cost-sharing reduction eligibility and generosity
18 was targeted to those receiving unemployment compensation. Individuals receiving unemployment
19 compensation in 2021 who qualify for exchange coverage and enroll in a silver plan—regardless of
20 income—are eligible for substantial cost-sharing reductions.

21
22 At the time that this report was written, 38 states and the District of Columbia had adopted the
23 Medicaid expansion provided for in the ACA, which extended Medicaid eligibility to individuals
24 with incomes up to 133 percent FPL.¹ ARPA included new incentives for states to implement
25 Medicaid expansions. States that have not yet expanded Medicaid are now eligible for a five-
26 percentage-point increase in their traditional Federal Medical Assistance Percentage Rate (FMAP)
27 for two years if they newly implement the Medicaid expansion, applicable to a large share of their
28 Medicaid population and spending. In the near term, the new five-percentage-point increase would
29 be in addition to the current 6.2-percentage-point increase in the match rate provided under the
30 Families First Coronavirus Response Act (FFCRA) pursuant to the COVID-19 public health
31 emergency. Importantly, states that newly expand would also receive a 90 percent federal match
32 for the expansion population.

33 34 THE AMA PROPOSAL FOR REFORM

35
36 Covering the uninsured and improving health insurance affordability have been long-standing goals
37 of the AMA. Since the enactment of the ACA, the AMA proposal for reform has continued to
38 evolve to ensure that AMA policy is able to address how to best cover the remaining uninsured in
39 the current coverage environment. The AMA proposal for reform focuses on expanding health
40 insurance coverage to four main population targets:

- 41
- 42 1. Individuals eligible for ACA’s premium tax credits who remain uninsured (11 million);
- 43 2. Individuals eligible for Medicaid or the Children’s Health Insurance Program (CHIP) who
- 44 remain uninsured (7.3 million);
- 45 3. People who remain uninsured who are ineligible for ACA’s premium tax credits due to an
- 46 offer of “affordable” employer-sponsored coverage (3.5 million); and
- 47 4. People with low incomes who remain uninsured and are ineligible for Medicaid (2.2
- 48 million).²

1 By appropriately targeting the provision of coverage to the uninsured population, the AMA
 2 proposal for reform has aimed to make significant strides in covering the remaining uninsured and
 3 providing health insurance to millions more Americans:

- 4
- 5 • Premium tax credits would be available to individuals without an offer of “affordable”
 6 employer coverage, with no upper income limit (Policy H-165.824).
- 7 • Individuals currently caught in the “family glitch” and unable to afford coverage offered
 8 through their employers for their families would become eligible for ACA financial
 9 assistance based on the premium for family coverage of their employer plan (Policy H-
 10 165.828). Currently, in determining eligibility for premium tax credits, coverage for family
 11 members of an employee is considered to be affordable as long as employee-only coverage
 12 is affordable. The employee-only definition of affordable coverage pertaining to employer-
 13 sponsored coverage, commonly referred to as ACA’s “family glitch,” does not take into
 14 consideration the cost of family-based coverage, which commonly is much more expensive
 15 than employee-only coverage. As a result, the “family glitch” leaves many workers and
 16 their families ineligible to receive premium and cost-sharing subsidies to purchase
 17 coverage on health insurance exchanges, even though in reality they would likely have to
 18 pay well over 9.83 percent of their income for family coverage.
- 19 • To help employees currently having difficulties affording coverage, the threshold used to
 20 determine the affordability of employer coverage would be lowered, which would make
 21 more people eligible for ACA financial assistance based on income (Policy H-165.828).
- 22 • The generosity of premium tax credits would be increased to improve premium
 23 affordability, by tying premium tax credit size to gold-level instead of silver-level plan
 24 premiums, and/or lowering the cap on the percentage of income individuals are required to
 25 pay for premiums of the benchmark plan (Policy H-165.824).
- 26 • Young adults facing high premiums would be eligible for “enhanced” tax credits based on
 27 income (Policy H-165.824).
- 28 • Eligibility for cost-sharing reductions would be expanded to help more people with the
 29 cost-sharing obligations of the plan in which they enroll (Policy H-165.824).
- 30 • The size of cost-sharing reductions would be increased to lessen the cost-sharing burdens
 31 many individuals with low incomes face, which impact their ability to access and afford
 32 the care they need (Policy H-165.824).
- 33 • A permanent federal reinsurance program would be established, to address the impact of
 34 high-cost patients on premiums (Policy H-165.842).
- 35 • State initiatives to expand their Medicaid programs will continue to be supported. To
 36 incentivize expansion decisions, states that newly expand Medicaid would still be eligible
 37 for three years of full federal funding (Policies D-290.979 and H-290.965).
- 38 • Public options would be explored as potential pathways to provide health insurance
 39 coverage to uninsured individuals who fall into the “coverage gap” at no or nominal cost,
 40 provided that they meet the standards outlined in Policy H-165.823.
- 41 • To maximize coverage rates, the AMA would support the auto-enrollment of individuals
 42 who qualify for zero-premium marketplace coverage or Medicaid/CHIP in health insurance
 43 coverage, and continue to support the use of individual mandate penalties at the state and
 44 federal levels (Policies H-165.823, H-165.824 and H-165.848).
- 45 • To improve coverage rates of individuals eligible for either ACA financial assistance or
 46 Medicaid/CHIP but who remain uninsured, the AMA would support investments in
 47 outreach and enrollment assistance activities (Policies H-165.824, H-290.976, H-290.971,
 48 H-290.982 and D-290.982).
- 49 • States would continue to have the ability to test different innovations to cover the
 50 uninsured, provided such experimentations: a) meet or exceed the projected percentage of
 51 individuals covered under an individual responsibility requirement while maintaining or

1 improving upon established levels of quality of care; b) ensure and maximize patient
 2 choice of physician and private health plan; and c) include reforms that eliminate denials
 3 for pre-existing conditions (Policy D-165.942).
 4

5 NEED FOR NEW AMA POLICY TO ADDRESS THE POST-ARPA UNINSURED: FILLING IN
 6 URGENT POLICY GAPS
 7

8 While the exact number of the uninsured is in flux due to the COVID-19 pandemic and resulting
 9 changes in employment and eligibility for either ACA premium assistance or Medicaid, Kaiser
 10 Family Foundation (KFF) released estimates that offer a profile of the post-ARPA uninsured. Of
 11 note, these estimates are based on 2019 American Community Survey data; the time delay may
 12 affect overall numbers, but these estimates are still expected to provide a representative overview
 13 of the uninsured population. Overall, KFF estimates that 28.9 million nonelderly individuals are
 14 uninsured.³ The Council has analyzed the remaining uninsured post-ARPA to assess whether new
 15 AMA policy is needed targeting select segments of the remaining uninsured. The Council's
 16 analysis concluded that how to best cover three segments of the uninsured population is currently
 17 not sufficiently addressed in AMA policy and AMA's plan to cover the uninsured: the uninsured
 18 who are ineligible for ACA financial assistance due to falling into ACA's coverage gap, the
 19 uninsured who are ineligible for ACA financial assistance due to immigration status, and the
 20 uninsured ineligible for ACA financial assistance due to having an offer of affordable employer
 21 coverage. Critically, without the implementation of policy solutions for these populations, many
 22 will be left without any affordable coverage options.
 23

24 *Uninsured Ineligible for ACA Financial Assistance Due to Falling into ACA's Coverage Gap*
 25

26 Resulting from states not implementing the Medicaid expansion provided for under the ACA, more
 27 than two million of the nonelderly uninsured find themselves in the coverage gap—not eligible for
 28 Medicaid, and not eligible for premium tax credits because they reside in states that did not expand
 29 Medicaid.⁴ Approximately 60 percent of individuals who fall into the coverage gap are people of
 30 color. Three of four individuals who fall into the coverage gap reside in four states—Florida,
 31 Georgia, North Carolina and Texas.⁵ Of note, an additional 1.8 million uninsured adults in non-
 32 expansion states with incomes between 100 and 133 percent FPL are currently eligible for
 33 premium tax credits and cost-sharing reductions to purchase ACA marketplace coverage but would
 34 become eligible for Medicaid if their state implemented the Medicaid expansion.⁶
 35

36 Medicaid eligibility for adults in states that did not expand their Medicaid programs is quite
 37 limited. The median limit for parents in these states is 40 percent FPL. Childless adults—regardless
 38 of income—remain ineligible for Medicaid in nearly all states that did not expand their Medicaid
 39 programs. Significantly, childless adults make up more than three of four individuals who fall into
 40 the coverage gap. Overall, approximately half of individuals who fall into the coverage gap have
 41 incomes under 50 percent FPL, which amounts to \$6,440 per year for an individual, or \$537 per
 42 month.⁷
 43

44 Approximately two-thirds of individuals in the coverage gap are in working families, with half
 45 working themselves.⁸ Overall, individuals who fall in the coverage gap are in households in which
 46 workers earn low wages, work part-time, or are not consistently employed. Without access to
 47 Medicaid or heavily subsidized marketplace coverage, the uninsured in the coverage gap simply do
 48 not have access to affordable coverage options. For example, in 2021, the national average
 49 unsubsidized premium for a 40-year-old non-smoker seeking coverage on ACA marketplaces was
 50 \$436 per month for the lowest-cost silver plan and \$328 per month for a bronze plan. This is
 51 equivalent to roughly 80 percent of income for those at the lower income range of the coverage gap

1 (below 40 percent FPL), and nearly a third of income for those with incomes closer to the poverty
 2 line.⁹

3
 4 Assessment of the Need for New AMA Policy

5
 6 Policy D-290.979 states that our AMA will work with state and specialty medical societies in
 7 advocating at the state level in support of Medicaid expansion. Policy H-290.965 supports states
 8 that newly expand Medicaid being made eligible for three years of full federal funding. Policy
 9 H-290.966 encourages policymakers at all levels to focus their efforts on working together to
 10 identify realistic coverage options for adults currently in the coverage gap; encourages states that
 11 are not participating in the Medicaid expansion to develop waivers that support expansion plans
 12 that best meet the needs and priorities of their low income adult populations; and encourages the
 13 Centers for Medicare & Medicaid Services (CMS) to review Medicaid expansion waiver requests
 14 in a timely manner, and to exercise broad authority in approving such waivers, provided that the
 15 waivers are consistent with the goals and spirit of expanding health insurance coverage and
 16 eliminating the coverage gap for low-income adults. Policies H-165.920 and H-165.865 advocate
 17 for the promotion of individually selected and owned health insurance using refundable and
 18 advanceable tax credits that are inversely related to income so that patients with the lowest incomes
 19 will receive the largest credits. Policy H-165.855 encourages state demonstrations to provide
 20 coverage to their Medicaid beneficiaries using subsidies that enable acute care Medicaid
 21 beneficiaries to obtain private health insurance. Policy H-165.823 states that any public option shall
 22 be made available to uninsured individuals who fall into the “coverage gap” in states that do not
 23 expand Medicaid—having incomes above Medicaid eligibility limits but below the federal poverty
 24 level, which is the lower limit for premium tax credit eligibility—at no or nominal cost.

25
 26 At the time that this report was written, there were three main pathways to provide coverage to the
 27 uninsured who fall into the coverage gap. One strategy, as past COVID-19 relief bill provisions
 28 aimed to do, would be to provide more incentives to states to adopt ACA’s Medicaid expansion.
 29 The Council notes that, at this juncture, it is unclear whether additional financial incentives would
 30 cause any additional states to expand Medicaid. Another strategy would be to extend eligibility for
 31 premium tax credits and cost-sharing reductions to individuals with incomes below the poverty
 32 line, the current floor for eligibility. Lastly, the establishment of a federal Medicaid-like program or
 33 another type of public option has been discussed to cover those individuals who fall in the coverage
 34 gap in non-expansion states. While the AMA has policy relevant to each of the leading legislative
 35 approaches to provide individuals in the coverage gap with a source of health insurance coverage,
 36 the Council believes that new policy is needed to address the affordability of coverage offered
 37 under any federal approach to provide coverage to this population, as well as the impacts of any
 38 intervention on states that have already expanded Medicaid. The Council believes that there is a
 39 need for new policy to ensure that any federal approach targeted at the uninsured who fall in the
 40 coverage gap makes health insurance coverage available to this population at no or nominal cost,
 41 with significant cost-sharing protections. In addition, the Council believes that it is critical for any
 42 federal approach to address the coverage gap protect against current expansion states from
 43 dropping their Medicaid expansions.

44
 45 *Uninsured Ineligible for ACA Financial Assistance Due to Immigration Status*

46
 47 Almost four million of the nonelderly uninsured are ineligible for ACA financial assistance due to
 48 their immigration status.¹⁰ Overall, lawfully present and undocumented immigrants were
 49 significantly more likely to be uninsured than citizens in 2019. Among the nonelderly population,
 50 25 percent of lawfully present immigrants and 46 percent of undocumented immigrants were

1 uninsured, compared to nine percent of citizens. Critically, noncitizen children are more likely to
2 be uninsured than citizen children.¹¹

3
4 The higher uninsured rate among noncitizens is partially rooted in eligibility restrictions for
5 Medicaid, CHIP and ACA marketplace coverage. Currently, many qualified non-citizens, including
6 many lawfully permanent residents or green card holders, face a five-year waiting period after
7 receiving qualified immigration status before becoming eligible for Medicaid and CHIP.
8 Populations exempt from the five-year waiting period include refugees, asylees and lawfully
9 permanent residents who used to be refugees or asylees. States currently have the option to
10 eliminate the five-year waiting period for lawfully present children and pregnant women without a
11 qualified immigration status. At the time this report was written, 35 states have extended coverage
12 to affected children, with half of states having done so for impacted pregnant women.¹²

13
14 An alternative to coverage for lawfully present immigrants who are affected by the five-year
15 waiting period or do not have a qualified immigration status is to seek coverage on ACA
16 marketplaces and receive subsidies for coverage. These lawfully present immigrants with incomes
17 below the poverty line are eligible to receive premium tax credits and cost-sharing reductions to
18 purchase ACA marketplace coverage even if they are ineligible for Medicaid based on their
19 immigration status. Lawfully present immigrants with incomes between 100 and 400 percent of
20 FPL are eligible for premium tax credits and cost-sharing reductions to purchase coverage if they
21 are not eligible for other coverage.

22
23 However, undocumented immigrants are not eligible to purchase coverage through the ACA
24 marketplaces, even if they pay the full cost because they are not eligible for subsidies. In addition,
25 they are not eligible to enroll in Medicaid or CHIP. These eligibility restrictions for Medicaid,
26 CHIP and marketplace coverage also extend to individuals with Deferred Action for Childhood
27 Arrivals (DACA) status, as they are not considered lawfully present and remain ineligible for
28 coverage options, according to rules issued by CMS. With these restrictions in place, some states
29 and localities have established programs to provide coverage to certain groups of immigrants
30 regardless of immigration status, without the use of federal funds.

31 32 Assessment of the Need for New AMA Policy

33
34 Policy H-290.983 opposes federal and state legislation denying or restricting lawfully present
35 immigrants Medicaid and immunizations. Policy H-440.903 directs the AMA to actively lobby
36 federal and state governments to restore and maintain funding for public health care benefits for all
37 lawfully present immigrants. Policy H-350.957 advocates for policies to make available and
38 effectively deploy resources needed to eliminate health disparities affecting immigrants, refugees
39 or asylees. Policy H-440.876 opposes any policies, regulations or legislation that would criminalize
40 or punish physicians and other health care providers for the act of giving medical care to patients
41 who are undocumented immigrants; opposes any policies, regulations, or legislation requiring
42 physicians and other health care providers to collect and report data regarding an individual
43 patient's legal resident status; and opposes proof of citizenship as a condition of providing health
44 care. Policy D-440.985 states that our AMA shall assist states on the issue of the lack of
45 reimbursement for care given to undocumented immigrants in an attempt to solve this problem on a
46 national level.

47
48 The Council believes that existing policy sufficiently addresses the need to provide health
49 insurance coverage to lawfully present immigrants and has enabled the AMA to advocate in
50 support of removing the five-year waiting period for lawfully present immigrants to enroll in
51 Medicaid/CHIP. The Council is cognizant that proper knowledge surrounding eligibility for

1 benefits is key to eligible immigrants enrolling in Medicaid, CHIP or marketplace coverage. The
2 Council believes that existing policy addressing outreach and enrollment assistance for
3 Medicaid/CHIP coverage, and financial assistance to purchase marketplace coverage, is sufficient
4 to address this barrier to enrollment in coverage. However, there remains a gap in AMA policy that
5 provides an avenue for undocumented immigrants and DACA recipients to access coverage
6 options. There is a need for AMA policy in support of allowing undocumented immigrants and
7 DACA recipients to purchase unsubsidized coverage on ACA marketplaces, with the guarantee that
8 health plans and ACA marketplaces will not collect and/or report data regarding enrollee
9 immigration status. Without that guarantee in place, fear of immigration enforcement could
10 preclude a segment of the immigrant population from enrolling in coverage. AMA policy also may
11 be needed to address state and local initiatives to provide coverage to immigrants regardless of
12 their immigration status; existing policy only addresses the reimbursement for the care provided to
13 undocumented immigrants.

14
15 *Uninsured Ineligible for ACA Financial Assistance Due to Having an Affordable Offer of Employer*
16 *Coverage*

17
18 Approximately 3.5 million of the nonelderly uninsured are ineligible for ACA's premium tax
19 credits because they have an "affordable" offer of employer-sponsored insurance coverage.¹³ To be
20 considered "affordable," employer coverage must have an actuarial value of at least 60 percent and
21 the employee share of the premium must be less than 9.83 percent of income in 2021. Notably,
22 following the enactment of ARPA into law, inconsistencies now exist between the definition of
23 affordable coverage pertaining to eligibility for premium and cost-sharing subsidies for those
24 offered employer coverage, and the percentage of income at which premiums are capped for
25 individuals with the highest incomes eligible for subsidized marketplace coverage. Premiums of the
26 second-lowest-cost silver plan for individuals with incomes at and above 400 percent FPL are
27 capped at 8.5 percent of their income. But employer coverage with an employee share of the
28 premium less than 9.83 percent of income is considered to be "affordable."

29
30 In determining eligibility for premium tax credits, coverage for family members of an employee is
31 considered to be affordable as long as employee-only coverage is affordable. Defining the
32 affordability of employer coverage based on the premium contribution for employee-only
33 coverage, and not family-based coverage, is rooted in ambiguity within the ACA as to how
34 affordability is defined for family members of employees offered employer-sponsored coverage.
35 As a result, the Joint Committee on Taxation interpreted the law to base the definition of employer-
36 sponsored coverage solely on the cost of employee-only coverage; this interpretation was
37 ultimately adopted in regulations issued by the Internal Revenue Service. The employee-only
38 definition of affordable coverage pertaining to employer-sponsored coverage, commonly referred
39 to as ACA's "family glitch," does not take into consideration the cost of family-based coverage,
40 which commonly is much more expensive than employee-only coverage. The average employee
41 contribution for self-only coverage was estimated to be \$1,243 in 2020, while the average
42 contribution for family coverage was estimated to be \$5,588.¹⁴

43
44 The "family glitch" leaves many families of workers ineligible to receive premium and cost-
45 sharing subsidies to purchase coverage on health insurance exchanges, even though in reality they
46 would likely have to pay well over 9.83 percent of their income for family coverage. Overall, 5.1
47 million individuals fall into ACA's family glitch, more than half of whom are children. Of this
48 number, 4.4 million are currently covered by an employer plan, 315,000 are enrolled in
49 unsubsidized individual market coverage, and 451,000 are uninsured.¹⁵ A study from 2016
50 estimated that, on average, families who fall into the family glitch spent 15.8 percent of their
51 incomes on employer-sponsored coverage.¹⁶

1 Assessment of the Need for New AMA Policy

2
 3 Policy H-165.828 supports modifying the eligibility criteria for premium credits and cost-sharing
 4 subsidies for those offered employer-sponsored coverage by lowering the threshold that determines
 5 whether an employee’s premium contribution is affordable to that which applies to the exemption
 6 from the individual mandate of the ACA. Existing AMA policy, therefore, does not take into
 7 consideration the inconsistency between the definition of affordable coverage pertaining to
 8 eligibility for premium and cost-sharing subsidies for those offered employer coverage, and the
 9 percentage of income at which premiums are capped for individuals with the highest incomes
 10 eligible for subsidized marketplace coverage. The Council believes that this inconsistency should
 11 be rectified.

12
 13 Policy H-165.828 also supports legislation or regulation, whichever is relevant, to fix the ACA’s
 14 “family glitch,” thus determining the affordability of employer-sponsored coverage with respect to
 15 the cost of family-based or employee-only coverage. However, current discussions surrounding
 16 fixing ACA’s family glitch are exploring a different solution to fixing the glitch, which would in
 17 effect decouple the worker from their family in determining eligibility for premium tax credits to
 18 purchase coverage. As such, a spouse and/or child in a family offered “affordable” employee-only
 19 coverage but unaffordable family coverage would become eligible for premium subsidies to
 20 purchase marketplace coverage. The worker, meanwhile, would remain only eligible for the
 21 employee-only employer-sponsored coverage, not premium subsidies to purchase coverage on the
 22 ACA marketplaces. Because employees would not be newly eligible for premium tax credits, there
 23 would be no impact on liability for employers under the employer mandate, as the mandate is only
 24 applicable if an employee receives subsidies, not their family members.

25
 26 Under this option, the family would be covered by at least two different health plans and would be
 27 responsible for the premiums associated with each plan, including that associated with the
 28 employee-only employer-sponsored coverage as well as that associated with the marketplace plan.
 29 Accordingly, not all families would necessarily be better off switching from their employer-
 30 sponsored family plan. However, many families would be better off, even those that may still need
 31 to pay more than 9.83 percent of their income for coverage of their entire family between
 32 employer-sponsored and marketplace plan premiums. It has been estimated that families switching
 33 from their employer plans would save approximately \$400 per person in premiums on average,
 34 with families with incomes below 200 percent FPL saving \$580 per person. Overall, while some
 35 currently covered by employer-sponsored coverage would transition to marketplace or
 36 Medicaid/CHIP coverage under this approach to fixing the family glitch, it also has been projected
 37 to cover nearly 200,000 uninsured individuals impacted by ACA’s family glitch.¹⁷

38
 39 POST-ARPA UNINSURED POPULATIONS FOR WHOM AMA POLICY IS SUFFICIENT:
 40 LOOKING AHEAD

41
 42 The Council’s analysis concluded that AMA policy sufficiently addresses how best to cover three
 43 segments of the post-ARPA uninsured population: the uninsured eligible for ACA premium tax
 44 credits, the uninsured eligible for Medicaid, and the uninsured who have an affordable ACA
 45 marketplace plan available to them without the need for any subsidy. That being said, the Council
 46 underscores the need for AMA policy to be implemented to cover these populations, ranging from
 47 ramping up outreach and enrollment assistance, to making additional improvements to ACA’s
 48 premium tax credits and cost-sharing subsidies, to implementing auto-enrollment for those eligible
 49 for zero-premium marketplace plans or Medicaid.

1 *Uninsured Eligible for ACA Premium Tax Credits*

2
 3 Eleven million of the nonelderly uninsured are eligible for premium tax credits, at least six million
 4 of whom are eligible for zero-premium marketplace plans.¹⁸ Of those individuals eligible for zero-
 5 premium marketplace plans, approximately 1.3 million have incomes below 150 percent FPL
 6 (\$19,140 for an individual and \$39,300 for a family of four based on 2020 federal poverty
 7 guidelines) and are eligible for zero-premium silver plans with cost-sharing reductions that result in
 8 their deductibles being reduced to an average of \$177 and thus resembling platinum-level
 9 coverage¹⁹ (90 percent of benefit costs covered). Individuals receiving unemployment
 10 compensation in 2021 who qualify for exchange coverage and enroll in a silver plan—regardless of
 11 income—are also eligible for substantial cost-sharing reductions that also cause their coverage to
 12 resemble that of a platinum plan. Even with the additional premium assistance provided for in the
 13 ARPA, a segment of the uninsured eligible for premium tax credits may not see the benefit in
 14 getting covered if they cannot afford their deductibles, copayments, and other cost-sharing
 15 responsibilities.

16
 17 Assessment of the Need for New AMA Policy

18
 19 Under Policy H-165.824, (1) there would be adequate funding for and expansion of outreach
 20 efforts to increase public awareness of advance premium tax credits; (2) the generosity of premium
 21 tax credits would be increased to improve premium affordability, by tying premium tax credit size
 22 to gold-level instead of silver-level plan premiums, and/or lowering the cap on the percentage of
 23 income individuals are required to pay for premiums of the benchmark plan; (3) young adults
 24 facing high premiums would be eligible for “enhanced” tax credits based on income; (4) eligibility
 25 for cost-sharing reductions would be expanded to help more people with the cost-sharing
 26 obligations of the plan in which they enroll; (5) the size of cost-sharing reductions would be
 27 increased to lessen the cost-sharing burdens many individuals with low incomes face, which impact
 28 their ability to access and afford the care they need; and (6) the subsidy “cliff” would be
 29 eliminated. Policy H-165.823 highlights the potential for auto-enrollment as a strategy to cover the
 30 more than six million individuals eligible for zero-premium marketplace plans who remain
 31 uninsured.

32
 33 As such, the Council believes that existing AMA policy is sufficient to address how best to cover
 34 uninsured individuals eligible for premium tax credits. Policy H-165.823 would provide a pathway
 35 for the six million uninsured individuals eligible for zero-premium coverage to become insured.
 36 Policy H-165.824 would enable the AMA to not only advocate to make the ARPA enhancements—
 37 improved premium tax credit generosity and ACA subsidy cliff elimination—permanent, but would
 38 support advocacy efforts to take additional steps to make premiums more affordable for the
 39 uninsured who are subsidy-eligible, as well as tackle barriers posed by deductibles and cost-sharing
 40 requirements. The policy also recognizes that uninsured individuals eligible for premium tax
 41 credits can only enroll in subsidized coverage if they are aware that they are eligible, which is why
 42 outreach efforts are so critical.

43
 44 *Uninsured Eligible for Medicaid*

45
 46 More than seven million of the nonelderly uninsured are eligible for Medicaid/CHIP, which
 47 includes adults in the Medicaid expansion population and populations eligible for Medicaid/CHIP
 48 under pre-ACA rules but who have not enrolled.²⁰ The reasons for this group remaining uninsured
 49 remain multifaceted, ranging from not being aware of their eligibility for coverage, to perceived
 50 stigma associated with public coverage, to facing barriers to enrollment, including those which are
 51 administrative or technical in nature.

1 Assessment of the Need for New AMA Policy

2
3 To improve coverage rates of individuals eligible for Medicaid/CHIP but who remain uninsured,
4 AMA policy supports investments in outreach and enrollment assistance activities (Policies H-
5 290.976, H-290.971, H-290.982 and D-290.982). Policy H-165.823 states that individuals should
6 only be auto-enrolled in health insurance coverage if they are eligible for coverage options that
7 would be of no cost to them after the application of any subsidies. Candidates for auto-enrollment
8 would, therefore, include individuals eligible for Medicaid/CHIP.

9
10 As such, the Council believes that existing AMA policy is sufficient to address how best to cover
11 uninsured individuals eligible for Medicaid. Policy H-165.823 would provide a mechanism through
12 which the uninsured who are Medicaid-eligible would be able to gain coverage via auto-
13 enrollment. Until auto-enrollment for Medicaid-eligible individuals is able to be implemented,
14 investments in outreach and enrollment assistance activities will be essential to get this segment of
15 the uninsured covered.

16
17 *Uninsured Who Have an Affordable Marketplace Plan Available to Them*

18
19 More than one million of the nonelderly uninsured have an affordable ACA marketplace plan
20 available to them with an unsubsidized benchmark premium that is less than 8.5 percent of their
21 household income without a premium tax credit, making them ineligible for ACA financial
22 assistance.²¹ Of note, this segment of the uninsured has higher incomes, but removing ACA's
23 subsidy cliff still does not make them eligible for premium assistance.

24
25 Assessment of the Need for New AMA Policy

26
27 Policy H-165.824 supports lowering the cap on the percentage of income individuals are required
28 to pay for premiums of the benchmark plan. Policy H-165.848 supports a requirement that
29 individuals and families earning greater than 500 percent FPL obtain, at a minimum, coverage for
30 catastrophic health care and evidence-based preventive health care, using the tax structure to
31 achieve compliance.

32
33 The Council notes that a segment of this population could potentially become eligible for premium
34 tax credits if the cap on premiums as a percentage of income were lowered even further than what
35 the ARPA accomplished. That being said, using a policy "stick" to get this population covered may
36 be necessary, including a state and/or federal individual mandate penalty. Accordingly, the Council
37 believes that existing AMA policy is sufficient to address how best to cover this segment of the
38 uninsured population.

39
40 COVERING THE UNINSURED AGES 60 TO 64

41
42 Following the referral of Resolution 123 at the June 2021 Special Meeting of the House of
43 Delegates, the Council examined the segment of the uninsured ages 60 to 64 to ascertain what
44 improvements, if any, need to be made to AMA's proposal for reform to ensure that this population
45 has a pathway to coverage, and to assess the merits of lowering the Medicare eligibility age to age
46 60. Of the 20.8 million individuals ages 60 to 64 in the US, 56.3 percent are enrolled in employer-
47 sponsored coverage, 14.5 percent are enrolled in Medicaid, 11.3 percent are enrolled in non-group
48 coverage, 10.1 percent are enrolled in other public coverage (e.g., Medicare and military coverage),
49 and 7.8 percent are uninsured.²²

1 Of the uninsured ages 60 to 64, nearly half are eligible for premium tax credits. Further, nearly 20
 2 percent are eligible for Medicaid, 15 percent are ineligible for ACA financial assistance due to
 3 having an affordable offer of employer coverage, 10 percent fall in the coverage gap and seven
 4 percent are ineligible for ACA financial assistance due to immigration status.²³

5
 6 *Assessment of the Need for New AMA Policy*

7
 8 The Council notes that the earlier sections of this report address how existing AMA policy pertains
 9 to each segment of the uninsured population ages 60 to 64. For the uninsured eligible for premium
 10 tax credits, making premium tax credit assistance more generous, and expanding eligibility for and
 11 improving the generosity of cost-sharing subsidies, will be highly beneficial. The Council
 12 understands that when this population is able to enroll in ACA marketplace coverage, affordable
 13 cost-sharing levels will be critical so they will be able to access the care they need. The Council
 14 believes that subsidized ACA marketplace coverage with improved cost-sharing assistance is the
 15 preferable option to cover this segment of the uninsured population ages 60 to 64, especially
 16 considering that most current traditional Medicare beneficiaries are enrolled in supplemental
 17 insurance through either a Medicare supplemental plan, Medicaid, or an employer to provide more
 18 comprehensive cost-sharing protections than what is offered in the traditional Medicare program.
 19 Subsidized ACA marketplace assistance would also become available to some of the uninsured
 20 ages 60-64 currently ineligible due to having an affordable offer of employer coverage under
 21 current AMA policy, as well as recommendations for new policy proposed in this report.

22
 23 For uninsured individuals ages 60 to 64 who are eligible for zero-premium marketplace coverage,
 24 as well as the 20 percent of the uninsured eligible for Medicaid, the Council believes that auto-
 25 enrollment again can be used as a mechanism to provide health insurance to these individuals at no
 26 cost to them. Existing AMA policy, and recommendations for new policy in this report, applicable
 27 to the uninsured who fall in the coverage gap, and ineligible for ACA financial assistance due to
 28 immigration status, would also pertain to those ages 60 to 64.

29
 30 The Council also recognizes the role Policy H-330.896 plays in improving the consistency between
 31 Medicare and Social Security eligibility. The policy supports restructuring Medicare's age-
 32 eligibility requirements and incentives to match the Social Security schedule of benefits. However,
 33 lowering the age to become eligible for Medicare from 65 to 60 is not consistent with the intent of
 34 Policy H-330.896, and is projected to have unintended consequences.

35
 36 While lowering the age of Medicare eligibility to 60 could cover many of the uninsured in the 60-
 37 64 age bracket, the Council believes that the AMA proposal for reform, as well as the
 38 recommendations of this report, provide a better pathway to get this age cohort of the uninsured
 39 covered without causing significant health system changes and potential negative impacts to
 40 physicians, hospitals, and other entities. For example, lowering the age of Medicare eligibility to 60
 41 has been projected by KFF to also have the potential to shift nearly 12 million individuals with
 42 employer coverage and 2.4 million with non-group coverage into Medicare.²⁴ Such a shift would
 43 notably impact the payer mix of physician practices. At the same time, only one-third of the
 44 approximately 1.6 million uninsured in this age cohort remains ineligible for premium tax credits to
 45 purchase marketplace coverage, or Medicaid, because they do not qualify for ACA financial
 46 assistance due to an affordable offer of employer coverage, falling into the coverage gap, or due to
 47 immigration status. Accordingly, the Council believes that the AMA proposal for reform can cover
 48 this population without the unwanted policy tradeoffs that lowering the Medicare eligibility age
 49 would present.

1 The Council recognizes that there are equity considerations associated with each alternative to
 2 cover the uninsured ages 60 to 64, and those associated with lowering the Medicare eligibility age
 3 must be examined. While lowering the Medicare eligibility age to 60 would open the door to
 4 Medicare to individuals aged 60-64, doing so would notably eliminate subsidized marketplace
 5 coverage eligibility for these individuals, potentially increasing their cost of coverage. They still
 6 would, however, be able to choose to remain on their employer-sponsored coverage. In light of the
 7 premium tax credit enhancements included in the ARPA, lower-income individuals currently
 8 enrolled in a marketplace plan may have the potential to face higher premiums in traditional
 9 Medicare. In addition, considering that half of the uninsured ages 60 to 64 are eligible for premium
 10 tax credits, the Council believes that they should not lose access to the most affordable coverage
 11 pathway available to them—critical for those with the lowest incomes. Avalere found that current
 12 marketplace subsidies are consistently more generous for lower-income individuals than the
 13 subsidies available to Medicare beneficiaries.²⁵ Accordingly, the Council believes that improving
 14 the generosity of premium tax credits and cost-sharing reductions, and making cost-sharing
 15 reductions available to more people, as outlined in AMA policy, provides low-income uninsured
 16 ages 60 to 64 with a more preferable choice of coverage option than lowering the Medicare
 17 eligibility age to 60.

18
 19 Overall, lowering the Medicare eligibility age to 60 has been projected to cost \$200 billion over ten
 20 years.²⁶ The aforementioned shift in coverage from employer coverage to Medicare shifts a large
 21 share in health spending to the federal budget. While certain proposals to date reiterate that
 22 lowering the Medicare eligibility age to 60 would be funded by general revenues, they would still
 23 need a pay-for. Proposals to lower the Medicare eligibility age to 60 could also threaten the fiscal
 24 stability of the Medicare Trust Fund. Notably, the Council emphasizes that the AMA proposal for
 25 reform would not only have a smaller fiscal footprint over a ten-year period, but also would not
 26 negatively impact the Medicare Trust Fund. The potential for other unintended consequences of
 27 lowering the Medicare eligibility age must be assessed, including on graduate medical education
 28 (GME).

29
 30 Finally, the Council is highly concerned that lowering the Medicare eligibility age to 60 would
 31 negatively impact the payer mix of physician practices. It is expected that lowering the Medicare
 32 eligibility age to 60 would lower the revenues for physicians, hospitals, and other providers
 33 delivering care to the 60-64 age cohort. Physician and hospital payment rates from private plans
 34 tend to be higher than those paid by Medicare, with the difference between the two increasing over
 35 time.²⁷

36
 37 **DISCUSSION**

38
 39 The AMA proposal for reform, based on AMA policy, is still the right direction to pursue in order
 40 to cover the remaining uninsured. The enactment of the ARPA into law has provided a preview as
 41 to what ACA improvements, many of which reflect the AMA proposal for reform, can accomplish.
 42 The Council underscores that Policy H-165.824 supports making the ARPA changes to the ACA
 43 permanent—increasing the generosity of premium tax credits as well as eliminating ACA’s subsidy
 44 “cliff.” However, the Council is cognizant that more needs to be done to cover the uninsured
 45 eligible for premium tax credits and Medicaid, as well as the uninsured already eligible for an
 46 affordable ACA marketplace plan without any subsidy. Policy H-165.823, by outlining the
 47 potential for auto-enrollment for the segment of the uninsured eligible for coverage options that
 48 would be of no cost to them after the application of any subsidies, provides a coverage pathway for
 49 the 7.3 million uninsured individuals eligible for Medicaid/CHIP and the six million eligible for
 50 zero-premium marketplace coverage. Until auto-enrollment is enacted for these populations, the
 51 Council believes that outreach and enrollment assistance efforts will be absolutely critical, so

1 individuals are aware that they are eligible for premium tax credits or Medicaid/CHIP and receive
 2 any necessary assistance to enroll in coverage. Outreach and enrollment assistance efforts are also
 3 vital to facilitate the enrollment of immigrants eligible for ACA financial assistance in health
 4 insurance coverage.

5
 6 Policy H-165.824 also contains highly important provisions to improve the affordability of not only
 7 the premiums for individuals who remain uninsured despite being eligible for premium tax credits
 8 as well as those who already have access to an affordable marketplace plan, but also deductibles
 9 and other cost-sharing obligations. A component of the uninsured may not see the benefit to
 10 enrolling in coverage if they know they will not be able to afford the cost-sharing responsibilities
 11 of the plan in which they can enroll. In addition, uninsured individuals already eligible for
 12 affordable ACA marketplace coverage without any subsidy may need the “stick” of an individual
 13 mandate penalty to get coverage, advocated for in Policies H-165.848 and Policy H-165.824.

14
 15 However, the Council sees an opportunity to further maximize coverage rates and improve
 16 coverage affordability under the AMA proposal for reform by either amending existing policy, or
 17 establishing new policy, impacting the uninsured ineligible for ACA financial assistance due to
 18 falling into the coverage gap, immigration status, or having an affordable offer of employer
 19 coverage. The Council is highly concerned about the more than two million uninsured who fall into
 20 ACA’s coverage gap. It has been the hope of the Council that, following existing AMA policy, the
 21 states that have not yet expanded their Medicaid programs would do so, and enjoy the associated
 22 significant, positive financial incentives. With policy alternatives emerging to cover this segment
 23 of the uninsured, ranging from making them eligible for premium tax credits and cost-sharing
 24 reductions to purchase marketplace coverage, to establishing a standalone federal Medicaid-like
 25 program or other public option, the Council underscores that Policies H-165.838 and H-165.823
 26 recommended for reaffirmation collectively constitute a critical baseline for any federal approach
 27 to cover the uninsured who fall in the coverage gap to meet. In addition, the Council recommends
 28 new policy to advocate that any approach to cover the uninsured who fall into the coverage gap
 29 ensure this population has access to affordable, quality coverage, and protect against current
 30 expansion states from dropping their Medicaid expansions. These new policies, as well as existing
 31 policy outlining standards that any public option to expand health insurance coverage must meet,
 32 supersede Policy H-290.966, which is recommended to be rescinded.

33
 34 Addressing the uninsured ineligible for ACA financial assistance due to immigration status, Policy
 35 H-290.983 already enables the AMA to advocate in support of removing the five-year waiting
 36 period for lawfully present immigrants to enroll in Medicaid/CHIP. However, additional policy is
 37 needed not only to provide a coverage option via unsubsidized ACA marketplace coverage for
 38 undocumented immigrants and DACA recipients, but to recognize state and local efforts to provide
 39 coverage to immigrants regardless of immigration status. In implementing initiatives to improve
 40 the coverage rates of immigrants, the Council believes it is critical that entities overseeing these
 41 programs do not collect and/or report data regarding enrollee immigration status.

42
 43 The Council believes that additional policy options must be pursued to make coverage more
 44 affordable to individuals and families offered an “affordable” employer-sponsored plan which, in
 45 reality, is actually not affordable to them. To do so, the Council recommends the amendment of
 46 Policy H-165.828, to open the door to eligibility for premium tax credits and cost-sharing
 47 reductions to those facing an employer plan premium that is above the maximum affordability
 48 threshold applied to subsidized ACA marketplace plans. In addition, the Council recommends the
 49 amendment of the policy to enable the AMA to support additional solutions to fix ACA’s “family
 50 glitch,” to ensure that more families of workers are able to become eligible for subsidized ACA
 51 marketplace coverage.

1 In assessing the options available to cover the uninsured ages 60 to 64, the Council finds that the
2 AMA proposal for reform, as well as the recommendations of this report, are preferable to other
3 options, including lowering the Medicare eligibility age to 60. Current AMA policy and these
4 recommendations strongly target each segment of the uninsured population ages 60 to 64, without
5 causing health system disruptions. The Council still believes there is a role for Policy H-330.896,
6 which supports restructuring age-eligibility requirements and incentives of Medicare to match the
7 Social Security schedule of benefits. The Council finds lowering the Medicare eligibility age to 60
8 has multiple downsides:

- 9
- 10 • Individuals ages 60 to 64 would lose access to health plan choices, including subsidized
11 ACA marketplace coverage.
 - 12 • As current ACA marketplace subsidies are consistently more generous for lower-income
13 individuals than the subsidies available to Medicare beneficiaries, lower-income
14 individuals currently enrolled in a marketplace plan may have the potential to face higher
15 premiums in traditional Medicare.
 - 16 • The level of benefits under Medicare differs from options currently available to individuals
17 ages 60 to 64, underscoring why most current, traditional Medicare beneficiaries are also
18 enrolled in supplemental insurance.
 - 19 • The projected crowd-out of millions of individuals from employer-sponsored and other
20 private coverage to Medicare has the potential to negatively impact the payer mix of
21 physician practices and hospitals.
 - 22 • Physician and hospital payment rates from private plans tend to be higher than those paid
23 by Medicare, with the difference between the two increasing over time.
- 24

25 The Council believes its recommendations address gaps in AMA policy with respect to covering
26 the uninsured—including those ages 60 to 64—necessary to ensure that our patients are able to secure
27 affordable and meaningful coverage and access the care that they need. There is now an
28 opportunity to build upon the ACA and ARPA to cover more of the uninsured. The Council affirms
29 that our AMA is well-positioned to move forward in its advocacy efforts in support of coverage of
30 the uninsured, guided by policy and its resulting plan to cover the uninsured, which will include the
31 recommendations of this report.

32
33 **RECOMMENDATIONS**

34
35 The Council on Medical Service recommends that the following be adopted in lieu of Resolution
36 123-J-21, and that the remainder of the report be filed.

- 37
- 38 1. That our American Medical Association (AMA) advocate that any federal approach to cover
39 uninsured individuals who fall into the “coverage gap” in states that do not expand Medicaid—
40 having incomes above Medicaid eligibility limits but below the federal poverty level, which is
41 the lower limit for premium tax credit eligibility—make health insurance coverage available to
42 uninsured individuals who fall into the coverage gap at no or nominal cost, with significant
43 cost-sharing protections. (New HOD Policy)
 - 44
 - 45 2. That our AMA advocate that any federal approach to cover uninsured individuals who fall into
46 the coverage gap provide states that have already implemented Medicaid expansions with
47 additional incentives to maintain their expansions. (New HOD Policy)
 - 48
 - 49 3. That our AMA support extending eligibility to purchase unsubsidized Affordable Care Act
50 (ACA) marketplace coverage to undocumented immigrants and Deferred Action for Childhood

- 1 Arrivals (DACA) recipients, with the guarantee that health plans and ACA marketplaces will
2 not collect and/or report data regarding enrollee immigration status. (New HOD Policy)
3
- 4 4. That our AMA recognize the potential for state and local initiatives to provide coverage to
5 immigrants without regard to immigration status. (New HOD Policy)
6
- 7 5. That our AMA reaffirm Policy H-290.983, which opposes federal and state legislation denying
8 or restricting lawfully present immigrants Medicaid and immunizations. (Reaffirm HOD
9 Policy)
10
- 11 6. That our AMA amend Policy H-165.828 by addition and deletion to read as follows:
12
- 13 a. Our AMA supports modifying the eligibility criteria for premium credits and cost-sharing
14 subsidies for those offered employer-sponsored coverage by lowering the threshold that
15 determines whether an employee's premium contribution is affordable to ~~that which applies~~
16 ~~to the exemption from the individual mandate of the~~ level at which premiums are capped
17 for individuals with the highest incomes eligible for subsidized coverage in Affordable
18 Care Act (ACA) marketplaces.
- 19 b. Our AMA supports legislation or regulation, whichever is relevant, to fix the ACA's
20 "family glitch," thus determining the eligibility of family members of workers for premium
21 tax credits and cost-sharing reductions based on the affordability of family employer-
22 sponsored coverage with respect to the cost of family-based or employee-only coverage
23 and household income. ... (Modify Current HOD Policy)
24
- 25 7. That our AMA reaffirm Policy D-290.979, which states that our AMA will work with state and
26 specialty medical societies in advocating at the state level in support of Medicaid expansion.
27 (Reaffirm HOD Policy)
28
- 29 8. That our AMA reaffirm Policy H-290.965, which supports states that newly expand Medicaid
30 being made eligible for three years of full federal funding. (Reaffirm HOD Policy)
31
- 32 9. That our AMA reaffirm Policy H-165.823, which supports auto-enrolling individuals in health
33 insurance coverage if they are eligible for coverage options that would be of no cost to them
34 after the application of any subsidies, including zero-premium marketplace coverage and
35 Medicaid/Children's Health Insurance Program (CHIP); and outlines standards that any public
36 option to expand health insurance coverage must meet. (Reaffirm HOD Policy)
37
- 38 10. That our AMA reaffirm Policy H-165.838, which states that insurance coverage options
39 offered in a health insurance exchange should be self-supporting, have uniform solvency
40 requirements; not receive special advantages from government subsidies; include payment
41 rates established through meaningful negotiations and contracts; not require provider
42 participation; and not restrict enrollees' access to out-of-network physicians. (Reaffirm HOD
43 Policy)
44
- 45 11. That our AMA reaffirm Policy H-165.824, which supports: (1) adequate funding for and
46 expansion of outreach efforts to increase public awareness of advance premium tax credits;
47 (2) providing young adults with enhanced premium tax credits while maintaining the current
48 premium tax credit structure which is inversely related to income; (3) state innovation,
49 including considering state-level individual mandates, auto-enrollment and/or reinsurance, to
50 maximize the number of individuals covered and stabilize health insurance premiums without
51 undercutting any existing patient protections; (4) eliminating the subsidy "cliff," thereby

- 1 expanding eligibility for premium tax credits beyond 400 percent of the federal poverty level
2 (FPL); (5) increasing the generosity of premium tax credits; (6) expanding eligibility for cost-
3 sharing reductions; and (7) increasing the size of cost-sharing reductions. (Reaffirm HOD
4 Policy)
5
- 6 12. That our AMA reaffirm Policies H-290.976, H-290.971, H-290.982 and D-290.982, which
7 support investments in Medicaid/CHIP outreach and enrollment assistance activities. (Reaffirm
8 HOD Policy)
9
- 10 13. That our AMA reaffirm Policy H-165.848, which supports a requirement that individuals and
11 families earning greater than 500 percent FPL obtain, at a minimum, coverage for catastrophic
12 health care and evidence-based preventive health care, using the tax structure to achieve
13 compliance. (Reaffirm HOD Policy)
14
- 15 14. That our AMA rescind Policy H-290.966, as it is superseded by Policy H-165.823 as well as
16 the recommendations of this report. (Rescind HOD Policy)
17
- 18 15. That our AMA reaffirm Policy H-330.896, which supports restructuring Medicare age-
19 eligibility requirements and incentives to match the Social Security schedule of benefits.
20 (Reaffirm HOD Policy)

Fiscal note: Less than \$500.

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REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 5-N-21

Subject: Integrating Care for Individuals Dually Eligible for Medicare and Medicaid

Presented by: Asa C. Lockhart, MD, Chair

Referred to: Reference Committee A

1 [Council on Medical Service Report 5-Nov-20](#), Medicaid Reform, addressed the Medicaid program
2 generally without specifically addressing coverage and payment for care of individuals dually
3 eligible for Medicare and Medicaid. Delivery of care and financing reform for the dual eligible
4 population was the topic of [Council on Medical Service Report 5-A-13](#), when several state
5 demonstrations designed to better integrate care were just getting started. Evidence from a variety
6 of integrated models tested over the intervening years is now available to inform new American
7 Medical Association (AMA) policy on integrated benefits for this predominantly low-income,
8 medically complex population. Although many dually eligible individuals live with some
9 combination of chronic conditions, mental illness, substance use disorder, and cognitive and/or
10 physical disabilities, this is an extremely heterogeneous group. Because they tend to be high-need,
11 high-cost enrollees, state and federal policymakers continuously search for ways to increase care
12 quality while saving Medicare and Medicaid dollars. For example, recent policy discussions have
13 focused on how to enroll more dually eligible individuals into integrated plans, especially Medicare
14 Advantage Dual-Eligible Special Needs Plans (D-SNPs).

15
16 The incidence of long COVID-19, considered a disabling condition under the Americans with
17 Disabilities Act when it substantially limits major life activities, may increase the number of dually
18 eligible enrollees—a group already disproportionately impacted by the pandemic—and highlight
19 the need for improved health outcomes. Integrated care refers to delivery system and financing
20 approaches that coordinate and integrate covered services and supports for dually eligible
21 individuals. In theory, integrated plans should have a high potential for reducing costs and
22 improving care; in reality, achieving integration has been difficult due in part to the complex and
23 diverse needs among dually eligible people and the involvement of siloed government health
24 programs that were not designed to work together. This report, initiated by the Council, provides an
25 overview of existing integrated models, summarizes relevant AMA policy, and recommends new
26 AMA policy outlining criteria essential to successful integrated care.

27

28 BACKGROUND

29

30 The number of individuals dually eligible for Medicare and Medicaid has risen steadily in recent
31 years to almost 12.3 million people.¹ In comparison to Medicare-only enrollees, dually eligible
32 patients have more complex and chronic health needs and are more likely to experience inequities
33 in social determinants of health that contribute to chronic disease.² Nearly half of dually eligible
34 enrollees are people of color; dually eligible individuals are also more likely to be female, have
35 functional and activities of daily living limitations, and report being in poorer health.³

36

37 According to preliminary Medicare COVID-19 data from the Centers for Medicare & Medicaid
38 Services (CMS), dually eligible individuals were more than twice as likely to be infected with

1 COVID-19, and more than three times as likely to be hospitalized by the virus, than Medicare-only
 2 patients.⁴ Sixty-one percent of dually eligible individuals are age 65 and over, and 40 percent
 3 utilize Medicaid long-term services and supports (LTSS) ranging from nursing home care to home
 4 and community-based supports.⁵ Over 40 percent have at least one mental health diagnosis, and
 5 just over half become dually eligible for Medicare-Medicaid because of disability.⁶

6
 7 Although dually eligible individuals often face barriers to accessing primary and preventive care,
 8 this population utilizes more covered services,⁷ including services in emergency departments.⁸
 9 Accordingly, dually eligible patients are disproportionately more costly to Medicare and Medicaid
 10 than traditional enrollees.⁹ Although dually eligible individuals make up 20 percent of Medicare
 11 enrollees and 15 percent of Medicaid enrollees, they account for 34 percent of Medicare spending
 12 and 32 percent of Medicaid spending.¹⁰

13
 14 Because Medicare and Medicaid are complex programs, each with distinct goals and coverage and
 15 payment rules, care for dually eligible individuals can be fragmented, poorly coordinated and
 16 difficult for patients to navigate. Cost-shifting persists across Medicare and Medicaid, and one
 17 program may be less likely to implement policy or program changes that result in savings to the
 18 other. Many stakeholders have noted that the disconnect between Medicare and Medicaid
 19 complicates care coordination and increases inefficiencies as well as administrative burdens among
 20 patients, physicians, and other providers.¹¹ Suboptimal care coordination may in turn compromise
 21 patient care and increase program spending.

22
 23 Medicare benefits for this population include primary care, preventive care, inpatient and
 24 outpatient acute care, post-acute skilled nursing (SNF) care, and prescription drug coverage.
 25 Medicare is the primary payer while Medicaid may cover a range of services not covered by
 26 Medicare, including—depending on the state—LTSS, some behavioral health benefits, and
 27 transportation. Medicaid coverage varies by state and between partial-benefit and full-benefit
 28 dually eligible enrollees, with full-benefit enrollees—who make up over 70 percent of the dual
 29 eligible population—eligible for all services that are covered by Medicaid in their state. Partial-
 30 benefit enrollees receive Medicaid assistance with Medicare premiums and, in some cases,
 31 Medicare cost-sharing, but are not eligible for other Medicaid benefits. State and federal efforts to
 32 integrate benefits focus predominantly on full-benefit dual eligible enrollees.

33
 34 **INTEGRATED CARE MODELS**

35
 36 Many stakeholders have maintained that managed care plans offering both Medicare and Medicaid
 37 services would improve quality and reduce spending for dually eligible individuals, and several
 38 integrated models were developed over the last decade. Early integrated care plans in
 39 Massachusetts, Minnesota, and Wisconsin were identified as promising in that they reduced
 40 enrollee use of hospital services and, importantly, redirected some LTSS use from nursing facilities
 41 to home and community-based care.¹² The most prominent integrated care plans include models
 42 tested through CMS demonstrations, D-SNPs, and the Program of All-Inclusive Care for the
 43 Elderly (PACE).

44
 45 *Financial Alignment Initiative:* CMS has long cited financial misalignment between Medicare and
 46 Medicaid as a barrier to coordinating care for dually eligible enrollees, and it tests models with
 47 states using waivers. Financial Alignment Initiative (FAI) demonstrations are designed to better
 48 align financing and integrate primary, acute, behavioral health and LTSS for Medicare-Medicaid
 49 enrollees. FAI, which began in 2013, offers options to states for integrating care, including a
 50 capitated model that establishes Medicare-Medicaid Plans (MMP), a managed fee-for-service
 51 model, and a state option to create an alternative model. Nine of the 11 states that currently

1 participate have chosen the capitated MMP model, in which CMS, a state, and a health plan enter a
 2 contract under which CMS and the state pay each health plan a prospective capitated monthly
 3 payment. States are permitted under the FAI to increase participation in MMPs using passive
 4 enrollment, which automatically enrolls dually eligible individuals in an MMP with the ability to
 5 opt out. Enrollment in MMPs has been lower than expected, although participation rates vary
 6 across participating states. Notably, a significant number of dually eligible people who have been
 7 passively enrolled in an MMP have subsequently opted out. Although evaluations have shown this
 8 model to be associated with decreased emergency department use and hospitalizations, other
 9 impacts—for example, on Medicare spending and savings—have been mixed and varied across
 10 participating states.¹³

11
 12 Under FAI’s managed fee-for-service (FFS) model, care is provided through FFS with assigned
 13 care coordinators to help enrollees obtain needed care. The state of Washington is implementing
 14 the FFS model and has experienced good enrollment numbers. Washington uses Medicaid health
 15 homes with a care coordinator and multidisciplinary team serving dually eligible enrollees.
 16 Evaluations of this model have shown decreased inpatient and SNF admissions and long-stay
 17 nursing facility use as well as major reductions in Medicare spending (which the state was able to
 18 share).

19
 20 *Dual-Eligible Special Needs Plans:* D-SNPs were introduced in the Medicare Prescription Drug,
 21 Improvement, and Modernization Act of 2003 and made permanent under the Bipartisan Budget
 22 Act of 2018. D-SNPs are available in 44 states and are required to contract with the Medicaid
 23 agency in each state in which they operate. “MIPPA” contracts, named for the Medicare
 24 Improvements for Patients and Providers Act under which they are authorized, are used by states to
 25 increase the level of integration. For example, states can use MIPPA contracts to require D-SNPs to
 26 align with managed LTSS (where such managed programs are available) so that dually eligible
 27 individuals are able to access Medicare and Medicaid services (including LTSS) through the same
 28 entity. States can similarly require D-SNP contractors to ensure coordination of behavioral health
 29 and/or other Medicaid services, and to share Medicare data with the state.

30
 31 Predominant D-SNP integrated models fall into two categories: those that require aligned Medicaid
 32 managed LTSS; and fully integrated D-SNPs, which provide Medicare and Medicaid benefits,
 33 consistent with state policy. Research has found D-SNPs to be associated with reduced
 34 hospitalizations and readmissions; however, results have been mixed with regard to emergency
 35 department use and LTSS services.¹⁴ There has been some evidence of decreased Medicare
 36 spending among D-SNPs, and many stakeholders find D-SNPs promising because they are widely
 37 available and have enrolled over three million dually eligible people.¹⁵

38
 39 *PACE:* PACE provides comprehensive, interdisciplinary medical and social services to certain frail
 40 people over age 55, enabling them to remain at home instead of in a nursing home. PACE is the
 41 most integrated model but only serves about one percent of dually eligible individuals across 31
 42 states. The program has been associated with reduced inpatient hospital use but the impact on
 43 nursing facility use and Medicaid spending has been mixed.

44
 45 Only about one in ten dually eligible individuals is enrolled in integrated care models despite
 46 considerable work over the years. Although D-SNPs have enrolled over three million people,
 47 PACE and FAI—both highly integrated—have enrolled 55,000 and 395,000 enrollees,
 48 respectively.¹⁶ Most dually eligible enrollees (more than 70 percent) are in fee-for-service plans
 49 and, among those with Medicare Advantage plans, one quarter are in non-integrated plans.¹⁷ Low
 50 enrollment numbers have been attributed to the lack of program availability in some areas and high

1 rates of disenrollment from certain programs.¹⁸ Resource constraints and competing priorities in
2 states may also limit the availability of integrated programs.

3 4 ELEMENTS OF SUCCESSFUL INTEGRATED CARE MODELS

5
6 At least 43 combinations of Medicare and Medicaid coverage are available nationwide, giving
7 many dually eligible enrollees several plan options from which to choose.¹⁹ D-SNP, MMP and
8 PACE are targeted towards dually eligible individuals; additionally, some qualify for institutional
9 special needs (I-SNP) plans, which are MA plans limited to patients with institutional-level care
10 needs. While the literature has highlighted data challenges, including the lack of available
11 Medicaid data, individuals enrolled in integrated programs have reported satisfaction with reduced
12 cost-sharing and improved access to medical, behavioral health and other services.²⁰

13
14 Each of the integrated models has different strengths and limitations in terms of level of
15 integration, availability across states, enrollee experience, capacity to scale, and cost savings. A
16 literature review of integrated models by Health Management Associates highlighted the following
17 factors that contribute to improved programming for dually eligible individuals:

- 18
- 19 • Individual consumer engagement in program design, communications, implementation and
- 20 ongoing program oversight;
- 21 • Provider engagement and robust networks;
- 22 • Care coordination and risk stratification;
- 23 • Strong state and federal government collaboration;
- 24 • Adequate state capacity; and
- 25 • Performance and outcome measures tailored to the population.²¹
- 26

27 Stakeholder interviews with patients, physicians, advocates, health plans, and state officials
28 informed a second Health Management Associates brief that identified essential program elements
29 needed for plans to successfully support dually eligible individuals. As stated in the report, the ten
30 essential elements are:

- 31
- 32 1. Simplified Medicare and Medicaid eligibility processes and paperwork;
- 33 2. Comprehensive and expert consumer choice counseling and/or enrollment assistance;
- 34 3. Diverse consumer engagement to inform tailored delivery systems and integrated
- 35 programs;
- 36 4. Robust data infrastructure to tailor and adapt program approaches and drive health equity;
- 37 5. Coordinated efforts to maximize capabilities to address unmet social needs;
- 38 6. Single process for assessments and plans of care, and one care team for each consumer;
- 39 7. Meaningful and transparent quality measurement to empower consumers and stakeholders;
- 40 8. Payment models to incentivize consumer quality of life improvements;
- 41 9. Adequate, engaged, and diverse workforce to support consumer needs; and
- 42 10. Access to needed services in rural areas.²²
- 43

44 Of note, states are at various junctures of integrating care for dually eligible individuals. Some
45 states, including Arizona, Idaho, and Tennessee, have made greater use of MIPPA authority and
46 are providing fully integrated care. On the other hand, no integrated care options are available in
47 North Dakota and Wyoming.²³ States may also employ multiple strategies to integrate care, as
48 Ohio does by implementing both PACE and FAI.

49
50 Viable enhancements to integrated care plans are regularly discussed by the Medicaid and CHIP
51 Payment and Access Commission and the Medicare Payment Advisory Commission. At least one

1 proposal, from the Dual Eligible Coalition and Leavitt Partners, envisions consolidation of care
2 under a new program—Title 22—that combines Medicare, Medicaid, and state funding into a fully
3 integrated program specifically for dually eligible individuals.²⁴

4
5 RELEVANT AMA POLICY

6
7 Policy H-290.967, established by Council Report 5-A-13, includes the following principles on the
8 delivery of care and financing reform for Medicare and Medicaid dually eligible patients:

9 (1) various approaches to integrated delivery of care should be promoted under demonstrations;
10 (2) customized benefits and services from health plans are necessary according to each
11 beneficiary’s specific medical needs; (3) care coordination demonstrations should not interfere with
12 established patient-physician relationships; delivery and payment reform for dually eligible
13 beneficiaries should involve practicing physicians and take into consideration the diverse patient
14 population and local area resources; (4) states with approved financial alignment demonstration
15 models should provide education and counseling to beneficiaries on options for receiving Medicare
16 and Medicaid benefits; (5) conflicting payment rules between the Medicare and Medicaid programs
17 should be eliminated; (6) Medicare and Medicaid benefit plans and the delivery of benefits should
18 be coordinated; and (7) care plans for beneficiaries should be streamlined among all clinicians and
19 social service agencies.

20
21 Addressing Medicare-Medicaid dual eligible demonstration programs, Policy D-290.980 advocates
22 that established patient-provider relationships and current treatment plans will not be disrupted;
23 dually eligible individuals should not be automatically enrolled without their approval or consent;
24 any savings from coordination of care to dually eligible individuals should arise from better health
25 outcomes and efficiencies gained; and demonstrations should not be employed as a policy lever to
26 reduce provider payment rates. Policy H-290.984 strongly opposes mandatory enrollment of
27 Medicare and/or Medicaid patients in managed care plans. Similarly, Policy D-290.978 calls on
28 CMS to require states to develop processes to facilitate opting out of managed care programs by
29 dual-eligible individuals. Policies D-290.998 and H-290.978 advocate that states pay Medicare
30 deductibles and cost-sharing for dual-eligible patients.

31
32 The AMA advocates for the same policies for Medicaid managed care that are advocated for
33 private managed care plans, as well as criteria for federal and state oversight of Medicaid managed
34 care plans that are delineated in Policy H-290.985. Network adequacy elements for public and
35 private health plans are outlined in Policy H-285.908. Policy H-285.973 (1) advocates that all
36 managed care plans be required to provide appropriate access, when geographically available, to
37 representatives of all medical and surgical specialties and subspecialties; and (2) advocates that
38 health plans not restrict appropriate referrals to medical and surgical subspecialists, including those
39 specialties that are age group specific.

40
41 Policy H-280.945 supports (1) incentivizing states to expand the availability of and access to home
42 and community-based services; and (2) better integration of health and social services and
43 supports, including the PACE program. Policy H-165.822 (1) encourages new and continued
44 partnerships to address non-medical, yet critical health needs and the underlying social
45 determinants of health; (2) supports continued efforts by public and private health plans to address
46 social determinants of health in health insurance benefit designs; and (3) encourages public and
47 private health plans to examine implicit bias and the role of racism and social determinants of
48 health. Policy H-180.944 states that “health equity,” defined as optimal health for all, is a goal
49 toward which our AMA will work by advocating for health care access, research and data
50 collection; promoting equity in care; increasing health workforce diversity; influencing
51 determinants of health; and voicing and modeling commitment to health equity.

1 DISCUSSION

2
 3 Because dually eligible individuals are typically medically complex and in need of a wide range of
 4 services and supports, they are among the highest need and highest cost enrollees within Medicare
 5 and Medicaid.²⁵ Integrated care plans are promising models for providing care that addresses the
 6 medical, behavioral, long-term care and social needs of this diverse patient population. In its
 7 review of the literature, the Council found that new models as well as enhancements to existing
 8 models have the potential to improve care quality and life quality for dually eligible people, but
 9 that success often depends on state capacity and resources available to implement integrated care.
 10 Managing the costs of care for dually eligible people is particularly challenging because nearly half
 11 of enrollees require LTSS, including those who receive institutional-level care. The Council
 12 highlights its recent work on LTSS, including Council on Medical Service Report 5-A-18,
 13 Financing LTSS, which established AMA policy (Policy H-280.945) supportive of incentivizing
 14 states to expand the availability of and access to home and community-based services. Council on
 15 Medical Service Report 4, presented at this meeting, recommends new AMA supporting
 16 streamlined funding for home and community-based services.

17
 18 The Council supports ongoing study and refinement by CMS and states and hopes that increased
 19 collaboration and learning will help expand best practices. Accordingly, in lieu of supporting any
 20 specific model, the Council recommends support for integrated care that aligns with AMA policy
 21 and meets additional criteria that are critical to ensuring an integrated model’s success.

22
 23 The Council further recommends reaffirmation of Policy H-290.967, which establishes principles
 24 on care delivery and financing reform for dually eligible patients; Policy D-290.978, which calls on
 25 CMS to require all states to develop processes to facilitate opting out of managed care programs by
 26 dual eligible individuals; and Policy H-165.822 on health plan initiatives addressing social
 27 determinants of health. Finally, the Council recommends reaffirmation of Policy H-180.944, which
 28 defines health equity as optimal health for all and promotes equity in care. In comparison to
 29 Medicare enrollees, a greater share of dual eligible individuals are people of color, women, and
 30 people with disabilities. Advances in health equity and reducing disparities in health and health
 31 access must be considered by integrated care models if they are to improve care quality, life
 32 quality, and health outcomes over the long term.

33
 34 RECOMMENDATIONS

35
 36 The Council on Medical Service recommends that the following recommendations be adopted and
 37 the remainder of the report be filed:

- 38
 39 1. That our American Medical Association (AMA) support integrated care for individuals dually
 40 eligible for Medicare and Medicaid that aligns with AMA policy and meets the following
 41 criteria:
 42
 43 a. Care is grounded in the diversity of dually eligible enrollees and services are
 44 tailored to individuals’ needs and preferences.
 45 b. Coverage of medical, behavioral health, and long-term services and supports is
 46 aligned.
 47 c. Medicare and Medicaid eligibility and enrollment processes are simplified, with
 48 enrollment assistance made available as needed.
 49 d. Enrollee choice of plan and physician is honored, allowing existing patient-
 50 physician relationships to be maintained.
 51 e. Services are easy to navigate and access, including in rural areas.

- 1 f. Care coordination is prioritized, with quality case management available as
2 appropriate.
- 3 g. Barriers to access, including inadequate networks of physicians and other
4 providers and prior authorizations, are minimized.
- 5 h. Administrative burdens on patients, physicians and other providers are minimized.
- 6 i. Educational materials are easy to read and emphasize that the ability and power to
7 opt in or out of integrated care resides solely with the patient.
- 8 j. Physician participation in Medicare or Medicaid is not mandated nor are eligible
9 physicians denied participation. (New HOD Policy)
- 10
- 11 2. That our AMA reaffirm Policy H-290.967, which establishes principles on the delivery of care
12 and financing reform for Medicare and Medicaid dually eligible patients. (Reaffirm HOD
13 Policy)
- 14
- 15 3. That our AMA reaffirm Policy D-290.978, which calls on the Centers for Medicare &
16 Medicaid Services to require all states to develop processes to facilitate opting out of managed
17 care programs by dual eligible individuals. (Reaffirm HOD Policy)
- 18
- 19 4. That our AMA reaffirm Policy H-165.822, which encourages new and continued partnerships
20 to address non-medical health needs and the underlying social determinants of health; supports
21 continued efforts by public and private health plans to address social determinants of health in
22 health insurance benefit designs; and encourages public and private health plans to examine
23 implicit bias and the role of racism and social determinants of health. (Reaffirm HOD Policy)
- 24
- 25 5. That our AMA reaffirm Policy H-180.944, which states that health equity, defined as optimal
26 health for all, is a goal toward which our AMA will work by advocating for health services,
27 research and data collection; promoting equity in care; increasing health workforce diversity;
28 influencing social determinants of health; and voicing and modeling commitment to health
29 equity. (Reaffirm HOD Policy)

Fiscal Note: Less than \$500.

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 101
(N-21)

Introduced by: Virginia, American Association of Clinical Urologists, District of Columbia, Oklahoma, Tennessee, Alabama, New Jersey, North Carolina, Mississippi, Georgia, Kentucky

Subject: Standardized Coding for Telehealth Services

Referred to: Reference Committee A

1 Whereas, Telehealth services have expanded rapidly during the SARS-CoV-2 pandemic and
2 these services are anticipated to continue to be highly utilized moving forward; and
3

4 Whereas, Physicians and other health care providers face complex rules for coding and
5 reimbursement which hinder the efficient utilization of telehealth for the benefit of our patients;
6 and
7

8 Whereas, Telehealth services are easily identified by using place of service (02) on claims
9 submitted for reimbursement. However, many private payors additionally require a modifier
10 (GT or 95) to indicate the service was performed using telemedicine. Other payors require
11 additional billing requirements making claim submission even more complex and prone to
12 errors leading to rejected claims and delayed or absent reimbursement for these services;
13 therefore be it
14

15 RESOLVED, That our American Medical Association advocate by regulation and/or legislation
16 that telehealth services are uniformly identified by using place of service (02) without any
17 additional requirements, such as modifiers imposed by third party payors, for claim submission
18 and reimbursement. (Directive to Take Action)

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

Received: 09/07/21

AUTHOR'S STATEMENT OF PRIORITY

As the United States enters the 4th wave of the SARS-Cov-2 pandemic, telehealth will continue to be an important vehicle for physicians to provide care for their patients. Also, during the pandemic overall reimbursement for medical services has declined for many practices while costs, such as PPE's, have significantly increased. The varied and complex rules for coding telehealth by the various payors cause unnecessary confusion for physician practices and invariably leads to rejected claims and delayed or absent reimbursement. Our AMA should immediately advocate for standardized and simplified telehealth coding in order to help sustain physician practices and allow them to continue to provide telehealth and other essential services during this pandemic and afterwards.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 102
(N-21)

Introduced by: Senior Physicians Section

Subject: Prevention of Hearing Loss-Associated-Cognitive-Impairment through Earlier Recognition and Remediation

Referred to: Reference Committee A

1 Whereas, Our AMA holds out as a primary objective “to promote the art and science of medicine
2 and the betterment of public health;” and
3

4 Whereas, Our AMA has adopted policy in support of health promotion and preventive care,
5 community preventive services, healthy lifestyles, coverage for preventive care and
6 immunizations, health information and education, training in the principles of population-based
7 medicine, values-based decision-making in the healthcare system, and encouragement of
8 new advances in science and medicine via strong financial and policy support for all aspects
9 of biomedical science and research;¹⁻⁸ and
10

11 Whereas, Our AMA has prior policy supporting insurance coverage for hearing remediation⁹
12 as well as for dementia treatment;¹⁰ and
13

14 Whereas, There is mounting evidence that there is a strong link between hearing impairment
15 in middle and later life and the development of cognitive, as well as social impairments and
16 falls, although its specific causality in relation to later cognitive loss has not yet conclusively
17 been established;¹¹⁻³¹ and
18

19 Whereas, The landmark Lancet Commission on Dementia Prevention, Intervention and Care of
20 2017, amplified by the 2020 follow-up report¹³⁻¹⁵ concluded that age-related hearing loss (ARHL)
21 may account for nine percent of all cases of dementia, making this the single largest potentially
22 modifiable risk factor for that condition, beginning in mid-life; and
23

24 Whereas, Compared to individuals with normal hearing, those individuals with a mild, moderate,
25 and severe hearing impairment, respectively, have been shown to have a 2-, 3-, and 5-fold
26 increased risk of incident all-cause dementia over 10 years of follow-up in one study;²⁹ and
27

28 Whereas, Based on prior and pilot studies,³⁰⁻³¹ the causative link between hearing impairment in
29 middle age and later life to cognitive impairment is likely to be confirmed by ongoing ACHIEVE³²
30 and other clinical trials now in progress; and
31

32 Whereas, The return on investment for hearing remediation, especially but not exclusively in
33 mid-life, will be substantial and time-sensitive insofar as it may ameliorate (by delay in onset or
34 even prevention of cognitive decline) far more costly care for those with cognitive decline (direct
35 and indirect costs). Delaying the onset of Alzheimer’s Disease by even one year has significant
36 fiscal benefits. A 2014 study estimated a one-year delay in the onset of Alzheimer’s disease
37 would save \$113 Billion by 2030. This underscores the urgency of current action to reduce the
38 cost of healthcare (including, and perhaps especially, to Medicare) while improving other
39 measures influencing the quality of life;³³⁻⁴⁰ and

1 Whereas, A generally held calculation for the yearly cost of caring for those with dementia
2 exceeds \$307 billion as of 2010, and is expected to rise to \$624 billion in 2030 and \$1.5 trillion
3 by 2050. The current yearly market cost of hearing aids in the US is estimated at \$9 billion. This
4 suggests that, with a 9% increase in risk of development of cognitive loss later in life due to
5 unaddressed hearing loss,^{13,15} remediating even this single important element linked to cognitive
6 decline would be cost-effective immediately, and will be increasingly so in the future;^{39,40} and
7

8 Whereas, The issue of hearing impairment is also a matter of health and social equity, with
9 serious immediate and long-term consequences resulting from neglect of remediation.
10 Unaddressed hearing loss reduces earnings potential and increases disability during gainful
11 years, even before factoring in the likelihood of developing cognitive loss later. Sadly, the cost of
12 hearing amplification and other forms of remediation is significant enough (even with over-the-
13 counter products, which while possibly helpful do not come with professional guidance) to defer
14 purchase and implementation by an indigent population;⁴⁶ and
15

16 Whereas, It is indisputable that promotion of any possibly effective means of delay, prevention,
17 as well as timely treatment of cognitive impairment and dementia is highly desirable for public
18 health, for humane as well as financial reasons; and
19

20 Whereas, Congress has shown interest in expanding coverage for hearing remediation in the
21 most recent bill, HR 1118, 'Medicare Hearing Act of 2021,' filed in the current Congressional
22 Session, affording a strategic opportunity for our AMA to more effectively advocate now for
23 expanding coverage to include coverage of preventive strategies in middle age, promoting that
24 as a way to mitigate future Medicare costs;⁴¹⁻⁴³ and
25

26 Whereas, Some developed countries such as Brazil have launched national efforts to bring
27 hearing remediation to the masses⁴⁵ as a means of reducing later cognitive decline, suggesting
28 that early remediating of hearing is felt by other nations to be a cost-effective pursuit; and
29

30 Whereas, The issues involved in analyzing all factors impeding adequate distribution of hearing
31 remediation are complex, and require physicians to be current, informed, and involved in the
32 discussion with patients;^{44,47-48} and
33

34 Whereas, A number of groups have a stake in promoting hearing remediation, including
35 professional and citizen and Federal Agencies, such as the Agency for Health Research and
36 Quality and the National Institute on Deafness and Other Communication Disorders (NIDCD);
37 therefore be it
38

39 RESOLVED, That our American Medical Association promote awareness of hearing impairment
40 as a potential contributor to the development of cognitive impairment in later life, to physicians
41 as well as to the public (Directive to Take Action); and be it further
42

43 RESOLVED, That our AMA promote, and encourage other stakeholders, including public,
44 private, and professional organizations and relevant governmental agencies, to promote, the
45 conduct and acceleration of research into specific patterns and degrees of hearing loss to
46 determine those most linked to cognitive impairment and amenable to correction (Directive to
47 Take Action); and be it further
48

49 RESOLVED, That our AMA advocate for increased hearing screening, and expanding all
50 avenues for third party coverage for effective hearing loss remediation beginning in mid-life or
51 whenever detected, especially when such loss is shown conclusively to contribute significantly
52 to the development of, or to magnify the functional deficits of cognitive impairment, and/or to limit
53 the capacity of individuals for independent living. (Directive to Take Action)

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

Received: 09/30/21

AUTHORS STATEMENT OF PRIORITY

Unaddressed hearing loss has a major effect on many physicians and patients, especially seniors. Additionally, unaddressed hearing loss has been shown to have a disproportionate impact on underrepresented or disadvantaged populations, an important health care disparity issue for our AMA. Increased hearing screening and remediation is a public health issue that is very consistent with our mission and strategic plan. It is reliably estimated that at 9%, unaddressed age-related hearing loss is the single most remediable cause of cognitive decline. Delaying the onset of cognitive decline by even one year has predictably VERY significant societal and fiscal benefits, and accordingly, there is a remarkably negative societal impact for every year that this issue is not effectively addressed.

AMA has significant related policy, but important gaps exist, including education about the connection between hearing loss and cognitive decline, emphasizing the importance of hearing screening at MIDlife, in order to promote remediation, and thereby help to prevent cognitive decline. A few commercial insurers have begun to acknowledge the need. Our AMA must update policy and promote this trend. The proposed action is likely to have meaningful impact but requires new policy or modification of existing policy to implement. There is pending Congressional action that makes this a timely political issue. An AMA resolution is one of the most appropriate avenues to address the issue.

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7. H-460.943 Potential Impact of Health System Reform Legislative Reform Proposals on Biomedical Research and Clinical Investigation
8. H-450.938 Value-Based Decision-Making in the Health Care System
9. H-185.929 Hearing Aid Coverage
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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 103
(N-21)

Introduced by: Senior Physicians Section
Subject: Oral Healthcare IS Healthcare
Referred to: Reference Committee A

1 Whereas, Nationwide, around 50% of Americans 65 and older lack any source of dental
2 insurance, and since its inception in 1965, Medicare has only covered dental care under
3 narrowly prescribed circumstances¹; and
4
5 Whereas, Nearly half of Americans 65 and over didn't visit a dentist in the last year, citing
6 expense, (and 12% have not received dental care in five or more years). Nearly one in five have
7 lost all their natural teeth (even higher in black and non-Hispanic populations)²; and
8
9 Whereas, Unaddressed tooth and gum disease dramatically increases the risks of
10 cardiovascular events such as heart attacks and stroke, and such events are leading causes of
11 death and disability in Medicare recipients, and there is a correlation between poor oral health
12 and chronic diseases more common in the elderly, such as diabetes and Alzheimer's, as well as
13 head and neck cancers³; and
14
15 Whereas, Prevention and treatment of dental diseases is effective in reducing many of these
16 adverse health consequences; and
17
18 Whereas, Dental issues are a major source of pain, interfering directly with nutrition and
19 hydration, and painful dental infections are a common cause of emergency department visits,
20 some life threatening, requiring hospitalization and major expense; and
21
22 Whereas, In a 2019 AARP poll, 84 percent of Americans supported adding dental, vision and
23 hearing coverage to Medicare, even if their costs would increase⁴, and
24
25 Whereas, In all populations, including seniors, dental issues are a major source of both
26 economic as well as healthcare disparity, and
27
28 Whereas, Congress is poised to consider Medicare expansion under various current and
29 pending proposals; therefore be it
30
31 RESOLVED, That our American Medical Association reaffirm that dental and oral health are
32 integral components of basic health care and maintenance regardless of age (Reaffirm HOD
33 Policy); and be it further
34
35 RESOLVED, That our AMA, through the Center for Healthcare Equity, highlight the substantial
36 contribution of dental and oral healthcare disparities to health inequity as well as to social and
37 economic disparities (Directive to Take Action); and be it further

1 RESOLVED, That our AMA support ongoing research, legislative actions and administrative
2 efforts to promote access to and adequate coverage in the public and private payers by
3 preventative and therapeutic dental services as integral parts of overall health maintenance to
4 all populations (New HOD Policy); and be it further
5

6 RESOLVED, That our AMA work with other organizations to explore avenues to promote efforts
7 to expand Medicare benefits to include preventative and therapeutic dental services without
8 increasing the already proposed decrease in Medicare Part B Reimbursements. (Directive to
9 Take Action)

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

Received: 09/30/21

AUTHORS STATEMENT OF PRIORITY

Poor dental and oral health have proven, and sometimes disastrous deleterious effects on many physicians and patients, especially seniors. Additionally, poor oral health has been shown to have a disproportionate impact on underrepresented or disadvantaged populations, which is an important health care disparity issue for our AMA. Limited access to preventative and therapeutic dental care is a public health issue, addressing which is very consistent with our mission and strategic plan. Lack of access to dental healthcare has very well documented deleterious effects on physical health, and the seriousness and costs of delayed or denied dental care especially in older populations with their vulnerability to cardiovascular and neoplastic conditions expand dramatically with every year of delay. Poor oral health is a well-documented economic and social disparity issue as well.

AMA has related policy, but has not lobbied effectively for Medicare dental coverage, seemingly for non-health related reasons. The proposed action is likely to have meaningful impact, but requires new policy or modification of existing policy to implement. There is pending Congressional action in the 117th Session (the Medicare Dental Coverage Act of 2021) that makes this a very timely political issue, especially at our Advocacy meeting. An AMA resolution promoting legislative action is one of the most appropriate avenues to address the issue.

RELEVANT AMA POLICY

Medicare Coverage for Dental Services H-330.872

Our AMA supports: (1) continued opportunities to work with the American Dental Association and other interested national organizations to improve access to dental care for Medicare beneficiaries; and (2) initiatives to expand health services research on the effectiveness of expanded dental coverage in improving health and preventing disease in the Medicare population, the optimal dental benefit plan designs to cost-effectively improve health and prevent disease in the Medicare population, and the impact of expanded dental coverage on health care costs and utilization.

Citation: CMS Rep. 03, A-19;

Importance of Oral Health in Patient Care D-160.925

Our AMA: (1) recognizes the importance of (a) managing oral health and (b) access to dental care as a part of optimal patient care; and (2) will explore opportunities for collaboration with the American Dental Association on a comprehensive strategy for improving oral health care and education for clinicians.

Citation: Res. 911, I-16; Reaffirmed: CMS Rep. 03, A-19;

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 104
(N-21)

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

Subject: Improving Access to Vaccinations for Patients

Referred to: Reference Committee A

1 Whereas, Over the past two years a new shingles vaccine, Shingrix, has become available.
2 However, that vaccine is only reimbursed under Medicare Part D, which does not pay for office-
3 based treatment. It remains unclear why that decision was made as the previous shingles
4 vaccine, Zostavax, was covered in an office-based practice (Medicare Part B); and
5
6 Whereas, Medicare does cover other vaccines (influenza, both pneumococcal vaccines and Td)
7 in the office; and
8
9 Whereas, Commercial insurers in Massachusetts, unlike Medicare, cover this vaccine in an
10 office-based practice as they do with other vaccines; and
11
12 Whereas, This policy of the Centers for Medicaid and Medicare Services (not to cover in-office
13 administration of the Shingrix vaccine) encourages our patients to forego the convenience of
14 having their vaccine while being present for an office visit. They must travel to the pharmacy to
15 obtain the vaccine; and
16
17 Whereas, It is generally acknowledged that patients are much more likely to accept a treatment
18 as part of a meeting with their health care provider than if they have to make a separate trip to
19 access the treatment, such that deferring the vaccination lessens the likelihood that the patient
20 will receive it; and
21
22 Whereas, It is important to improve our patients access to this vaccine; therefore be it
23
24 RESOLVED That our American Medical Association encourage all payors, including the
25 Centers for Medicare and Medicaid Services, to cover, without cost sharing, all vaccines
26 recommended by the Centers for Disease Control and Prevention, when administered in the
27 physician office. (Directive to Take Action)

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

Received: 10/06/21

AUTHORS STATEMENT OF PRIORITY

This is urgent because current Medicare policy forces patients to seek alternative sites for having their vaccine thus delaying vaccination. Shingles itself is a very common healthcare condition estimated to effect up to 50% of individuals over their lifetime. Making access to this vaccination more difficult is not in our patients' best interest. It often takes a few years of encouragement before people finally get their vaccinations done whereas it would have been done at the time of their initial visit. This delay in care is inappropriate, never mind absorbing a healthcare providers time to readdress the same issue repeatedly when our time could be put to better use.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 105
(N-21)

Introduced by: Women Physicians Section

Subject: Fertility Preservation Insurance Coverage for Women in Medicine

Referred to: Reference Committee A

- 1 Whereas, Many women in medicine feel pressure to defer pregnancy during their training, which
2 often coincides with peak fertility years;¹ and
3
4 Whereas, Many Fortune 100 Companies offer an employee benefit of egg freezing, allowing
5 women to have the option of having children while managing their careers;² and
6
7 Whereas, As a medical industry that performs egg freezing procedures, employers should offer
8 this as a covered benefit through employer paid insurance plans or cash reimbursement for their
9 own physician employees, including the medical student level; and
10
11 Whereas, By doing so, women physicians gain reproductive autonomy, reducing the pressure to
12 sacrifice their careers in order to start their families, thereby reducing the gender gap in
13 leadership roles;² and
14
15 Whereas, It may increase women physician retention in an organization, as employees who
16 obtain social egg freezing benefits are more loyal to their employers;^{2,3} and
17
18 Whereas, Fertility preservation benefits for active duty military personnel is being explored as a
19 covered benefit with Tricare (AMA Policy H-510.984); and
20
21 Whereas, Data from one study of U.S. female physicians indicate that medical professionals
22 have substantially higher infertility rates than the general population, with one in four
23 respondents reporting a diagnosis of infertility;⁴ and
24
25 Whereas, Our AMA has policy that encourages infertility and fertility preservation insurance
26 coverage (AMA Policy H-185.990); and
27
28 Whereas, Our AMA has policy which encourages insurance coverage for medical students
29 (AMA Policy H-295.942); therefore be it
30
31 RESOLVED, That our American Medical Association advocate for fertility preservation as a
32 covered employee benefit through employer paid insurance plans or cash reimbursement for
33 women in medicine. (Directive to Take Action)

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

Received: 10/07/21

AUTHORS STATEMENT OF PRIORITY

Women physicians have made conscious decisions to become physicians in various fields of medicine. After completing medical school, residency, and fellowship before embarking on our careers, some of us are faced with the reality that our fertility (or the ability to naturally conceive a child) has decreased for various reasons. As women age and face decreasing fertility, there may be a conflict between choosing their careers and being mothers. Data from one study of women physicians indicate that medical professionals have substantially higher infertility rates than the general population, with one in four respondents reporting a diagnosis of infertility. While many businesses offer egg freezing as an employee benefit, thus allowing women the option of having children while managing their careers, this option is often not afforded to women in medicine as a whole. This resolution is a way to support women physicians' choices in preserving their fertility while accomplishing their professional goals.

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RELEVANT AMA POLICY

Infertility Benefits for Veterans H-510.984

1. Our AMA supports lifting the congressional ban on the Department of Veterans Affairs (VA) from covering in vitro fertilization (IVF) costs for veterans who have become infertile due to service-related injuries.
2. Our AMA encourages interested stakeholders to collaborate in lifting the congressional ban on the VA from covering IVF costs for veterans who have become infertile due to service-related injuries.
3. Our AMA encourages the Department of Defense (DOD) to offer service members fertility counseling and information on relevant health care benefits provided through TRICARE and the VA at pre-deployment and during the medical discharge process.
4. Our AMA supports efforts by the DOD and VA to offer service members comprehensive health care services to preserve their ability to conceive a child and provide treatment within the standard of care to address infertility due to service-related injuries.
5. Our AMA supports additional research to better understand whether higher rates of infertility in servicewomen may be linked to military service, and which approaches might reduce the burden of infertility among service women.

Citation: CMS Rep. 01, I-16; Appended: Res. 513, A-19

Infertility and Fertility Preservation Insurance Coverage H-185.990

1. Our AMA encourages third party payer health insurance carriers to make available insurance benefits for the diagnosis and treatment of recognized male and female infertility.
2. Our AMA supports payment for fertility preservation therapy services by all payers when iatrogenic infertility may be caused directly or indirectly by necessary medical treatments as determined by a licensed physician, and will lobby for appropriate federal legislation requiring payment for fertility preservation therapy services by all payers when iatrogenic infertility may be caused directly or indirectly by necessary medical treatments as determined by a licensed physician.

Citation: (Res. 150, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CMS Rep. 4, A-08; Appended: Res. 114, A-13; Modified: Res. 809, I-14)

Insurance Coverage for Medical Students and Resident Physicians H-295.942

The AMA urges (1) all medical schools to pay for or offer affordable policy options and, assuming the rates are appropriate, require enrollment in disability insurance plans by all medical students; (2) all residency programs to pay for or offer affordable policy options for disability insurance, and strongly encourage the enrollment of all residents in such plans; (3) medical schools and residency training programs to pay for or offer comprehensive and affordable health insurance coverage, including but not limited to medical, dental, and vision care, to medical students and residents which provides no less than the minimum benefits currently recommended by the AMA for employer-provided health insurance and to require enrollment in such insurance; (4) carriers offering disability insurance to: (a) offer a range of disability policies for medical students and residents that provide sufficient monthly disability benefits to defray any educational loan repayments, other living expenses, and an amount sufficient to continue payment for health insurance providing the minimum benefits recommended by the AMA for employer-provided health insurance; and (b) include in all such policies a rollover provision allowing continuation of student disability coverage into the residency period without medical underwriting. (5) Our AMA: (a) actively encourages medical schools, residency programs, and fellowship programs to provide access to portable group health and disability insurance, including human immunodeficiency virus positive indemnity insurance, for all medical students and resident and fellow physicians; (b) will work with the ACGME and the LCME, and other interested state medical societies or specialty organizations, to develop strategies and policies to ensure access to the provision of portable health and disability insurance coverage, including human immunodeficiency virus positive indemnity insurance, for all medical students, resident and fellow physicians; and (c) will prepare informational material designed to inform medical students and residents concerning the need for both disability and health insurance and describing the available coverage and characteristics of such insurance.

Citation: (BOT Rep. W, I-91; Reaffirmed: BOT Rep. 14, I-93; Appended: Res. 311, I-98;
Modified: Res. 306, A-04; Modified: CME Rep. 2, A-14)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 106
(N-21)

Introduced by: Medical Student Section

Subject: Reimbursement of School-Based Health Centers

Referred to: Reference Committee A

1 Whereas, School Based Health Centers (SBHCs) are facilities located within the kindergarten
2 through twelfth grade school setting that provide an array of high-quality health care services to
3 students^{1,2}; and
4

5 Whereas, SBHCs were first established in the 1960's by the American Academy of Pediatrics to
6 increase access to primary health care and preventative health services, especially for the most
7 vulnerable underserved population of children³; and
8

9 Whereas, Services available are driven by community need, ranging from primary medical care
10 to dental, vision, and behavioral health services, alongside wraparound programming such as
11 substance abuse counseling and social case management, and about 40% of SBHCs employ
12 physicians^{1,2,4}; and
13

14 Whereas, The benefits of routine preventive care are well-established and are incredibly
15 important for children from infancy to adolescence, providing 1) prevention of serious medical
16 illnesses through vaccination and screening, 2) tracking growth and development, 3) raising
17 medical-related concerns, and 4) creating a strong patient-centered medical home⁵; and
18

19 Whereas, The SBHC model provides students with increased access to health care resources
20 and improved long- and short-term health care outcomes, including decreased emergency
21 department visits and hospital utilizations^{3,6,7}; and
22

23 Whereas, SBHCs act as a "safety net health care delivery model" for uninsured, underinsured
24 children or those who lack accessible healthcare⁸; and
25

26 Whereas, SBHCs can receive both grant funding by private organizations and the government,
27 and reimbursement for services rendered by a third-payer payer, most commonly Medicaid and
28 the Children's Health Insurance Program (CHIP); through private organizations;⁹ or through
29 direct funding programs established by federal, state and local governments¹⁰; and
30

31 Whereas, The federally qualified health center (FQHC) program funds community health
32 centers that serve medically underserved populations, such as SBHCs, by providing cash
33 grants, drug discounts, legal protections, medical staff and, most uniquely, per-visit
34 reimbursement by Medicaid¹¹; and
35

36 Whereas, Funding SBHCs has been shown to be cost-effective by increasing access to
37 preventive care and reducing utilization of expensive acute care services, leading to a net
38 savings for Medicaid of \$30 to \$969 per visit¹²; and

1 Whereas, School-based health centers have grown substantially over the past two decades,
2 primarily due to an increase in federally qualified health center (FQHC) sponsorship, with 2,584
3 SBHCs in the United States in 2017, more than double in number present in 1998, and since
4 2008, SBHC growth in urban areas has been greatly outpaced by growth in rural and suburban
5 settings¹³; and

6
7 Whereas, The majority of students without access to SBHCs attend schools in low-income
8 communities eligible for Title I funding, and while increased FQHC sponsorship has greatly
9 contributed to recent growth, 80% of FQHCs are not currently partnered with SBHCs⁴; and

10
11 Whereas, Many SBHCs rely on public funding,⁹ although in 2014 only 89% of SBHCs billed
12 Medicaid and 71% billed CHIP in 2014⁴; and

13
14 Whereas, Not all services rendered can be reimbursed under Medicaid at SBHCs, since among
15 many requirements: 1) the child must be Medicaid-eligible, 2) the service must be among those
16 covered by Medicaid and 3) the service must be provided by a Medicaid-participating provider -
17 further, until 2014, reimbursement was not allowed for services given without charge to the
18 beneficiary, except under rare exceptions^{4,14,15}; and

19
20 Whereas, Apart from seven state Medicaid agencies, SBHCs are not considered a provider
21 type¹⁶ making the reimbursement of services more difficult for SBHCs;

22
23 Whereas, The lack of differentiation on claims data means that Medicaid is unable to identify
24 what services were rendered by an SBHC versus a different type of provider, making it difficult
25 to track and attribute improvements in quality of care or outcomes to SBHCs, making it difficult
26 for SBHCs to meet quality standards expected by the state¹⁶; and

27
28 Whereas, Multiple states have recently enacted policies that have facilitated or increased
29 Medicaid reimbursement to SBHCs, with seven states (Delaware, Illinois, Louisiana, Maine,
30 New Mexico, North Carolina, and West Virginia) naming SBHCs as a provider under Medicaid,
31 four states (Louisiana, Maryland, Michigan, and New Mexico) mandating Medicaid
32 reimbursement through a managed care organization, and eight states (Connecticut, Delaware,
33 Illinois, Louisiana, Maine, Maryland, North Carolina, and West Virginia) waiving prior
34 authorization¹⁶; and

35
36 Whereas, The AMA supports the study of SBHCs and recommends SBHC standards (H-
37 60.991), supports adequately resourced SBHCs for healthcare delivery to children and
38 adolescents (H-60.921), and supports physician service reimbursement and reimbursement for
39 physician practices (H-240.966; H-385.990; H-385.942; 385.952); therefore be it

1 RESOLVED, That our American Medical Association amend Policy H-60.921, "School-Based
2 and School-Linked Health Centers," by addition and deletion to read as follows:
3

4 **School-Based and School-Linked Health Centers, H-60.921**

5 1. Our AMA supports the concept of adequately equipped and staffed the
6 implementation, maintenance, and equitable expansion of school-based or school-
7 linked health centers (SBHCs) for the comprehensive management of conditions of
8 childhood and adolescence.

9 2. Our AMA recognizes that school-based health centers increase access to care in
10 underserved child and adolescent populations.

11 3. Our AMA supports identifying school-based health centers in claims data from
12 Medicaid and other payers for research and quality improvement purposes.

13 4. Our AMA supports efforts to extend Medicaid reimbursement to school-based health
14 centers at the state and federal level, including, but not limited to the recognition of
15 school-based health centers as a provider under Medicaid. (Modify Current HOD
16 Policy)

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

Date Received: 09/30/21

AUTHORS STATEMENT OF PRIORITY

The pandemic has had particularly profound impacts upon the health of pediatric populations. Children are facing pandemic-induced setbacks to their development and their physical, mental, and emotional health, and it is urgent that our healthcare system be ready to better support them. Our AMA recognizes health care as a human right and strives to increase access through various methods. School-Based Health Centers (SBHCs) are an important tool for providing healthcare for kids in kindergarten through 12th grade, especially for underserved populations. However, it is difficult for SBHCs to bill Medicaid, leading to financial problems for these critical safety nets. Our AMA has previously supported the concept of SBHCs but not addressed their difficulty in obtaining funding. This resolution will amend current policy to support the expansion of these centers, enable future research on quality improvement methods, and enable SBHCs to receive reimbursement from Medicaid. These asks align with the AMA's increasing focus on equity in healthcare and we believe should be considered a priority for the House of Delegates.

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RELEVANT AMA POLICY

Providing Medical Services through School-Based Health Programs H-60.991

(1) The AMA supports further objective research into the potential benefits and problems associated with school-based health services by credible organizations in the public and private sectors. (2) Where school-based services exist, the AMA recommends that they meet the following minimum standards: (a) Health services in schools must be supervised by a physician, preferably one who is experienced in the care of children and adolescents. Additionally, a physician should be accessible to administer care on a regular basis. (b) On-site services should be provided by a professionally prepared school nurse or similarly qualified health professional. Expertise in child and adolescent development, psychosocial and behavioral problems, and emergency care is desirable. Responsibilities of this professional would include coordinating the health care of students with the student, the parents, the school and the student's personal physician and assisting with the development and presentation of health education programs in the classroom. (c) There should be a written policy to govern provision of health services in the school. Such a policy should be developed by a school health council consisting of school and community-based physicians, nurses, school faculty and administrators, parents, and (as appropriate) students, community leaders and others. Health services and curricula should be carefully designed to reflect community standards and values, while emphasizing positive health practices in the school environment. (d) Before patient services begin, policies on confidentiality should be established with the advice of expert legal advisors and the school health council. (e) Policies for ongoing monitoring, quality assurance and evaluation should be established with the advice of expert legal advisors and the school health council. (f) Health care services should be available during school hours. During other hours, an appropriate referral system should be instituted. (g) School-based health programs should draw on outside resources for care, such as private practitioners, public health and mental health clinics, and mental health and neighborhood health programs. (h) Services should be coordinated to ensure comprehensive care. Parents should be encouraged to be intimately involved in the health supervision and education of their children.

CSA Rep. D, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: Res. 412, A-05; Reaffirmed in lieu of Res. 908, I-12

School-Based and School-Linked Health Centers H-60.921

Our AMA supports the concept of adequately equipped and staffed school-based or school-linked health centers (SBHCs) for the comprehensive management of conditions of childhood and adolescence.

CSAPH Rep. 1, A-15

Reimbursement to Physicians and Hospitals for Government Mandated Services H-240.966

(1) It is the policy of the AMA that government mandated services imposed on physicians and hospitals that are peripheral to the direct medical care of patients be recognized as additional practice cost expense.

(2) Our AMA will accelerate its plans to develop quantitative information on the actual costs of

regulations.

(3) Our AMA strongly urges Congress that the RBRVS and DRG formulas take into account these additional expenses incurred by physicians and hospitals when complying with governmentally mandated regulations and ensure that reimbursement increases are adequate to cover the costs of providing these services.

(4) Our AMA will advocate to the CMS and Congress that an equitable adjustment to the Medicare physician fee schedule (or another appropriate mechanism deemed appropriate by CMS or Congress) be developed to provide fair compensation to offset the additional professional and practice expenses required to comply with the Emergency Medical Treatment and Labor Act.

Sub Res. 810, I-92; Appended by CMS 10, A-98; Reaffirmation: I-98; Reaffirmation: A-02; Reaffirmation: I-07; Reaffirmed in lieu of Res. 126, A-09; Reaffirmed: CMS Rep. 01, A-19

Payment for Physicians' Services H-385.990

Our AMA:

(1) Recognizes the validity of a pluralistic approach to third party reimbursement methodology and recognizes that indemnity reimbursement, as a schedule of benefits, as well as "usual and customary or reasonable" (UCR), have positive aspects which merit further study.

(2) Reaffirms its support for: (a) freedom for physicians to choose the method of payment for their services and to establish fair and equitable fees; (b) freedom of patients to select their course of care; and (c) neutral public policy and fair market competition among alternative health care delivery and financing systems.

(3) Reaffirms its policy encouraging physicians to volunteer fee information to patients and to discuss fees in advance of services, where feasible.

(4) Urges physicians to continue and to expand the practice of accepting third party reimbursement as payment in full in cases of financial hardship, and to voluntarily communicate to their patients through appropriate means their willingness to consider such arrangements in cases of financial need or other circumstances.

CMS Rep. B, I-83; Reaffirmed: BOT Rep. TT, I-92; Reaffirmed: CMS Rep. E, A-93; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: Sub. Res. 137, A-94; Reaffirmed: CMS Rep. 5, A-04; Reaffirmed: BOT Rep. 10, I-05; Reaffirmed in lieu of Res. 127, A-10; Reaffirmed: CMS Rep. 01, A-20

CMS Use of Regulatory Authority to Implement Reimbursement Policy H-385.942

The AMA urge (1) CMS in the strongest terms possible to solicit the participation and counsel of relevant professional societies before implementing reimbursement policies that will affect the practice of medicine; (2) CMS to make every effort to determine the clinical consequences of such reimbursement policy changes before the revised policies are put in place; and (3) CMS in the strongest terms possible not to misapply either quality measurement data or clinical practice guidelines developed in good faith by the professional medical community as either standards or the basis for changes in reimbursement policies.

Res. 124, A-98; Modified and Reaffirmed: CMS Rep. 4, A-08; Reaffirmed: CMS Rep. 01, A-18; Reaffirmed: Res. 105, A-18

Appropriate Physician Reimbursement by Centers for Medicare & Medicaid Services H-385.952

Our AMA: (1) opposes both CMS's and local carriers' efforts to reduce or deny physician payments for appropriate services; and (2) will work to assure that all evaluation and management services are appropriately reimbursed.

Res. 118, I-95; Reaffirmation: A-00; Reaffirmation: A-02; Reaffirmation: A-06; Reaffirmation: A-09; Reaffirmed: CMS Rep. 01, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 107
(N-21)

Introduced by: Medical Student Section

Subject: Expanding Medicaid Transportation to Include Healthy Grocery
Destinations

Referred to: Reference Committee A

- 1 Whereas, Food insecurity is defined as the disruption of food intake or eating patterns due to
2 lack of money and other resources¹⁻⁵; and
3
- 4 Whereas, Food insecurity increases the risk of developing chronic diseases such as obesity,
5 type II diabetes, and cardiovascular disease¹⁻⁷; and
6
- 7 Whereas, Health care expenditures from 2011-2013 of food-insecure individuals were \$1,863
8 higher per person compared to food-secure individuals, resulting in \$77.5 billion of additional
9 health care spending⁸; and
10
- 11 Whereas, Medicaid eligibility is correlated with food insecurity and lack of access to grocery
12 stores⁹; and
13
- 14 Whereas, In 2015, 12.7% of the United States census tracts were categorized as low income
15 and were concurrently categorized as areas with limited access to a food store (supermarket,
16 grocery store)¹⁰; and
17
- 18 Whereas, In 2015, 18.2 million housing units were estimated to be in low-income census tracts
19 where at least 100 households without a vehicle lived more than half a mile from the nearest
20 supermarket or large grocery store, or where at least a third of the tract was more than 20 miles
21 from the nearest store¹⁰; and
22
- 23 Whereas, Over 9.5 million parents, 15.6 million nonparents, and 25.8 million children were
24 eligible for Supplemental Nutrition Assistance Program (SNAP) and Medicaid benefits in 2015¹¹;
25 and
26
- 27 Whereas, Individuals of lower socioeconomic status report inadequate geographical location of
28 food stores as a major barrier to proper nutrition, including inadequate transportation¹²⁻¹⁵; and
29
- 30 Whereas, Lack of access to supermarkets, as compared to relatively ready access to
31 convenience stores, can limit the availability of healthy foods, resulting in poorer health
32 outcomes, such as obesity or diabetes¹⁶⁻²⁰; and
33
- 34 Whereas, There is extensive research to support that initiatives improving food access in low
35 income populations results in improved health outcomes²¹⁻²³; and

1 Whereas, Non-emergency medical transportation services (NEMT) covered by State Medicaid
2 includes transportation for prescriptions and medical supplies but not grocery stores, farmers
3 markets, food banks or pantries^{24,25}; and
4

5 Whereas, In the past 2 decades, various pilot programs in areas such as Los Angeles,
6 California, north Nampa, Idaho and Flint, Michigan were initiated to provide transportation to
7 and from specific grocery stores for residents in food deserts^{23,26-29}; and
8

9 Whereas, A 10-week pilot program in Michigan's Upper Peninsula to improve food access,
10 involving a local farmer's market and 32 patients with at least one chronic disease, motivation to
11 begin a healthy lifestyle, and demonstrated difficulty in accessing fruits and vegetables, resulted
12 in an increase of 1.2 cups of fruits and vegetables consumed per day and a significant increase
13 in reported quality of life²²; and
14

15 Whereas, Participants in an East Texas transportation voucher program that included grocery
16 store access reported improved health and well-being, and were more likely to be aware of and
17 utilize SNAP benefits³⁰; and
18

19 Whereas, Pilot test healthy food access programs found that when barriers such as cost and
20 access were removed, individuals from lower SES communities increased their purchase and
21 consumption of fruits and vegetables^{31,32}; and
22

23 Whereas, One study found that after a full-service supermarket was opened in a low-SES
24 neighborhood, the rate of increase of diagnosed high cholesterol and arthritis incidence was
25 reduced³³; and
26

27 Whereas, Many pilot programs, such as LyftUp Grocery Access Program, run for a limited
28 period of time, with ambiguity of future continuity, therefore offering only temporary aid^{34,35}; and
29

30 Whereas, Medicaid has offered NEMT services since 1966 under the Code of Federal
31 Regulations and authorized under the Social Security Act, providing 104 million healthcare-
32 related trips at no cost to eligible individuals in 2013^{24,36}; and
33

34 Whereas, NEMT costs Medicaid less than one percent of its total expenditures annually^{37,38};
35 and
36

37 Whereas, Current AMA policy (D-150.978) encourages the "development of a healthier food
38 system through tax incentive programs, community-level initiatives and federal legislation"; and
39

40 Whereas, Current AMA policy (H-130.954) only encourages the "development of non-
41 emergency patient transportation systems... [for the accessibility] of health care", there is no
42 policy that addresses the lack of transportation support to and from healthy grocery
43 destinations; therefore be it
44

45 RESOLVED, That our American Medical Association: (1) support the implementation and
46 expansion of transportation services for accessing healthy grocery options; and (2) advocate for
47 inclusion of supermarkets, food banks and pantries, and local farmers markets as destinations
48 offered by Medicaid transportation at the federal level; and (3) support efforts to extend
49 Medicaid reimbursement to non-emergent medical transportation for healthy grocery
50 destinations. (Directive to Take Action)

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

Date Received: 09/30/21

AUTHORS STATEMENT OF PRIORITY

Although there are various existing AMA policies that address food deserts, the ongoing pandemic has highlighted their inadequacy to address issues of food insecurity and nutrition, particularly for older adults and other high-risk populations. The majority of those who live in food deserts also rely on Medicaid. Access to healthy foods is essential to maintaining good health, much like access to healthcare.

Our resolution adds to policy by asking our AMA to advocate for increasing access to healthy food options, utilizing the already existing non-emergent medical transportation service of Medicaid to connect Medicaid participants with healthy groceries. Healthcare only comprises 10-15% of one's health outcomes, and the rest - genetics, individual behavior, social/environmental factors - all have a play in the food one has access to.

There have been various pilot programs offering transportation services to and from grocery destinations. Many of these pilot programs run for a couple months and then dispel with wide uncertainty of whether or not they return to stay. Medicaid would provide a stable baseline service to its participants and its inclusion is integral for the longevity of such services. Once this baseline is established, then other companies/options can be utilized as supplementation.

This resolution addresses a critical gap for marginalized populations, suggesting innovative ways to focus on prevention and better daily living. Our AMA has recently been a leader in addressing discrimination, and as the issue of achieving appropriate nutrition becomes exacerbated by the difficulties of the ongoing pandemic, this issue is an urgent, timely, and priority resolution for American physicians.

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RELEVANT AMA POLICY

Non-Emergency Patient Transportation Systems H-130.954

The AMA: (1) supports the education of physicians and the public about the costs associated with inappropriate use of emergency patient transportation systems; and (2) encourages the development of non-emergency patient transportation systems that are affordable to the patient, thereby ensuring cost effective and accessible health care for all patients.

Res 812, I-93; Reaffirmed: CMS Rep 10, A-03; Reaffirmed in lieu of Res 101, A-12; Modified: CMS Rep 02, I-18

Food Environments and Challenges Accessing Healthy Food H-150.925

Our AMA (1) encourages the U.S. Department of Agriculture and appropriate stakeholders to study the national prevalence, impact, and solutions to challenges accessing healthy affordable food, including, but not limited to, food environments like food mirages, food swamps, and food deserts; (2) recognizes that food access inequalities are a major contributor to health inequities, disproportionately affecting marginalized communities and people of color; and (3) supports policy promoting community-based initiatives that empower resident businesses, create economic opportunities, and support sustainable local food supply chains to increase access to affordable healthy food.

Res 921, I-18; Modified: Res. 417, A-21

Improvements to Supplemental Nutrition Programs H-150.937

1. Our AMA supports: (a) improvements to the Supplemental Nutrition Assistance Program (SNAP) and Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) that are designed to promote adequate nutrient intake and reduce food insecurity and obesity; (b) efforts to decrease the price gap between calorie-dense, nutrition-poor foods and naturally nutrition-dense foods to improve health in economically disadvantaged populations by encouraging the expansion, through increased funds and increased enrollment, of existing programs that seek to improve nutrition and reduce obesity, such as the Farmer's Market Nutrition Program as a part of the Women, Infants, and Children program; and (c) the novel application of the Farmer's Market Nutrition Program to existing programs such as the Supplemental Nutrition Assistance Program (SNAP), and apply program models that incentivize the consumption of naturally nutrition-dense foods in wider food distribution venues than solely farmer's markets as part of the Women, Infants, and Children program.
2. Our AMA will request that the federal government support SNAP initiatives to (a) incentivize healthful foods and disincentivize or eliminate unhealthful foods and (b) harmonize SNAP food offerings with those of WIC.
3. Our AMA will actively lobby Congress to preserve and protect the Supplemental Nutrition Assistance Program through the reauthorization of the 2018 Farm Bill in order for Americans to live healthy and productive lives.

Res 414, A-10; Reaffirmed A-12; Reaffirmation A-13; Appended: CSAPH Rep 1, I-13; Reaffirmation A-14; Reaffirmation I-14; Reaffirmation A-15; Appended: Res 407, A-17; Appended: Res 233, A-18

Sustainable Food D-150.978

Our AMA: (1) supports practices and policies in medical schools, hospitals, and other health care facilities that support and model a healthy and ecologically sustainable food system, which provides food and beverages of naturally high nutritional quality; (2) encourages the development of a healthier food system through tax incentive programs, community-level initiatives and federal legislation; and (3) will consider working with other health care and public health organizations to educate the health care community and the public about the importance of healthy and ecologically sustainable food systems.

CSAPH Rep. 8, A-09; Reaffirmed in lieu of Res. 411, A-11; Reaffirmation: A-12; Reaffirmed in lieu of Res. 205, A-12; Modified: Res. 204, A-13; Reaffirmation: A-15

Medicare's Ambulance Service Regulations H-240.978

1. Our AMA supports changes in Medicare regulations governing ambulance service coverage guidelines that would expand the term "appropriate facility" to allow full payment for transport to the most appropriate facility based on the patient's needs and the determination made by

physician medical direction; and expand the list of eligible transport locations from the current three sites of care (nearest hospital, critical access hospital, or skilled nursing facility) based upon the onsite evaluation and physician medical direction.

2. Our AMA will work with the Centers for Medicare & Medicaid Services (CMS) to pay emergency medical services providers for the evaluation and transport of patients to the most appropriate site of care not limited to the current CMS defined transport locations.

Res 37, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CMS Rep 3, A-08; Modified: Res 124, A-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 108
(N-21)

Introduced by: Medical Student Section

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

Referred to: Reference Committee A

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

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

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

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

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

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

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

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

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

1 Whereas, CGMs offer a cost-effective alternative to traditional self-monitoring via fingerprick at
2 an additional \$653 over a patient's lifetime, translating to \$8898 per QALY (quality-adjusted life
3 year) gained that is well below the \$100,000 per QALY cost-effectiveness threshold often cited
4 in healthcare economics studies^{30,31}; and

5
6 Whereas, Approximately 14% of adults under 65 covered by Medicaid have a form of
7 diabetes³²; and

8
9 Whereas, Retrospective analysis of patients prescribed to a professional CGM for T2DM
10 showed no statistically significant increase in total annual costs compared to those who were
11 not prescribed a professional CGM, but did see an improvement in hemoglobin A1c (HbA1c)
12 without intensification of the current treatment regimen^{19,33}; and

13
14 Whereas, While long-term cost effectiveness studies have demonstrated CGMs' potential to
15 decrease overall costs for patients with T2DM through elimination of test strips and lancets, a
16 majority of financial benefit is due to lower HbA1c readings and mitigation of direct diabetes
17 related complications such as hospitalizations, emergency room visits, non-diabetes
18 prescription medications, and indirect costs such as hampered productivity, which collectively
19 account for 73.1% of total diabetes care cost^{17,33}; and

20
21 Whereas, The lowest-cost option among CGMs, with an out-of-pocket price of less than \$100
22 for uninsured individuals, are an alternative non-invasive glucose monitor called flash glucose
23 monitoring which provides glucose readings on demand and allows for downloadable glucose
24 data, and use has been found to decrease acute diabetes-related events and all-cause inpatient
25 hospitalizations in patients with T2DM treated with short or rapid acting insulin³⁴⁻³⁶; and

26
27 Whereas, Patients with T2DM treated with oral agents are often placed on a basal-bolus
28 regimen of insulin while admitted to the hospital for glucose control, and use of flash glucose
29 monitoring in these patients during admission demonstrated lower average daily glucose and
30 increased detection of hypoglycemia^{37,38}; and

31
32 Whereas, CGMs have been able to provide increased insight into nocturnal glucose levels,
33 glucose metabolism during exercise and feeding, and relative impact of medications on ambient
34 glucose than any form of episodic self-monitoring of blood glucose for all patients with diabetes,
35 and CGM users spent significantly less time in hypoglycemic ranges compared to their self-
36 monitoring of blood glucose counterparts^{17,39}; and

37
38 Whereas, AMA Directive D-185.983 asks our AMA Board of Trustees to consider a legal
39 challenge, if appropriate, to the authority of the Centers for Medicare & Medicaid Services
40 (CMS) and other health care insurers placing onerous barriers on diabetic patients to procure
41 medically necessary "durable medical equipment and supplies"; and

42
43 Whereas, Certain CGMs which require adjunctive therapy are deemed "non-therapeutic" and
44 thus are ineligible to be classified as durable medical equipment (DME) and supplies, despite
45 their ability to influence medical decision making⁴⁰; and

46
47 Whereas, CMS Proposal CMS-1739-P includes a section on reclassifying "therapeutic" and
48 "non-therapeutic" CGMs as DME, as access to DME has been associated with better outcomes
49 and significantly lower healthcare spending due to patients' ability to receive care at home, and
50 variations in Medicaid definitions of DME have been linked to variations in geographic
51 healthcare expenditure^{40,41}; and

1 Whereas, Increased eligibility and access to all glucose monitors, including CGM and flash
2 glucose monitoring, would provide improved, cost-effective health care outcomes for low-
3 income patients with diabetes on Medicaid and Medicare^{19,33-35,37,38}; and
4

5 Whereas, Medicaid and public state medical insurance expansions that include CGM devices
6 have been demonstrated to improve glycemic control and reduce disparities in pediatric patients
7 with type 1 diabetes^{42,43}; and
8

9 Whereas, Current AMA policy H330.885 supports coverage of CGM for Medicare patients with
10 insulin-dependent diabetes but does not address Medicaid or CHIP; therefore be it
11

12 RESOLVED, That our American Medical Association advocate for broadening the classification
13 criteria of Durable Medical Equipment to include all clinically effective and cost-saving diabetic
14 glucose monitors (Directive to Take Action); and be it further
15

16 RESOLVED, That our AMA amend AMA Policy H-330.885 by addition and deletion to read as
17 follows:
18

19 ~~Medicare~~ Public Insurance Coverage of Continuous Glucose Monitoring Devices for
20 Patients with Insulin-Dependent Diabetes H-330.885
21

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

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

Date Received: 09/30/21

AUTHORS STATEMENT OF PRIORITY

Diabetes is a slow, silent, but remarkably effective killer. In the current pandemic, diabetes has been an impactful comorbid condition greatly increasing morbidity and mortality with COVID-19. Glucose monitoring is a tool that is effective at improving glucose control and preventing complications. Although our AMA currently supports glucose monitoring, it does not support equal access to glucose monitoring for all patients, thereby leaving a gap that results in tens of thousands of patients without this tool. This resolution supports patient access to tools that can help protect them from this current epidemic as well as other complications from varying glucose levels. Barriers to coverage right now include discrepancies in classification of certain monitors as Durable Medical Equipment and differences in coverage between various public insurance programs. This resolution aims to bridge those gaps and allow for a low-cost, high-quality intervention for our patients. It is vital for our AMA to continue to be on the forefront of protecting this vulnerable patient population's access to tools that make a literal life-and-death difference for them every day.

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RELEVANT AMA POLICY

Diabetic Documentation Requirements D-185.983

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

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

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

Res. 126, A-14

CMS Required Diabetic Supply Forms H-330.908

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

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

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

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

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

Access to Medical Care D-480.991

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

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

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 109
(N-21)

Introduced by: Medical Student Section

Subject: Amending D-440.985, "Health Care Payment for Undocumented Persons," to Study Methods to Increase Health Care Access for Undocumented Immigrants

Referred to: Reference Committee A

1 Whereas, Based on results from the 2018 American Community Survey (ACS), the current
2 undocumented immigrant population within the United States is around 10.6 million¹; and
3
4 Whereas, The Personal Responsibility and Work Opportunity Act of 1996 bars the majority of
5 both authorized and unauthorized immigrants who have not resided in the United States for 5
6 years from qualifying for federally funded benefits²; and
7
8 Whereas, Around two thirds of undocumented immigrants who would qualify for Medicaid live
9 below the federal poverty line and around half are uninsured^{2,3}; and
10
11 Whereas, Thirty-three percent of undocumented immigrant children are uninsured⁴; and
12
13 Whereas, Undocumented immigrants are not eligible for any type of coverage offered under the
14 Affordable Care Act, including participation in the insurance marketplaces⁴; and
15
16 Whereas, Most undocumented immigrants receive health care through Federally Qualified
17 Health Centers (FQHCs) or free medical clinics⁵; and
18
19 Whereas, FQHCs are funded by federal grants, non-profits, or private donations, which allow
20 them to provide care regardless of immigration status⁵; and
21
22 Whereas, Emergency Medicaid is often utilized by undocumented immigrants and authorized
23 immigrants who have been lawfully present for less than 5 years in order to obtain medical care
24 in both urgent and chronic medical condition⁶; and
25
26 Whereas, Emergency Medicaid costs around \$2 billion per year to provide health care to
27 approximately 100,000 individuals who would qualify for Medicaid if not for their immigration
28 status⁶; and
29
30 Whereas, Allowing immigrants increased access to health care could reduce the burden of
31 chronic diseases through preventative care, alleviate public health concerns such as
32 tuberculosis, and reduce the utilization of emergency health services⁵; and
33
34 Whereas, Immigrants often have lower rates of health care utilization and expenditures as
35 compared to natural born citizens^{2,3,7}; and

1 Whereas, As of January 2020, only 6 states provided Medicaid or Children’s Health Insurance
2 Program (CHIP) to children regardless of immigration status, while 26 other states provide
3 coverage to lawfully residing children⁸; and
4

5 Whereas, California and Massachusetts have expanded health insurance access to
6 undocumented immigrants who are not lawfully residing through mechanisms that are state
7 funded²; and
8

9 Whereas, Through a program known as MediCal, California has expanded health insurance
10 access to children and young adults up to the age of 25, with the goal of providing care to
11 undocumented seniors in the near future^{9,10}; and
12

13 Whereas, The COVID-19 pandemic has highlighted the need for appropriate health care
14 coverage at both the state and federal level for undocumented immigrants, especially given the
15 fact that undocumented immigrants had difficulty accessing testing and treatment throughout
16 the pandemic^{9,10}; and
17

18 Whereas, Current AMA policies establish precedent for increasing health care and providing
19 equitable care to immigrants, refugees, and migrant farm workers regardless of immigration
20 status, especially covering care for children of undocumented immigrants (D-65.992-Medical
21 Needs of Unaccompanied, Undocumented Immigrant Children); and
22

23 Whereas, The AMA has made a commitment to assisting states with the issue of
24 uncompensated care to undocumented immigrants by solving the problem on a national level
25 (D-440.985, “Health Care Payment for Undocumented Persons”); therefore be it
26

27 RESOLVED, That our American Medical Association amend Policy D-440.985, “Health Care
28 Payment for Undocumented Persons,” by addition to read as follows:
29

30 **Health Care Payment for Undocumented Persons D-440.985**
31

32 Our American Medical Association: (1) shall assist states on the issue of the lack of
33 reimbursement for care given to undocumented immigrants in an attempt to solve this
34 problem on a national level-; and (2) support methods to increase health insurance
35 access for undocumented immigrants, such as allowing them to purchase health
36 insurance on the Affordable Care Act marketplaces. (Modify Current HOD Policy)

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

Date Received: 09/30/21

AUTHORS STATEMENT OF PRIORITY

The combination of the COVID-19 pandemic and multiple high-publicity episodes of mistreatment of refugees and immigrants have made it clear that these vulnerable populations urgently need better protection. Undocumented immigrants in particular have faced worse health outcomes in the pandemic, in part due to their lack of access to regular care. This lack of regular care leads to eventual worse outcomes, making it more expensive to have had undocumented immigrants lacking health insurance, besides leading to preventable and tragic losses of human life and ability. This resolution addresses the urgent inequity of lacking care by supporting methods to increase health insurance access for undocumented immigrants, such as allowing them to purchase health insurance on the Affordable Care Act marketplaces. Our AMA's increasing recognition of the importance of health equity, and the increasing awareness in the ongoing pandemic that the health of the whole community is interwoven, makes this issue a high priority meriting consideration at this meeting.

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RELEVANT AMA POLICY

Impact of Immigration Barriers on the Nation's Health D-255.980

1. Our AMA recognizes the valuable contributions and affirms our support of international medical students and international medical graduates and their participation in U.S. medical schools, residency and fellowship training programs and in the practice of medicine.
2. Our AMA will oppose laws and regulations that would broadly deny entry or re-entry to the United States of persons who currently have legal visas, including permanent resident status (green card) and student visas, based on their country of origin and/or religion.
3. Our AMA will oppose policies that would broadly deny issuance of legal visas to persons based on their country of origin and/or religion.
4. Our AMA will advocate for the immediate reinstatement of premium processing of H-1B visas for physicians and trainees to prevent any negative impact on patient care.
5. Our AMA will advocate for the timely processing of visas for all physicians, including residents, fellows, and physicians in independent practice.
6. Our AMA will work with other stakeholders to study the current impact of immigration reform efforts on residency and fellowship programs, physician supply, and timely access of patients to health care throughout the U.S.

Alt. Res. 308, A-17; Modified: CME Rep. 01, A-18; Reaffirmation: A-19; Reaffirmed: CME Rep. 4, A-21

Patient and Physician Rights Regarding Immigration Status H-315.966

Our AMA supports protections that prohibit U.S. Immigration and Customs Enforcement, U.S. Customs and Border Protection, or other law enforcement agencies from utilizing information from medical records to pursue immigration enforcement actions against patients who are undocumented.

Res. 018, A-17

Opposing the Detention of Migrant Children H-60.906

Our AMA: (1) opposes the separation of migrant children from their families and any effort to end or weaken the Flores Settlement that requires the United States Government to release undocumented children “without unnecessary delay” when detention is not required for the protection or safety of that child and that those children that remain in custody must be placed in the “least restrictive setting” possible, such as emergency foster care; (2) supports the humane treatment of all undocumented children, whether with families or not, by advocating for regular, unannounced, auditing of the medical conditions and services provided at all detention facilities by a non-governmental, third party with medical expertise in the care of vulnerable children; and (3) urges continuity of care for migrant children released from detention facilities.

Res. 004, I-18

Addressing Immigrant Health Disparities H-350.957

1. Our American Medical Association recognizes the unique health needs of refugees, and encourages the exploration of issues related to refugee health and support legislation and policies that address the unique health needs of refugees.

2. Our AMA: (A) urges federal and state government agencies to ensure standard public health screening and indicated prevention and treatment for immigrant children, regardless of legal status, based on medical evidence and disease epidemiology; (B) advocates for and publicizes medically accurate information to reduce anxiety, fear, and marginalization of specific populations; and (C) advocates for policies to make available and effectively deploy resources needed to eliminate health disparities affecting immigrants, refugees or asylees.

3. Our AMA will call for asylum seekers to receive all medically-appropriate care, including vaccinations in a patient centered, language and culturally appropriate way upon presentation for asylum regardless of country of origin.

Res. 804, I-09 Appended: Res. 409, A-15; Reaffirmation: A-19; Appended: Res. 423, A-19; Reaffirmation: I-19

HIV, Immigration, and Travel Restrictions H-20.901

Our AMA recommends that: (1) decisions on testing and exclusion of immigrants to the United States be made only by the U.S. Public Health Service, based on the best available medical, scientific, and public health information; (2) non-immigrant travel into the United States not be restricted because of HIV status; and (3) confidential medical information, such as HIV status, not be indicated on a passport or visa document without a valid medical purpose.

CSA Rep. 4, A-03; Modified: Res. 2, I-10; Modified: Res. 254, A-18

Redefining AMA's Position on ACA and Healthcare Reform D-165.938

1. Our AMA will develop a policy statement clearly stating this organization's policies on the following aspects of the Affordable Care Act (ACA) and healthcare reform:

- A. Opposition to all P4P or VBP that fail to comply with the AMA's Principles and Guidelines;
- B. Repeal and appropriate replacement of the SGR;

- C. Repeal and replace the Independent Payment Advisory Board (IPAB) with a payment mechanism that complies with AMA principles and guidelines;
 - D. Support for Medical Savings Accounts, Flexible Spending Accounts, and the Medicare Patient Empowerment Act ("private contracting");
 - E. Support steps that will likely produce reduced health care costs, lower health insurance premiums, provide for a sustainable expansion of healthcare coverage, and protect Medicare for future generations;
 - F. Repeal the non-physician provider non-discrimination provisions of the ACA.
2. Our AMA will immediately direct sufficient funds toward a multi-pronged campaign to accomplish these goals.
 3. There will be a report back at each meeting of the AMA HOD.
- Res. 231, A-13; Reaffirmed in lieu of Res. 215, A-15; Reaffirmation: A-17

Presence and Enforcement Actions of Immigration and Customs Enforcement (ICE) in Healthcare D-160.921

Our AMA: (1) advocates for and supports legislative efforts to designate healthcare facilities as sensitive locations by law; (2) will work with appropriate stakeholders to educate medical providers on the rights of undocumented patients while receiving medical care, and the designation of healthcare facilities as sensitive locations where U.S. Immigration and Customs Enforcement (ICE) enforcement actions should not occur; (3) encourages healthcare facilities to clearly demonstrate and promote their status as sensitive locations; and (4) opposes the presence of ICE enforcement at healthcare facilities.

Res. 232, I-17

Increasing Access to Healthcare Insurance for Refugee Populations H-350.956

Our AMA supports state, local, and community programs that remove language barriers and promote education about low-cost health-care plans, to minimize gaps in health-care for refugees.

Res. 006, A-17

Improving Medical Care in Immigrant Detention Centers D-350.983

Our AMA will: (1) issue a public statement urging U.S. Immigrations and Customs Enforcement Office of Detention Oversight to (a) revise its medical standards governing the conditions of confinement at detention facilities to meet those set by the National Commission on Correctional Health Care, (b) take necessary steps to achieve full compliance with these standards, and (c) track complaints related to substandard healthcare quality; (2) recommend the U.S. Immigrations and Customs Enforcement refrain from partnerships with private institutions whose facilities do not meet the standards of medical, mental, and dental care as guided by the National Commission on Correctional Health Care; and (3) advocate for access to health care for individuals in immigration detention.

Res. 017, A-17

Opposition to Regulations That Penalize Immigrants for Accessing Health Care Services D-440.927

Our AMA will, upon the release of a proposed rule, regulations, or policy that would deter immigrants and/or their dependents from utilizing non-cash public benefits including but not limited to Medicaid, CHIP, WIC, and SNAP, issue a formal comment expressing its opposition.

Res. 254, A-18

Medical Needs of Unaccompanied, Undocumented Immigrant Children D-65.992

1. Our AMA will take immediate action by releasing an official statement that acknowledges that

the health of unaccompanied immigrant children without proper documentation is a humanitarian issue.

2. Our AMA urges special consideration of the physical, mental, and psychological health in determination of the legal status of unaccompanied minor children without proper documentation.
 3. Our AMA will immediately meet and work with other physician specialty societies to identify the main obstacles to the physical health, mental health, and psychological well-being of unaccompanied children without proper documentation.
 4. Our AMA will participate in activities and consider legislation and regulations to address the unmet medical needs of unaccompanied minor children without proper documentation status, with issues to be discussed to include the identification of: (A) the health needs of this unique population, including standard pediatric care as well as mental health needs; (B) health care professionals to address these needs, to potentially include but not be limited to non-governmental organizations, federal, state, and local governments, the US military and National Guard, and local and community health professionals; (C) the resources required to address these needs, including but not limited to monetary resources, medical care facilities and equipment, and pharmaceuticals; and (D) avenues for continuity of care for these children during the potentially extended multi-year legal process to determine their final disposition.
- Res. 5, I-15; Reaffirmed: BOT Action in response to referred for decision: Res. 003, I-18

Opposition to Criminalization of Medical Care Provided to Undocumented Immigrant Patients H-440.876

1. Our AMA: (a) opposes any policies, regulations or legislation that would criminalize or punish physicians and other health care providers for the act of giving medical care to patients who are undocumented immigrants; (b) opposes any policies, regulations, or legislation requiring physicians and other health care providers to collect and report data regarding an individual patient's legal resident status; and (c) opposes proof of citizenship as a condition of providing health care.
2. Our AMA will work with local and state medical societies to immediately, actively and publicly oppose any legislative proposals that would criminalize the provision of health care to undocumented residents.

Res. 920, I-06; Reaffirmed and Appended: Res. 140, A-07; Modified: CCB/CLRPD Rep. 2, A-14

Health Care Payment for Undocumented Persons D-440.985

Our AMA shall assist states on the issue of the lack of reimbursement for care given to undocumented immigrants in an attempt to solve this problem on a national level.

Res. 148, A-02; Reaffirmation A-07; Reaffirmed: CMS Rep. 01, A-17; Reaffirmation: A-19; Reaffirmation: I-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 110
(N-21)

Introduced by: Medical Student Section

Subject: Caps on Insulin Co-Payments for Patients with Insurance

Referred to: Reference Committee A

1 Whereas, Diabetes affects approximately 9.4% of the U.S. population and is the seventh
2 leading cause of death nationally^{1,2}; and
3
4 Whereas, Direct medical costs for diagnosed diabetes were estimated at \$327.2 billion in 2017,
5 with nearly \$102 billion lost due to lower productivity resulting from diabetes³; and
6
7 Whereas, The annual average medical cost per person with diabetes is \$13,240 with
8 approximately 44% of expenditures stemming from prescription medications, including insulin⁴;
9 and
10
11 Whereas, From 2012 to 2016, the average point-of-sale price of insulin nearly doubled from 13
12 cents per unit to 25 cents per unit, translating to a daily cost increase from \$7.80 to \$15 for a
13 patient with Type 1 diabetes using an average amount of insulin (60 units per day)⁵; and
14
15 Whereas, One in four patients reported cost-related insulin underuse, including taking smaller
16 doses and skipping doses, which was independent of the patient's prescription drug coverage
17 plan⁶; and
18
19 Whereas, Patients who report cost-related underuse were more likely to have poor glycemic
20 control, which is associated with an increased risk for complications such as hypertension,
21 chronic kidney disease, neuropathy, lower limb amputations, retinopathy, stroke, coronary heart
22 disease, depression, and cancer^{6,7}; and
23
24 Whereas, Seven states have approved legislation on insulin copayment caps since April 2020,
25 instituting a \$35-\$100 maximum copayment for a 30-day insulin supply⁸; and
26
27 Whereas, The Centers for Medicare & Medicaid Services (CMS) plans to limit insulin
28 prescription costs through Medicaid Part D for the 2021 plan year to a maximum \$35 copay for
29 a 30-day supply, and estimate annual out-of-pocket savings per patient to be reduced by 66%⁹;
30 and
31
32 Whereas, Individual and family savings resulting from caps on insulin copayments have the
33 potential to alleviate financial burden¹⁰; and
34
35 Whereas, The AMA has policy consistent with the principle of increasing access to prescription
36 medications including insulin for patients¹¹⁻¹⁶; and

1 Whereas, Some private insurance programs have shown the capability to offer a capped
2 copayment on insulin for their customers, without any increased cost to their insurance premium
3 or plan¹⁷; therefore be it
4

5 RESOLVED, That our American Medical Association amend Policy H-110.984, "Insulin
6 Affordability," by addition to read as follows:
7

8 Insulin Affordability H-110.984

9 Our AMA will: (1) encourage the Federal Trade Commission (FTC) and the
10 Department of Justice to monitor insulin pricing and market competition and take
11 enforcement actions as appropriate; ~~and~~ (2) support initiatives, including those by
12 national medical specialty societies, that provide physician education regarding the
13 cost-effectiveness of insulin therapies; and (3) support state and national efforts to
14 limit the copayments insured patients pay per month for prescribed insulin. (Modify
15 Current HOD Policy)

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

Date Received: 09/30/21

AUTHORS STATEMENT OF PRIORITY

Insulin prices tripled since 2005 because of predatory PBMs. Millions of patients now ration insulin due to cost. Copay caps would save patients hundreds of dollars a year, prevent the harmful, potentially lethal effects of DKA, and avoid millions in hospitalization expenses. Twelve states have passed caps, and another 30 states across the political spectrum debated legislation this year. However, these laws only impact state-regulated plans. CMS instated \$35 monthly caps for Medicare Part D this year, but Congressional legislation on caps in federally regulated ERISA and ACA plans is still pending. Existing AMA policy on tying cost-sharing in general to patient income and clinical value is laudable, but those broader systemic changes to our insurance market require years to decades of incremental advocacy, addressing hundreds of services and medications, in dozens of policies, in 50 states and Congress, facing formidable resistance from insurers and PhRMA. While we continue long-term efforts to build a better system, the political dominoes on insulin affordability are aligned, thanks to invested policymakers and vocal patient advocates. Our AMA cannot give up this historic chance to directly address an urgent and legislatively timely issue--a tangible win is within reach. We must join diabetes advocates now to improve insulin affordability for all patients. Given ongoing bipartisan momentum on this issue, our AMA should explicitly support federal and state policies to ensure consistent insulin affordability in all plans nationwide. No patient should be forced to ration insulin and risk DKA.

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RELEVANT AMA POLICY

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

1. Our AMA will advocate that the use of arbitration in determining the price of prescription drugs meet the following standards to lower the cost of prescription drugs without stifling innovation:
 - a. The arbitration process should be overseen by objective, independent entities;
 - b. The objective, independent entity overseeing arbitration should have the authority to select neutral arbitrators or an arbitration panel;
 - c. All conflicts of interest of arbitrators must be disclosed and safeguards developed to minimize actual and potential conflicts of interest to ensure that they do not undermine the integrity and legitimacy of the arbitration process;
 - d. The arbitration process should be informed by comparative effectiveness research and cost-effectiveness analysis addressing the drug in question;
 - e. The arbitration process should include the submission of a value-based price for the drug in question to inform the arbitrator's decision;
 - f. The arbitrator should be required to choose either the bid of the pharmaceutical manufacturer or the bid of the payer;
 - g. The arbitration process should be used for pharmaceuticals that have insufficient competition; have high list prices; or have experienced unjustifiable price increases;
 - h. The arbitration process should include a mechanism for either party to appeal the arbitrator's decision; and
 - i. The arbitration process should include a mechanism to revisit the arbitrator's decision due to new evidence or data.
2. Our AMA will advocate that any use of international price indices and averages in determining the price of and payment for drugs should abide by the following principles:

- a. Any international drug price index or average should exclude countries that have single-payer health systems and use price controls;
 - b. Any international drug price index or average should not be used to determine or set a drug's price, or determine whether a drug's price is excessive, in isolation;
 - c. The use of any international drug price index or average should preserve patient access to necessary medications;
 - d. The use of any international drug price index or average should limit burdens on physician practices; and
 - e. Any data used to determine an international price index or average to guide prescription drug pricing should be updated regularly.
3. Our AMA supports the use of contingent exclusivity periods for pharmaceuticals, which would tie the length of the exclusivity period of the drug product to its cost-effectiveness at its list price at the time of market introduction.
- CMS Rep. 4, I-19; Reaffirmed: CMS Rep. 3, I-20

Insulin Affordability H-110.984

Our AMA will: (1) encourage the Federal Trade Commission (FTC) and the Department of Justice to monitor insulin pricing and market competition and take enforcement actions as appropriate; and (2) support initiatives, including those by national medical specialty societies, that provide physician education regarding the cost-effectiveness of insulin therapies.

CMS Rep. 07, A-18

Pharmaceutical Costs H-110.987

1. Our AMA encourages Federal Trade Commission (FTC) actions to limit anticompetitive behavior by pharmaceutical companies attempting to reduce competition from generic manufacturers through manipulation of patent protections and abuse of regulatory exclusivity incentives.
2. Our AMA encourages Congress, the FTC and the Department of Health and Human Services to monitor and evaluate the utilization and impact of controlled distribution channels for prescription pharmaceuticals on patient access and market competition.
3. Our AMA will monitor the impact of mergers and acquisitions in the pharmaceutical industry.
4. Our AMA will continue to monitor and support an appropriate balance between incentives based on appropriate safeguards for innovation on the one hand and efforts to reduce regulatory and statutory barriers to competition as part of the patent system.
5. Our AMA encourages prescription drug price and cost transparency among pharmaceutical companies, pharmacy benefit managers and health insurance companies.
6. Our AMA supports legislation to require generic drug manufacturers to pay an additional rebate to state Medicaid programs if the price of a generic drug rises faster than inflation.
7. Our AMA supports legislation to shorten the exclusivity period for biologics.
8. Our AMA will convene a task force of appropriate AMA Councils, state medical societies and national medical specialty societies to develop principles to guide advocacy and grassroots efforts aimed at addressing pharmaceutical costs and improving patient access and adherence to medically necessary prescription drug regimens.
9. Our AMA will generate an advocacy campaign to engage physicians and patients in local and national advocacy initiatives that bring attention to the rising price of prescription drugs and help to put forward solutions to make prescription drugs more affordable for all patients.
10. Our AMA supports: (a) drug price transparency legislation that requires pharmaceutical manufacturers to provide public notice before increasing the price of any drug (generic, brand, or specialty) by 10% or more each year or per course of treatment and provide justification for the price increase; (b) legislation that authorizes the Attorney General and/or the Federal Trade Commission to take legal action to address price gouging by pharmaceutical manufacturers and

increase access to affordable drugs for patients; and (c) the expedited review of generic drug applications and prioritizing review of such applications when there is a drug shortage, no available comparable generic drug, or a price increase of 10% or more each year or per course of treatment.

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

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

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

CMS Rep. 2, I-15; Reaffirmed in lieu of: Res. 817, I-16; Appended: Res. 201, A-17; Reaffirmed in lieu of: Res. 207, A-17; Modified: Speakers Rep. 01, A-17; Appended: Alt. Res. 806, I-17; Reaffirmed: BOT Rep. 14, A-18; Appended: CMS Rep. 07, A-18; Appended: BOT Rep. 14, A-19; Reaffirmed: Res. 105, A-19

Controlling the Skyrocketing Costs of Generic Prescription Drugs H-110.988

1. Our American Medical Association will work collaboratively with relevant federal and state agencies, policymakers and key stakeholders (e.g., the U.S. Food and Drug Administration, the U.S. Federal Trade Commission, and the Generic Pharmaceutical Association) to identify and promote adoption of policies to address the already high and escalating costs of generic prescription drugs.

2. Our AMA will advocate with interested parties to support legislation to ensure fair and appropriate pricing of generic medications, and educate Congress about the adverse impact of generic prescription drug price increases on the health of our patients.

3. Our AMA encourages the development of methods that increase choice and competition in the development and pricing of generic prescription drugs.

4. Our AMA supports measures that increase price transparency for generic prescription drugs.

Sub. Res. 106, A-15; Reaffirmed: CMS 2, I-15; Reaffirmed in lieu of: Res. 2017, A-17;

Reaffirmed: BOT Rep. 14, A-18

Cost of Prescription Drugs H-110.997

Our AMA:

(1) Consistent with AMA Policy H-165.925, supports coverage of prescription drugs, including insulin, in the AMA standard benefits package.

(2) Supports consumer choice of at least two options for their pharmaceutical benefits program.

This must include a fee-for-service option where restrictions on patient access and physician autonomy to prescribe any FDA-approved medication are prohibited.

(3) Reaffirms AMA Policy H-110.997, supporting the freedom of physicians to use either generic or brand name pharmaceuticals in prescribing drugs for their patients and encourage physicians to supplement medical judgments with cost considerations in making these choices.

(4) Supports a managed pharmaceutical benefits option with market-driven mechanisms to control costs, provided cost control strategies satisfy AMA criteria defined in AMA Policy H-110.997 and that drug formulary systems employed are consistent with standards defined in AMA Policy H-125.991.

(5) Supports prospective and retrospective drug utilization review (DUR) as a quality assurance component of pharmaceutical benefits programs, provided the DUR program is consistent with Principles of Drug Use Review defined in AMA Policy H-120.978.

(6a) Encourages physicians to counsel their patients about their prescription medicines and when appropriate, to supplement with written information; and supports the physician's role as the "learned intermediary" about prescription drugs.

(6b) Encourages physicians to incorporate medication reviews, including discussions about drug interactions and side effects, as part of routine office-based practice, which may include the use of medication cards to facilitate this process. Medication cards should be regarded as a supplement, and not a replacement, for other information provided by the physician to the patient via oral counseling and, as appropriate, other written information.

(7) Reaffirms AMA Policy H-120.991, supporting the voluntary time-honored practice of physicians providing drug samples to selected patients at no charge, and to oppose legislation or regulation whose intent is to ban drug sampling.

(8) Supports CEJA's opinion that physicians have an ethical obligation to report adverse drug or device events; supports the FDA's MedWatch voluntary adverse event reporting program; and supports FDA efforts to prevent public disclosure of patient and reporter identities.

(9) Opposes legislation that would mandate reporting of adverse drug and device events by physicians that would result in public disclosure of patient or reporter identities.

(10) Reaffirms AMA Policy H-120.988, supporting physician prescribing of FDA-approved drugs for unlabeled indications when such use is based upon sound scientific evidence and sound medical opinion, and supporting third party payer reimbursement for drugs prescribed for medically accepted unlabeled uses.

(11) Reaffirms AMA Policy H-100.989, supporting the present classification of drugs as either prescription or over-the-counter items and opposing the establishment of a pharmacist-only third (transitional) class of drugs..

BOT Rep. O, A-90; Sub. Res. 126 and Sub. Res. 503, A-95; Reaffirmed: Res. 502, A-98; Reaffirmed: Res. 520, A-99; Reaffirmed: CMS Rep. 9, I-99; Reaffirmed: CMS Rep. 3, I-00; Reaffirmed: Res. 707, I-02; Reaffirmation: A-04; Reaffirmed: CMS Rep. 3, I-04; Reaffirmation: A-06; Reaffirmed in lieu of Res. 814, I-09; Reaffirmed in lieu of Res. 201, I-11; Reaffirmed in lieu of Res. 207, A-17; Reaffirmed: BOT Rep. 14, A-18; Modified: CMS Rep. 1, A-21

Reducing Prescription Drug Prices D-110.993

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

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

Prescription Drug Prices and Medicare D-330.954

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

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

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

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

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 111
(N-21)

Introduced by: Medical Student Section

Subject: Addressing Healthcare Accessibility for Current and Aged-Out Youth in the Foster Care System

Referred to: Reference Committee A

1 Whereas, More than 33% of youth entering foster care have a chronic medical condition and up
2 to 80% struggle with significant mental health conditions, requiring sophisticated long-term
3 medical attention well past the age of 18 ^{1,2}; and
4

5 Whereas, Many youths in the foster care system struggle to receive regular health care as they
6 frequently change caregivers and locations, often leading to gaps in their medical and
7 immunization records and poor long term treatment follow through ¹; and
8

9 Whereas, Nearly 20,000 children age out of the foster system each year, with the majority
10 leaving with inadequate educational, social and financial support amongst other necessities ^{3, 4};
11 and
12

13 Whereas, Around 26,000 former foster youth face significant challenges in receiving health care
14 each year ^{5, 6}; and
15

16 Whereas, People who have aged out of the foster system are at increased risk for a lifetime of
17 health problems including severe obesity, diabetes, and stroke amongst others due to adverse
18 childhood experiences⁷; and
19

20 Whereas, The Affordable Care Act requires states to provide Medicare coverage for youth who
21 have aged out of the foster care system in their state until their 26th birthday ⁸; and
22

23 Whereas, Currently, 37 states interpret the law to require Medicaid coverage for 18 to 26-year-
24 old youths who aged out of the foster care system in their own state, not any other state ^{8,9}; and
25

26 Whereas, AMA policy supports comprehensive, evidence-based care only for children currently
27 in foster care (H-60.910); therefore be it
28

29 RESOLVED, That our American Medical Association amend Policy H-60.910 by addition and
30 deletion to read as follows:
31

32 Addressing Healthcare Needs of ~~Children~~ Youth in Foster Care

33 1. Our AMA advocates for comprehensive and evidence-based care that addresses
34 the specific health care needs of youth ~~children~~ in foster care.

35 2. Our AMA advocates that all youth currently in foster care remain eligible for
36 Medicaid or other publicly funded health coverage in their state until at least 26
37 years of age. (Modify Current Policy)
38

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

Date Received: 09/30/21

AUTHORS STATEMENT OF PRIORITY

Our AMA has made great strides toward prioritizing health protections and access for vulnerable populations. Youth in or aging out of the foster care system are a particularly vulnerable population and represent a large, at-risk population needing more consistent access to care. Current AMA policy on the subject of transitions of care and foster youth is lacking, making it important to expand the reach of our AMA's advocacy efforts in this area. The vast majority of U.S. states limit coverage for those who have aged-out from the foster care system. Aged-out individuals across the nation can receive timely detection and treatment for chronic health illness and mental health problems, both of which occur at higher rates in this population.

The new language will help ensure that all aged-out foster care individuals are supported until the age of 26, regardless of residence. We urge our AMA to consider this resolution and the health of this marginalized population a priority.

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RELEVANT AMA POLICY

Addressing Healthcare Needs of Children in Foster Care H-60.910

Our AMA advocates for comprehensive and evidence-based care that addresses the specific health care needs of children in foster care.

Res. 907, I-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 112
(N-21)

Introduced by: American Thoracic Society

Subject: Expanding Coverage for and Access to Pulmonary Rehabilitation

Referred to: Reference Committee A

1 Whereas, Pulmonary Rehabilitation is defined as: “a comprehensive intervention based on a
2 thorough patient assessment followed by patient-tailored therapies that include, but are not
3 limited to, exercise training, education, and behavior change, designed to improve the physical
4 and psychological condition of people with chronic respiratory disease and to promote the long-
5 term adherence to health-enhancing behaviors (1);” and
6

7 Whereas, Pulmonary Rehabilitation has been shown to have numerous benefits for patients
8 with chronic respiratory disease, including measurable physiologic benefits, reduction in
9 symptoms of shortness of breath, psychosocial benefits, and economic benefits (2); and
10

11 Whereas, Pulmonary Rehabilitation has been shown to be effective for numerous conditions,
12 including COPD and sequelae of acute COVID-19 infection (3,4); and
13

14 Whereas, Pulmonary Rehabilitation is a cost-effective intervention with benefits to the health
15 care system in addition to individual patients (5); and
16

17 Whereas, While many physicians prescribe pulmonary rehabilitation programs for their patients
18 with a wide variety of respiratory diseases and symptoms, patients often struggle to obtain
19 insurance coverage for these services; and
20

21 Whereas, Improved insurance coverage of Pulmonary Rehabilitation programs would lead to
22 proliferation of such programs, which is difficult for many patients to find; therefore be it
23

24 RESOLVED, That our American Medical Association advocate for insurance coverage for and
25 access to pulmonary rehabilitation for any patient with chronic lung disease or chronic
26 shortness of breath. (Directive to Take Action)

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

Received: 10/13/21

AUTHORS STATEMENT OF PRIORITY

Pulmonary Rehabilitation is a critical therapeutic option for patients with chronic lung disease or chronic shortness of breath, including symptoms related to sequelae of COVID-19. Even prior to the pandemic, obtaining access and/or insurance coverage to pulmonary rehabilitation programs was difficult. However, with millions of Americans infected with COVID-19 and significant fractions of them suffering prolonged respiratory symptoms, increasing coverage and access to pulmonary rehabilitation programs has become urgent that our AMA advocate for patients struggling to breathe.

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 113
(N-21)

Introduced by: California

Subject: Supporting Medicare Drug Price Negotiation

Referred to: Reference Committee A

1 Whereas, State Legislatures, Congress, and the Centers for Medicare and Medicaid Services
2 (CMS) continue to propose and implement health care cost containment measures aimed at
3 physicians - even though physician spending is growing at a slower rate than other sectors -
4 partly because it is politically difficult to impose those reforms on the powerful pharmaceutical
5 industry; and
6

7 Whereas, Patient spending on prescription drugs has nearly doubled since the 1990s (GAO
8 2017) and physicians are concerned that patients cannot afford necessary medications that will
9 improve their health; and
10

11 Whereas, One in four patients report that they or another family member did not fill a
12 prescription in the last year because of cost. One in four patients with cancer are choosing not
13 to fill a prescription or are taking less due to cost (KFF 2018); and
14

15 Whereas, Pharmaceutical and biotechnology sales revenue increased from \$534 billion to \$775
16 billion between 2006 and 2015; 67% of drug companies increased their annual profit margins
17 during the same period—with margins up to 20 percent for some companies - while drug
18 industry spending for research and development only increased from \$82 billion in 2008 to \$89
19 billion in 2014. (GAO 2017); and
20

21 Whereas, From 2016-2020, 14 leading drug companies spent \$577 billion on stock buybacks
22 and dividends - \$56 billion more than they spent on R&D over the same period and top
23 executive compensation totaled \$3.2 billion, a 14% increase over 5 years. (US House of
24 Representatives Committee on Oversight July 2021); and
25

26 Whereas, Multiple studies, including a 2021 nonpartisan Congressional Budget Office report,
27 found that pharmaceutical company drug price hikes have little to no connection to the cost of
28 drug development or improvements in drug efficacy; and
29

30 Whereas, 80% of Americans believe prescription drugs are too expensive and 90% support
31 allowing the government to negotiate drug prices. This is because half of all adults do not fill
32 their prescriptions reliably due to the cost (June 2021 Kaiser Family Foundation poll); and
33

34 Whereas, Congress is currently debating one of the most meaningful drug bills in decades that
35 would authorize Medicare to negotiate drug prices with pharmaceutical companies to reduce
36 drug costs. The bill is limited to the most expensive drugs and it sets a price ceiling at not more
37 than 120% of the drug's volume-weighted net average price in six large western industrialized
38 nations; and

1 Whereas, The nonpartisan Congressional Budget Office (CBO) estimates that Medicare drug
2 price negotiation bill would reduce net drug prices by an average 55% for Medicare and
3 privately insured patients if it is tied to an international drug price index; and
4

5 Whereas, There are other Congressional proposals that would limit annual drug price increases
6 to the rate of inflation similar to the way other providers are paid under Medicare; and
7

8 Whereas, According to a September 2021 Harvard University-POLITICO Poll, drug price
9 negotiation is the single most important issue to American voters. “Americans support letting
10 government negotiate drug prices above all other major priorities in the infrastructure and social
11 spending packages now before Congress”; and
12

13 Whereas, Medicaid and the Veterans Administration are authorized to directly negotiate best
14 prices for drugs and according to a recent *JAMA Internal Medicine* study, the VA pays 38-50%
15 less than Medicare Part D; and
16

17 Whereas, While current AMA policy supports Medicare drug price negotiation, the policy does
18 not support basing the prices on the average international market price if single-payer countries
19 are included, and therefore, AMA has not been able to support the legislation moving through
20 Congress; and
21

22 Whereas, Physicians, hospitals, nursing homes, home health and all other providers
23 participating in the Medicare program are subject to a fee schedule but Pharma is allowed to set
24 its own prices which places more Medicare cost containment pressure on physicians; and
25

26 Whereas, U.S. physicians and patients are subject to much higher drug prices than prices paid
27 in other industrialized nations and the Medicare program, which is essentially a single-payer
28 program for seniors ages 65+, should be allowed to negotiate prices based on reasonable rates
29 paid in these other countries. Otherwise, US taxpayers are subsidizing drug costs in these other
30 countries; and
31

32 Whereas, AMA’s strong engagement and advocacy for Medicare drug price negotiation could tip
33 the scales in Congress in favor of passing meaningful drug price reforms for our patients; and
34

35 Whereas, The nonpartisan Congressional Budget Office has estimated the cost savings to the
36 Medicare program from the Medicare drug price negotiation bill to be at least \$500 billion over
37 ten years; and
38

39 Whereas, Physicians are facing nearly 10% Medicare payment cuts on January 1, 2022, the
40 MACRA program no longer provides annual payment updates, and few physicians reporting on
41 quality measures have benefitted from meaningful MACRA bonus payments while other
42 Medicare providers enjoy annual inflation updates and Pharma continues to impose high costs
43 on the Medicare program and our patients; and
44

45 Whereas, Some of the savings from enacting Medicare drug price negotiation legislation could
46 be reinvested in Medicare physician payment which currently lags at least 20% behind the costs
47 to operate a practice; therefore be it
48

49 RESOLVED, That our American Medical Association aggressively advocate for passage of
50 legislation that authorizes Medicare to negotiate drug prices with pharmaceutical companies to
51 bring down the cost of prescription drugs for our patients (Directive to Take Action); and be it
52 further

1 RESOLVED, That our AMA amend Policy H-110.980, "Additional Mechanisms to Address High
2 and Escalating Pharmaceutical Prices" to support indexing Medicare Part D drug prices to a
3 reasonable percentage of the prices paid in other large western industrialized nations by
4 addition and deletion to read as follows:

5
6 H-110.980 - Additional Mechanisms to Address High and Escalating
7 Pharmaceutical Prices

8 2. Our AMA will advocate that any use of international price indices and averages
9 in determining the price of and payment for drugs should abide by the following
10 principles:

- 11 ~~a. Any international drug price index or average should exclude countries that~~
12 ~~have single-payer health systems and use price controls;~~
13 ~~b. Any international drug price index or average should not be used to determine~~
14 ~~or set a drug's price, or determine whether a drug's price is excessive, in isolation;~~
15 a. Any international drug price index used to determine Medicare Part D drug
16 prices should be based on a reasonable percentage of the drug's volume-
17 weighted net average price in at least six large western industrialized nations;
18 e.b. The use of any international drug price index or average should preserve
19 patient access to necessary medications;
20 d.c. The use of any international drug price index or average should limit burdens
21 on physician practices; and
22 e.d. Any data used to determine an international price index or average to guide
23 prescription drug pricing should be transparent and updated regularly; and
24 e. Any international drug price index used to determine Medicare Part D drug
25 prices should ensure that American taxpayers are not unnecessarily subsidizing
26 drug costs in other large western industrialized nations. (Modify Current HOD
27 Policy); and be it further

28
29 RESOLVED, That our AMA support legislation that limits Medicare annual drug price increases
30 to the rate of inflation (New HOD Policy); and be it further

31
32 RESOLVED, That our AMA support legislation that reinvests a portion of any savings from
33 Medicare drug price negotiation into the Medicare physician fee schedule and other Medicare
34 physician value-based payments. (New HOD Policy)

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

Received: 10/13/21

AUTHORS STATEMENT OF PRIORITY

Congress is working to pass legislation before December that would allow Medicare to negotiate drug prices with pharmaceutical companies. Therefore, immediate AMA policy and action is needed. This bill would reduce the cost of the 25 most expensive drugs by 55% for our Medicare patients. Half of adults report they do not fill their prescriptions reliably because of the cost. This legislation impacts all physicians and patient health. While AMA has policy supporting Medicare drug price negotiation, the policy does not support basing prices on the average international market price (for large western industrialized countries) if single-payer countries are included, and therefore, AMA has not been able to support the legislation moving through Congress. If AMA policy is amended, AMA's strong engagement could help tip the scales in Congress to pass this bill over the powerful pharmaceutical industry's objections. If physicians don't act, the bill may not pass. It is important that the AMA act now to help bring down drug costs and improve access to affordable medications to improve our patients' health. The savings from the legislation could also be applied to stop some of the Medicare payment cuts slated for January 1, 2022.

RELEVANT AMA POLICY**Additional Mechanisms to Address High and Escalating Pharmaceutical Prices H-110.980**

1. Our AMA will advocate that the use of arbitration in determining the price of prescription drugs meet the following standards to lower the cost of prescription drugs without stifling innovation:
 - a. The arbitration process should be overseen by objective, independent entities;
 - b. The objective, independent entity overseeing arbitration should have the authority to select neutral arbitrators or an arbitration panel;
 - c. All conflicts of interest of arbitrators must be disclosed and safeguards developed to minimize actual and potential conflicts of interest to ensure that they do not undermine the integrity and legitimacy of the arbitration process;
 - d. The arbitration process should be informed by comparative effectiveness research and cost-effectiveness analysis addressing the drug in question;
 - e. The arbitration process should include the submission of a value-based price for the drug in question to inform the arbitrator's decision;
 - f. The arbitrator should be required to choose either the bid of the pharmaceutical manufacturer or the bid of the payer;
 - g. The arbitration process should be used for pharmaceuticals that have insufficient competition; have high list prices; or have experienced unjustifiable price increases;
 - h. The arbitration process should include a mechanism for either party to appeal the arbitrator's decision; and
 - i. The arbitration process should include a mechanism to revisit the arbitrator's decision due to new evidence or data.
2. Our AMA will advocate that any use of international price indices and averages in determining the price of and payment for drugs should abide by the following principles:
 - a. Any international drug price index or average should exclude countries that have single-payer health systems and use price controls;
 - b. Any international drug price index or average should not be used to determine or set a drug's price, or determine whether a drug's price is excessive, in isolation;
 - c. The use of any international drug price index or average should preserve patient access to necessary medications;
 - d. The use of any international drug price index or average should limit burdens on physician practices; and
 - e. Any data used to determine an international price index or average to guide prescription drug

pricing should be updated regularly.

3. Our AMA supports the use of contingent exclusivity periods for pharmaceuticals, which would tie the length of the exclusivity period of the drug product to its cost-effectiveness at its list price at the time of market introduction.

Citation: CMS Rep. 4, I-19; Reaffirmed: CMS Rep. 3, I-20

Prescription Drug Prices and Medicare D-330.954

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

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

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

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

Pharmaceutical Costs H-110.987

1. Our AMA encourages Federal Trade Commission (FTC) actions to limit anticompetitive behavior by pharmaceutical companies attempting to reduce competition from generic manufacturers through manipulation of patent protections and abuse of regulatory exclusivity incentives.

2. Our AMA encourages Congress, the FTC and the Department of Health and Human Services to monitor and evaluate the utilization and impact of controlled distribution channels for prescription pharmaceuticals on patient access and market competition.

3. Our AMA will monitor the impact of mergers and acquisitions in the pharmaceutical industry.

4. Our AMA will continue to monitor and support an appropriate balance between incentives based on appropriate safeguards for innovation on the one hand and efforts to reduce regulatory and statutory barriers to competition as part of the patent system.

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

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

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

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

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

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

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

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

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

Citation: CMS Rep. 2, I-15; Reaffirmed in lieu of: Res. 817, I-16; Appended: Res. 201, A-17; Reaffirmed in lieu of: Res. 207, A-17; Modified: Speakers Rep. 01, A-17; Appended: Alt. Res. 806, I-17; Reaffirmed: BOT Rep. 14, A-18; Appended: CMS Rep. 07, A-18; Appended: BOT Rep. 14, A-19; Reaffirmed: Res. 105, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 114
(N-21)

Introduced by: New Mexico

Subject: Medicare and Private Health Insurance for Hearing Aids

Referred to: Reference Committee A

1 Whereas, Hearing loss affects one in eight people in the United States (13 percent, or 30
2 million) aged 12 years or older with hearing loss in both ears, based on standard hearing
3 examinations. About 2 percent of adults aged 45 to 54 have disabling hearing loss. The rate
4 increases to 8.5 percent for adults aged 55 to 64; and

5
6 Whereas, Hearing aids are considered not a covered benefit by Medicare, Medicaid, and most
7 other payers, resulting in depriving nearly two thirds of patients who would benefit from having
8 hearing aids; and

9
10 Whereas, Hearing loss contributes to the isolation, depression, memory loss and dementia of
11 patients, all of which are major health problems; and

12
13 Whereas, Impoverished patients with hearing loss suffer from worse health disparities, because
14 of the inability to access health care by telemedicine or telephone; and

15
16 Whereas, The isolation is made worse by the COVID Pandemic; therefore be it

17
18 RESOLVED, That our American Medical Association support Congress expanding Medicare
19 Coverage for medical grade hearing aids (New HOD Policy); and be it further

20
21 RESOLVED, That our AMA advocate for coverage with minimal copays or coinsurance for
22 medical-grade hearing aids as medically necessary for all health insurance, including Medicaid.
23 (Directive to Take Action)

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

Received: 10/12/21

AUTHORS STATEMENT OF PRIORITY

The NMMS submits a single resolution for the 2021 AMA Interim Meeting.

1. Hearing loss affects one in eight people in the United States (13% or 30 million).
2. Hearing loss contributes to the isolation, depression, memory loss and dementia of patients.
3. Medical grade hearing aids are expensive at \$3000+ each.
4. HR 1118, "Medicare Hearing Aid Coverage Act of 2021" was introduced on 2/18/2021. The bill would allow Medicare coverage of hearing aids and related examinations by amending title XVIII of the Social Security Act to remove the exclusion of Medicare coverage.
5. Excerpts from the Lancet (www.thelancet.com, Vol 396, August 8, 2020) summarize the concern precisely, "increased risk of dementia per 10 dB or worsening of hearing loss... midlife hearing impairment measured by audiometry, is associated with steeper temporal lobe volume loss, including in the hippocampus and entorhinal cortex... hearing loss was only associated with worse cognition in those not using hearing aids... immediate and delayed recall deteriorated less after initiation of hearing aid use... Hearing aid use was the largest factor protecting from decline... prospective studies suggest hearing aid use is protective."

The goal of the NMMS resolution is to require Medicare, private insurance, and Medicaid to purchase for prescription, medical-grade hearing aids for patients to prevent decline in cognition, and progression into dementia, in those with hearing loss.

RELEVANT AMA POLICY

Hearing Aid Coverage H-185.929

1. Our AMA supports public and private health insurance coverage that provides all hearing-impaired infants and children access to appropriate physician-led teams and hearing services and devices, including digital hearing aids.
2. Our AMA supports hearing aid coverage for children that, at minimum, recognizes the need for replacement of hearing aids due to maturation, change in hearing ability and normal wear and tear.
3. Our AMA encourages private health plans to offer optional riders that allow their members to add hearing benefits to existing policies to offset the costs of hearing aid purchases, hearing-related exams and related services.
4. Our AMA supports coverage of hearing tests administered by a physician or physician-led team as part of Medicare's Benefit.
5. Our AMA supports policies that increase access to hearing aids and other technologies and services that alleviate hearing loss and its consequences for the elderly.
6. Our AMA encourages increased transparency and access for hearing aid technologies through itemization of audiologic service costs for hearing aids.
7. Our AMA supports the availability of over-the-counter hearing aids for the treatment of mild-to-moderate hearing loss.

Citation: CMS Rep. 6, I-15; Appended: Res. 124, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 115
(N-21)

Introduced by: Ohio

Subject: Bundled Payments and Medically Necessary Care

Referred to: Reference Committee A

1 Whereas, Medicare has bundled payments for several diagnoses including total knee
2 replacements, total hip replacement, myocardial infarction, and others where the payment
3 needs to cover all medical care for 90 days after the initial hospital stay; and
4
5 Whereas, Medicaid is starting similar programs called Episodes of Care; and
6
7 Whereas, Even unrelated events (like cataract surgery or fractured hip from a fall) that occur
8 within 90 days after the initial hospital stay must be covered by the bundled payment, and
9
10 Whereas, Some unrelated events can be very costly and cause significant spending beyond the
11 limits of the bundle which cannot be controlled by the initial physician; and
12
13 Whereas, The incentive for the physicians who are caring for the patient is to save money by
14 limiting the services the patient receives regardless of the medical needs of the patient, because
15 the money saved is returned to the physician; and
16
17 Whereas, Every patient is an individual with different responses to treatment and different
18 co-morbidities; and
19
20 Whereas, Some patients need further therapy in an Inpatient Rehabilitation Unit or Skilled
21 Nursing Facility, but are not offered those options due to cost containment; therefore be it
22
23 RESOLVED, That our American Medical Association study the issue of “Bundled Payments and
24 Medically Necessary Care” and report back to the AMA House of Delegates at 2022 Annual
25 Meeting, to make sure that our health care system is reasonable and fair to all, allows medically
26 appropriate and necessary care for our patients, and allows for fair reimbursement for
27 physicians. (Directive to Take Action)

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

Received: 10/13/21

AUTHORS STATEMENT OF PRIORITY

Medicare has bundled payments for several diagnoses including total knee replacements, total hip replacement, myocardial infarction, and others where the payment needs to cover all medical care for 90 days after the initial hospital and Medicaid is starting similar programs called Episodes of Care.

Such unrelated events can be very costly and cause significant spending beyond the limits of the bundle which cannot be controlled by the initial physician. Physicians are then encouraged to save money by limiting the services the patient receives regardless of the medical needs of the patient.

Patient impact is broad as every patient is an individual with different responses to treatment and different co-morbidities. Some patients need further therapy in an Inpatient Rehabilitation Unit or Skilled Nursing Facility, but are not offered those options due to cost containment.

We would categorize this a medium to low priority resolution based on timelines in that it is asking for a study and report back.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 116
(N-21)

Introduced by: Resident and Fellow Section

Subject: Recognizing the Need to Move Beyond Employer-Sponsored Health Insurance

Referred to: Reference Committee A

1 Whereas, Americans entering the workforce currently have from one quarter to one eighth of the
2 average job tenure as workers now aging into retirement¹; and
3
4 Whereas, Trends such as a higher average worker education level and an increasing share of
5 available jobs in industries with shorter-tenured careers are also contributing to increasing
6 worker mobility, likely more so than any generational differences¹; and
7
8 Whereas, Union membership has been in a prolonged decline, decreasing by 50% in the last 40
9 years, decreasing the collective bargaining power of today's workers to attain benefits such as
10 quality health insurance²; and
11
12 Whereas, The number of Americans that have employer-sponsored health insurance has
13 declined steadily over the past 20 years to 66% in 2014, with the greatest decline seen among
14 low- and middle-income families³; and
15
16 Whereas, Even among those workers with employer-sponsored health insurance, as many as
17 25% have out-of-pocket costs so high as to be effectively uninsured⁴; and
18
19 Whereas, In addition to being increasingly inaccessible and insufficient for workers, reliance on
20 employer-sponsored health insurance results in undesirable effects on the American worker
21 such as "job-lock" (being unable to leave a job because of reliance on its health benefits),
22 medical bankruptcy when a patient changes or loses their job while they or a family member
23 requires ongoing medical treatment, and downward pressure on wages⁵; and
24
25 Whereas, The predominance of employer-sponsored insurance arose by accident out of an
26 attempt to reduce inflation during WWII by capping wage growth with the Stabilization Act of
27 1942, and was never intended to become the principal form of health insurance in the United
28 States⁶; and
29
30 Whereas, As a result of these and other trends, reliance upon a health insurance system tied to
31 employment is becoming increasingly untenable for large portions of the United States
32 population; therefore be it
33
34 RESOLVED, That our American Medical Association recognize the importance of providing
35 avenues for affordable health insurance coverage and health care access to patients who do
36 not have employer-sponsored health insurance, or for whom employer-sponsored health
37 insurance does not meet their needs (New HOD Policy); and be it further

1 RESOLVED, That our AMA recognize that a significant and increasing proportion of patients are
2 unable to meet their health insurance or health care access needs through employer-sponsored
3 health insurance, and that these patients must be considered in the course of ongoing efforts to
4 reform the healthcare system in pursuit of universal health insurance coverage and health care
5 access. (New HOD Policy)

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

Received: 10/12/21

AUTHORS STATEMENT OF PRIORITY

This policy position would create discussion around an important weakness in our country that all patients with employer-sponsored healthcare encounter. As we face discussions with the new administration around the future of healthcare, the AMA needs to have a clear answer to whether tying insurance to employment is a requirement for our support as an organization. There is no better way for the AMA to know how to move forward in this advocacy space than to know what our members think by bringing this to the floor of the HOD before a national political fight around healthcare which many members of the Biden administration and congress incorporated into their platforms.

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RELEVANT AMA POLICY

The Future of Employer-Sponsored Insurance H-165.829

Our AMA: (1) supports requiring state and federally facilitated Small Business Health Options Program (SHOP) exchanges to maximize employee choice of health plan and allow employees to enroll in any plan offered through the SHOP; and (2) encourages the development of state waivers to develop and test different models for transforming employer-provided health insurance coverage, including giving employees a choice between employer-sponsored coverage and individual coverage offered through health insurance exchanges, and allowing employers to purchase or subsidize coverage for their employees on the individual exchanges

Citation: CMS Rep. 6, I-14

Trends in Employer-Sponsored Health Insurance H-165.843

Our AMA encourages employers to:

- a) promote greater individual choice and ownership of plans;
- b) enhance employee education regarding how to choose health plans that meet their needs;
- c) offer information and decision-making tools to assist employees in developing and managing their individual health care choices;
- d) support increased fairness and uniformity in the health insurance market; and
- e) promote mechanisms that encourage their employees to pre-fund future costs related to retiree health care and long-term care.

Citation: CMS Rep. 4, I-07; Reaffirmed CMS Rep. 1, A-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 117
(N-21)

Introduced by: Resident and Fellow Section

Subject: Implant-Associated Anaplastic Large Cell Lymphoma

Referred to: Reference Committee A

-
- 1 Whereas, In 2016, the World Health Organization provisionally classified breast implant-
2 associated anaplastic large cell lymphoma (BIA-ALCL) as a T-cell lymphoma¹; and
3
4 Whereas, Policies concerning breast cancer treatment do not encompass BIA-ALCL given that
5 this cancer is a lymphoma; and
6
7 Whereas, The 2019 National Comprehensive Cancer Care Network consensus guidelines state
8 clearly that, “Essential to the treatment of BIA-ALCL is timely diagnosis and complete surgical
9 excision.”²; and
10
11 Whereas, Patients with BIA-ALCL suffer delays in care as they fight with their insurance
12 companies to cover surgery to remove the cancer and their breast implants, as the insurance
13 company may initially classify the surgery as cosmetic and not cover it,³ therefore be it
14
15 RESOLVED, That our American Medical Association support appropriate coverage of cancer
16 diagnosis, treating surgery and other systemic treatment options for implant-associated
17 anaplastic large cell lymphoma. (New HOD Policy)

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

Received: 10/12/21

AUTHORS STATEMENT OF PRIORITY

This policy is lower priority. It will help bring the spotlight on a disease often overlooked by insurance companies making it harder for this population of patients to cover the costs of their care.

References:

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2. Mark W Clemens, MD, FACS, Eric D Jacobsen, MD, Steven M Horwitz, MD “2019 NCCN Consensus Guidelines on the Diagnosis and Treatment of Breast Implant-Associated Anaplastic Large Cell Lymphoma (BIA-ALCL).” *Aesthetic Surgery Journal*. 2019, 39 (Supplement 1):S3–S13.
3. Denise Grady. A shocking diagnosis: breast implants 'gave me cancer.' *The New York Times*. 2017 May 14. Available at: <https://www.nytimes.com/2017/05/14/health/breast-implants-cancer.html>

**RELEVANT AMA POLICY
Breast Implants H-525.984**

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

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

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 118
(N-21)

Introduced by: Texas

Subject: Expanding Site-of-Service Neutrality

Referred to: Reference Committee A

1 Whereas, Site-of-service differential (also known as site-of-service neutrality) is a payment
2 policy issue stemming from the Medicare program's use of separate payment systems in its
3 rate-setting calculations; and
4

5 Whereas, Site-of-service differential policies support higher payment in the hospital outpatient
6 department (HOPD) setting, which results in a shift in the delivery of certain services from
7 community-based physician practices to the HOPD, resulting in increased costs to patients,
8 employers, and taxpayers; and
9

10 Whereas, Over a three-year period, Medicare paid an additional \$2.7 billion on services, and
11 patients spent \$411 million more out of pocket when certain services were delivered in a
12 hospital-owned setting; and
13

14 Whereas, A 2021 study found that employers and workers would collectively save \$14.1 billion
15 annually if price differentials between HOPDs and physician offices were eliminated for all
16 physician-administered outpatient drugs; and
17

18 Whereas, Site-of-service differential policies that support higher payment in the HOPD setting
19 also encourage the acquisition of office-based physician practices, further restricting patient
20 access to care in the lower-cost community setting; and
21

22 Whereas, Studies show that when care is initiated in the typically higher-paying HOPD setting,
23 the services that follow also result in higher spending relative to when care is initiated in the
24 office setting; and
25

26 Whereas, By passage of site-neutral payment provisions in the Bipartisan Budget Act of 2015,
27 Congress recognized the negative consequences this policy has on patients, employers, and
28 taxpayers; and
29

30 Whereas, Medicare should pay the same fee, adjusted for geographic differences in market
31 conditions and business costs, for the same service regardless of the setting where it is
32 performed; therefore be it
33

34 RESOLVED, That our American Medical Association continue to support Medicare payment
35 policies for outpatient services that are site-neutral without lowering total Medicare payments
36 (Directive to Take Action); and be it further
37

38 RESOLVED, That our AMA pursue and support passage of legislation and agency policies that
39 expand site-neutral payment to equalize payments across sites of service for all outpatient
40 services (Directive to Take Action); and be it further

- 1 RESOLVED, That our AMA pursue policy that creates patient incentives for services to be
- 2 performed in the most cost-effective location, such as a physician's office.(Directive to Take
- 3 Action)

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

Received: 10/13/21

AUTHORS STATEMENT OF PRIORITY

Fortifying AMA policy to call for the expansion of site-of-service neutrality payment policies affects all physician specialties, their patients, as well as taxpayers.

Since facilities are acquiring independent practices at alarming rates, it is important for the AMA to act upon this policy at this meeting.

Preservation of independent physician practices fits squarely within the AMA mission and strategic plan.

Immediate action on this resolution should be pursued to help address unnecessarily high patient copays for services received in higher cost settings.

Though AMA has some policy in this area, the expansion of site neutral payment policies should be pursued to equalize payments across sites of service for all outpatient services. The adoption of policy that creates patient incentives for services to be performed in the most cost-effective location, such as a physician's office, would help support the independent practice of medicine.

AMA action on this policy will be positive for physicians, their patients, and taxpayers, and the AMA is most appropriate organization to tackle this issue.