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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (N-21)

Report of Reference Committee A

Peter C. Amadio, MD, Chair

Your Reference Committee recommends the following consent calendar for acceptance:

RECOMMENDED FOR ADOPTION

1. Council on Medical Service Report 5 – Integrating Care for Individuals Dually Eligible for Medicare and Medicaid

RECOMMENDED FOR ADOPTION AS AMENDED OR SUBSTITUTED

2. Council on Medical Service Report 1 – End-of-Life Care
3. Council on Medical Service Report 3 – Covering the Remaining Uninsured
4. Resolution 101 – Standardized Coding for Telehealth Services
5. Resolution 113 – Supporting Medicare Drug Price Negotiation

Amendments
If you wish to propose an amendment to an item of business, click here: Submit New Amendment

RECOMMENDED FOR ADOPTION

(1) COUNCIL ON MEDICAL SERVICE REPORT 5 – INTEGRATING CARE FOR INDIVIDUALS DUALLY ELIGIBLE FOR MEDICARE AND MEDICAID

RECOMMENDATION:

Recommendations in Council on Medical Service Report 5 be adopted and the remainder of the Report be filed.

HOD ACTION: Recommendations in Council on Medical Service Report 5 adopted and the remainder of the Report filed.

1. That our American Medical Association (AMA) support integrated care for individuals dually eligible for Medicare and Medicaid that aligns with AMA policy and meets the following criteria:

a. Care is grounded in the diversity of dually eligible enrollees and services are tailored to individuals' needs and preferences.
b. Coverage of medical, behavioral health, and long-term services and supports is aligned.
c. Medicare and Medicaid eligibility and enrollment processes are simplified, with enrollment assistance made available as needed.
d. Enrollee choice of plan and physician is honored, allowing existing patient-physician relationships to be maintained.
e. Services are easy to navigate and access, including in rural areas.
f. Care coordination is prioritized, with quality case management available as appropriate.
g. Barriers to access, including inadequate networks of physicians and other providers and prior authorizations, are minimized.
h. Administrative burdens on patients, physicians and other providers are minimized.
i. Educational materials are easy to read and emphasize that the ability and power to opt in or out of integrated care resides solely with the patient.
j. Physician participation in Medicare or Medicaid is not mandated nor are eligible physicians denied participation. (New HOD Policy)

2. That our AMA reaffirm Policy H-290.967, which establishes principles on the delivery of care and financing reform for Medicare and Medicaid dually eligible patients. (Reaffirm HOD Policy)

3. That our AMA reaffirm Policy D-290.978, which calls on the Centers for Medicare & Medicaid Services to require all states to develop processes to facilitate opting out of managed care programs by dual eligible individuals. (Reaffirm HOD Policy)

4. That our AMA reaffirm Policy H-165.822, which encourages new and continued partnerships to address non-medical health needs and the underlying social determinants of health; supports continued efforts by public and private health plans to address social determinants of health in health insurance benefit designs; and encourages public and private health plans to examine implicit bias and the role of racism and social determinants of health. (Reaffirm HOD Policy)

5. That our AMA reaffirm Policy H-180.944, which states that health equity, defined as optimal health for all, is a goal toward which our AMA will work by advocating for health services, research and data collection; promoting equity in care; increasing health workforce diversity; influencing social determinants of health; and voicing and modeling commitment to health equity. (Reaffirm HOD Policy)

There was supportive testimony on Council on Medical Service Report 5. A member of the Council on Medical Service emphasized that integrated care that abides by the criteria outlined in Recommendation 1 can improve care and life quality for individuals dually eligible for Medicare and Medicaid. Speakers highlighted the complex health needs of many dually eligible people as well as the disproportionate impact of COVID-19. Testimony also supported the report recommendations' focus on reducing barriers to care, preserving patient choice, and ensuring adequate access to care in rural areas.

Your Reference Committee agrees with testimony offered against a proffered amendment to add "evidence-based" to Recommendation 1(b) because this amendment could allow payers to deny coverage of necessary and appropriate services for dually eligible enrollees. Accordingly, your Reference Committee believes that the recommendations of Council on Medical Service Report 5 should be adopted.

RECOMMENDED FOR ADOPTION AS AMENDED

(2) COUNCIL ON MEDICAL SERVICE REPORT 1 – END-OF-LIFE CARE

RECOMMENDATION A:

Recommendation 3 in Council on Medical Service Report 1 be <u>amended by addition</u> to read as follows:

3. That our AMA support increased access to <u>comprehensive interdisciplinary</u> palliative care services by Medicare patients in skilled nursing facilities. (New HOD Policy)

RECOMMENDATION B:

Recommendations in Council on Medical Service Report 1 be <u>adopted as amended</u> and the remainder of the report be <u>filed</u>.

HOD ACTION: Recommendations in Council on Medical Service Report 1 <u>adopted as amended</u> and the remainder of the report <u>filed</u>.

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

1. That our American Medical Association (AMA) support Medicare coverage of and appropriate payment for supportive care services, including assistance with activities of daily living, as needed, under Medicare's hospice benefit. (New HOD Policy)

2. That our AMA support study and pilot testing by the Centers for Medicare & Medicaid Services of care models that allow concurrent use of Medicare's hospice and skilled nursing facility (SNF) benefits for the same condition. (New HOD Policy)

3. That our AMA support increased access to palliative care services by Medicare patients in skilled nursing facilities. (New HOD Policy)

4. That our AMA reaffirm Policy H-85.966, which maintains that hospice care should provide the patient and family with appropriate physical and emotional support, but not preclude the use of appropriate palliative therapies to continue to treat underlying disease. (Reaffirm HOD Policy)

5. That our AMA reaffirm Policy H-70.915, which recognizes the importance of palliative care, encourages the education of health professionals and the public in caring for dying patients, and supports improved payment for health care practices that are important to good care of the dying patient. (Reaffirm HOD Policy)

There was testimony that was supportive of Council on Medical Service Report 1. A member of the Council on Medical Service introduced the report by highlighting the challenges of trying to find placements for terminally ill patients in need of custodial care. The Council member stated that the provision of supportive services, as determined by patient need, may improve quality of life and prevent utilization of higher-cost care.

Speakers supported the report recommendations' focus on helping patients at the end of their lives who, under current Medicare rules, cannot enroll in Medicare's skilled nursing and hospice benefits at the same time for the same condition. Your Reference Committee believes an amendment proffered in the online member forum strengthens Recommendation 3 by aligning that recommendation with clinical practice guidelines for palliative care. Therefore, your Reference Committee believes that the recommendations of Council on Medical Service Report 1 should be adopted as amended.

(3) COUNCIL ON MEDICAL SERVICE REPORT 3 – COVERING THE REMAINING UNINSURED

RECOMMENDATION A:

Recommendation 3 in Council on Medical Service Report 3 be <u>amended by deletion</u> to read as follows:

3. That our AMA support extending eligibility to purchase ~~unsubsidized~~ Affordable Care Act (ACA) marketplace coverage to undocumented immigrants and Deferred Action for Childhood Arrivals (DACA) recipients, with the guarantee that health plans and ACA marketplaces will not collect and/or report data regarding enrollee immigration status. (New HOD Policy)

RECOMMENDATION B:

Recommendations in Council on Medical Service Report 3 be <u>adopted as amended</u> and the remainder of the Report be <u>filed</u>.

HOD ACTION: Recommendations in Council on Medical Service Report 3 <u>adopted as amended</u> and the remainder of the Report <u>filed</u>.

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

1. That our American Medical Association (AMA) advocate that any federal approach to cover uninsured individuals who fall into the "coverage gap" in states that do not expand Medicaid–having incomes above Medicaid eligibility limits but below the federal poverty level, which is the lower limit for premium tax credit eligibility–make health insurance

coverage available to uninsured individuals who fall into the coverage gap at no or nominal cost, with significant cost-sharing protections. (New HOD Policy)

2. That our AMA advocate that any federal approach to cover uninsured individuals who fall into the coverage gap provide states that have already implemented Medicaid expansions with additional incentives to maintain their expansions. (New HOD Policy)

3. That our AMA support extending eligibility to purchase unsubsidized Affordable Care Act (ACA) marketplace coverage to undocumented immigrants and Deferred Action for Childhood Arrivals (DACA) recipients, with the guarantee that health plans and ACA marketplaces will not collect and/or report data regarding enrollee immigration status. (New HOD Policy)

4. That our AMA recognize the potential for state and local initiatives to provide coverage to immigrants without regard to immigration status. (New HOD Policy)

5. That our AMA reaffirm Policy H-290.983, which opposes federal and state legislation denying or restricting lawfully present immigrants Medicaid and immunizations. (Reaffirm HOD Policy)

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

a. Our AMA supports modifying the eligibility criteria for premium credits and cost-sharing subsidies for those offered employer-sponsored coverage by lowering the threshold that determines whether an employee's premium contribution is affordable to ~~that which applies to the exemption from the individual mandate of~~ the level at which premiums are capped for individuals with the highest incomes eligible for subsidized coverage in Affordable Care Act (ACA) marketplaces.
b. Our AMA supports legislation or regulation, whichever is relevant, to fix the ACA's "family glitch," thus determining the eligibility of family members of workers for premium tax credits and cost-sharing reductions based on the affordability of family employer-sponsored coverage ~~with respect to the cost of family-based or employee-only coverage~~ and household income. … (Modify Current HOD Policy)

7. That our AMA reaffirm Policy D-290.979, which states that our AMA will work with state and specialty medical societies in advocating at the state level in support of Medicaid expansion. (Reaffirm HOD Policy)

8. That our AMA reaffirm Policy H-290.965, which supports states that newly expand Medicaid being made eligible for three years of full federal funding. (Reaffirm HOD Policy)

9. That our AMA reaffirm Policy H-165.823, which supports auto-enrolling individuals in health insurance coverage if they are eligible for coverage options that would be of no cost to them after the application of any subsidies, including zero-premium marketplace coverage and Medicaid/Children's Health Insurance Program (CHIP); and outlines standards that any public option to expand health insurance coverage must meet. (Reaffirm HOD Policy)

10. That our AMA reaffirm Policy H-165.838, which states that insurance coverage options offered in a health insurance exchange should be self-supporting, have uniform solvency requirements; not receive special advantages from government subsidies; include payment rates established through meaningful negotiations and contracts; not require provider participation; and not restrict enrollees' access to out-of-network physicians. (Reaffirm HOD Policy)

11. That our AMA reaffirm Policy H-165.824, which supports: (1) adequate funding for and expansion of outreach efforts to increase public awareness of advance premium tax credits; (2) providing young adults with enhanced premium tax credits while maintaining the current premium tax credit structure which is inversely related to income; (3) state innovation, including considering state-level individual mandates, auto-enrollment and/or reinsurance, to maximize the number of individuals covered and stabilize health insurance premiums without undercutting any existing patient protections; (4) eliminating the subsidy “cliff,” thereby expanding eligibility for premium tax credits beyond 400 percent of the federal poverty level (FPL); (5) increasing the generosity of premium tax credits; (6) expanding eligibility for cost-sharing reductions; and (7) increasing the size of cost-sharing reductions. (Reaffirm HOD Policy)

12. That our AMA reaffirm Policies H-290.976, H-290.971, H-290.982 and D-290.982, which support investments in Medicaid/CHIP outreach and enrollment assistance activities. (Reaffirm HOD Policy)

13. That our AMA reaffirm Policy H-165.848, which supports a requirement that individuals and families earning greater than 500 percent FPL obtain, at a minimum, coverage for catastrophic health care and evidence-based preventive health care, using the tax structure to achieve compliance. (Reaffirm HOD Policy)

14. That our AMA rescind Policy H-290.966, as it is superseded by Policy H-165.823 as well as the recommendations of this report. (Rescind HOD Policy)

15. That our AMA reaffirm Policy H-330.896, which supports restructuring Medicare age-eligibility requirements and incentives to match the Social Security schedule of benefits. (Reaffirm HOD Policy)

There was generally supportive testimony on Council on Medical Service Report 3. Your Reference Committee appreciates all of the testimony provided on the online member forum and during the live hearing, and all of the amendments proffered, on the recommendations of Council on Medical Service Report 3. Your Reference Committee underscores that our AMA establishing new policy addressing the uninsured who are ineligible for ACA financial assistance due to falling into the coverage gap, immigration status, or having an affordable offer of employer coverage is critical to expanding the coverage reach of our AMA proposal for reform, as well as achieving the Association’s longstanding goal of covering the uninsured.

In introducing the report, a member of the Council on Medical Service underscored that in assessing the options available to cover the uninsured ages 60 to 64, the AMA plan to cover the uninsured, as well as the recommendations of this report, are preferable to other options, including lowering the Medicare eligibility age to 60. The Council member noted that, of the roughly 1.6 million uninsured ages 60 to 64, nearly half are eligible for

premium tax credits. Further, nearly 20 percent are eligible for Medicaid, 15 percent are ineligible for ACA financial assistance due to having an affordable offer of employer coverage, 10 percent fall in the coverage gap and seven percent are ineligible for ACA financial assistance due to immigration status. As such, covering most of the uninsured in this age group could be accomplished without causing health system disruptions associated with lowering the Medicare eligibility age to 60 – including potentially shifting nearly 12 million individuals with employer coverage and 2.4 million with non-group coverage into Medicare.

Your Reference Committee appreciates testimony provided that outlined that lowering the Medicare eligibility age not only addresses covering the uninsured ages 60 to 64, but also is critical to addressing underinsurance in this age group, as well as promoting health equity. However, your Reference Committee notes that lowering the Medicare eligibility age to 60 would eliminate subsidized marketplace coverage eligibility for individuals ages 60 to 64. This restriction in health plan choice would hit those with the lowest incomes the hardest. In light of the premium tax credit enhancements included in the American Rescue Plan, lower-income individuals currently enrolled in a marketplace plan may face higher premiums in traditional Medicare. As outlined in the Council report, Avalere found that current marketplace subsidies are consistently more generous for lower-income individuals than the subsidies available to Medicare beneficiaries.

Addressing underinsurance, most current traditional Medicare beneficiaries are enrolled in supplemental insurance through either a Medicare supplemental plan, Medicaid, or an employer to provide more comprehensive cost-sharing protections than what is offered in the traditional Medicare program. The sheer need for supplemental insurance shows that Medicare coverage by itself leaves many beneficiaries underinsured. As such, your Reference Committee agrees with the Council on Medical Service and does not accept the proposed amendment to the recommendations of the report to lower the Medicare eligibility age to 60.

Your Reference Committee did accept the amendment to remove “unsubsidized” from the third recommendation of the report. Of note, the amendment to remove “unsubsidized” did not replace it with “subsidized.” Your Reference Committee agrees with testimony that this amendment proffered to the third recommendation of the report would provide the AMA with additional flexibility in its advocacy efforts to expand eligibility for marketplace coverage to undocumented immigrants and Deferred Action for Childhood Arrivals (DACA) recipients (Dreamers), who currently are shut out from marketplace coverage, even if they pay the full cost. Your Reference Committee also notes that this flexibility of language may be important if the immigration status of Dreamers changes in the near future. There was a call to refer the third and fourth recommendations of the report, which would be new HOD policy. Your Reference Committee does not support referral, as providing a key pathway to coverage to the undocumented immigrant population is in line with our AMA’s pursuit of health equity, as well as testimony stressing the need for this population to seek preventive care versus relying on emergency care.

There were also amendments offered to Recommendation 6(b) of the report addressing the ACA’s “family glitch.” A member of the Council on Medical Service clarified that this recommendation of the report does not preclude the AMA from supporting the solution to the family glitch that makes a change so that if family coverage offered through an

employer is unaffordable, the worker and their family would become eligible for ACA premium tax credits to purchase marketplace coverage. It would, however, enable the AMA to support an additional solution to the glitch that can arguably be addressed through administrative action, which would in effect decouple the worker from their family in determining eligibility for premium tax credits to purchase coverage. As such, a spouse and/or child in a family offered "affordable" employee-only coverage but unaffordable family coverage would become eligible for premium subsidies to purchase marketplace coverage. But, the worker would remain enrolled in the employer plan. Your Reference Committee agrees with the assessment of the Council on Medical Service, as Recommendation 6(b) would enable the AMA to support determining the eligibility of family members of workers for premium tax credits and cost-sharing reductions based on the affordability of family employer-sponsored coverage – regardless of whether the worker remains covered by the employer plan or becomes eligible for subsidies for marketplace coverage as well.

Your Reference Committee believes that the recommendations of Council on Medical Service Report 3 should be adopted as amended, serving as a critical next step to cover the remaining uninsured. Your Reference Committee agrees with the member of the Council on Legislation that the recommendations of the report are especially timely, given congressional consideration of the Build Back Better Act.

RECOMMENDED FOR ADOPTION IN LIEU OF

(4) RESOLUTION 101 – STANDARDIZED CODING FOR TELEHEALTH SERVICES

RECOMMENDATION:

Alternate Resolution 101 be adopted in lieu of Resolution 101.

RESOLVED, That our American Medical Association support legislation, regulation and/or outreach, whichever is relevant, to ensure that public and private payors utilize one consistent set of reporting and coding rules to identify telehealth services in claims. (Directive to Take Action)

HOD ACTION: Alternate Resolution 101 referred for decision.

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

Your Reference Committee heard mixed testimony on Resolution 101. There was consensus, however, on the need for administrative simplification of the various methods to report and code telehealth services that were used and modified as payors coped with the demands created by the COVID-19 pandemic. Testimony highlighted experiences with administrative burdens and denied claims in this space. However, concerns were raised with the original and alternate resolution language submitted by the sponsor of Resolution 101. A member of the Council on Medical Service stated that, while having consistency in reporting and coding rules to identify telehealth services in claims is important, being overly prescriptive would undermine our advocacy in this arena.

A member of the RVS Update Committee (RUC) and AMA Digital Medicine Payment Advisory Group, who introduced the alternate resolution language proposed by the Reference Committee on behalf of his delegation, testified that a Place of Service (POS) 02 is not necessarily the optimal choice as it is specific to Medicare telehealth policies that are being waived due to the public health emergency. In fact, today, use of 02 in Medicare results in lower payment than the use of the POS code where the patient is normally seen with use of CPT® modifier 95. Additional speakers raised concerns with the consequence of original Resolution 101 in immediately decreasing physician payment for telehealth services. As such, your Reference Committee recommends that Alternate Resolution 101 be adopted in lieu of Resolution 101.

(5) RESOLUTION 113 – SUPPORTING MEDICARE DRUG PRICE NEGOTIATION

RECOMMENDATION:

Alternate Resolution 113 be adopted in lieu of Resolution 113.

RESOLVED, That our American Medical Association reaffirm Policy D-330.954, which states that our AMA will (1) 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) work toward eliminating Medicare prohibition on drug price negotiation, and (3) prioritize its support for the Centers for Medicare & Medicaid Services to negotiate pharmaceutical pricing for all applicable medications covered by CMS (Reaffirm HOD Policy); and be it further

RESOLVED, That our AMA reaffirm Policy H-110.980, which outlines principles guiding the use of international price indices and averages in determining the price of and payment for drugs, including those covered in Medicare Parts B and D (Reaffirm HOD Policy); and be it further

RESOLVED, That our AMA support legislation that limits Medicare annual drug price increases to the rate of inflation. (New HOD Policy)

HOD ACTION: Resolves 1 and 3 of Alternate Resolution 113 adopted in lieu of Resolution 113, with Resolve 2 and proffered amendment referred.

Adopted Resolves 1 and 3:

RESOLVED, That our American Medical Association reaffirm Policy D-330.954, which states that our AMA will (1) 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) work toward eliminating Medicare prohibition on drug price negotiation, and (3) prioritize its support for the Centers for Medicare & Medicaid Services to negotiate pharmaceutical pricing for all applicable medications covered by CMS (Reaffirm HOD Policy); and be it further

RESOLVED, That our AMA support legislation that limits Medicare annual drug price increases to the rate of inflation. (New HOD Policy)

Resolve 2 of Alternate Resolution 113 and proffered amendment that was referred:

Resolve 2: RESOLVED, That our AMA reaffirm Policy H-110.980, which outlines principles guiding the use of international price indices and averages in determining the price of and payment for drugs, including those covered in Medicare Parts B and D (Reaffirm HOD Policy); and be it further

Amendment: Amend Alternate Resolution 113 by addition and deletion as follows:

~~**RESOLVED, That our AMA reaffirm Policy H-110.980, which outlines principles guiding the use of international price indices and averages in determining the price of and payment for drugs, including those covered in Medicare Parts B and D (Reaffirm HOD Policy); and be it further**~~

RESOLVED, That our AMA will advocate for Medicare drug price negotiation to reduce prices paid by Medicare for medications in Part B and Part D and physician acquisition costs for medications in Part B.

Amend Policy H-110.980, "Additional Mechanisms to Address High and Escalating Pharmaceutical Prices," by addition and deletion to read as follows:

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;**~~

a. Any international drug price index used to determine Medicare Part D drug prices should be based on a reasonable percentage of the drug's volume weighted net average price in at least six large western industrialized nations;

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

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

H-110.980 - Additional Mechanisms to Address High and Escalating Pharmaceutical Prices
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;~~
a. Any international drug price index used to determine Medicare Part D drug prices should be based on a reasonable percentage of the drug's volume-weighted net average price in at least six large western industrialized nations;
~~c.~~b. The use of any international drug price index or average should preserve patient access to necessary medications;
~~d.~~c. The use of any international drug price index or average should limit burdens on physician practices; and
~~e.~~d. Any data used to determine an international price index or average to guide prescription drug pricing should be transparent and updated regularly~~.~~; and
e. Any international drug price index used to determine Medicare Part D drug prices should ensure that American taxpayers are not unnecessarily subsidizing drug costs in other large western industrialized nations. (Modify Current HOD Policy); and be it further

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

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

There was mixed testimony on Resolution 113. There was consensus in testimony as to the need to address high drug prices that are becoming increasingly unaffordable for our

patients, as well as enthusiasm for the momentum behind Medicare drug price negotiation in Congress. A member of the Council on Legislation testified that the first resolve of the resolution is already addressed by Policy D-330.954. Your Reference Committee agrees, and is recommending reaffirmation of the policy in lieu of the first resolve.

A member of the Council on Medical Service clarified the scope of Policy H-110.980, recommended for amendment in the second resolve of Resolution 113. The Council member noted that the scope of Policy H-110.980 goes beyond the prices of drugs in Medicare Part D; it also serves as the foundational policy guiding AMA advocacy in response to initiatives proposing international price averages pertaining to the pricing of drugs in Medicare Part B. A past president of our AMA testified that if international price averages were applied in Medicare Part B, it is not clear where said limitations on pricing would occur. Her testimony highlighted that physicians could be reimbursed at a lower amount than the purchase price of the drug, which would raise significant access concerns for our patients. Testimony of the Council on Medical Service member also raised the concern that the provisions of Policy H-110.980 suggested for deletion in the second resolve would impact our stance pertaining to Medicare Part B.

A member of the Council on Legislation noted that during the previous Administration, we saw the potential for the burden of negotiation and international index pricing in Medicare Part B to be placed on physicians. In addition, the Council member stated that the current version of the Build Back Better bill has moved away from using international pricing indices as part of Medicare drug price negotiation. In addition, qualifying Part B and Part D drugs would be subject to negotiation under the current version of the Build Back Better bill, if enacted into law. As such, the Council member questioned the need to consider the amendments to Policy H-110.980 as outlined in the second resolve of Resolution 113, considering the potential for severe unintended consequences. Accordingly, your Reference Committee recommends reaffirmation of Policy H-110.980 in lieu of the second resolve, to ensure consistency of AMA policy on the use of international price averages/indices for the pricing of drugs across health plans.

While there was generally supportive testimony on the third resolve of Resolution 113, there were questions raised by speakers as to which inflation rate would be used. Your Reference Committee notes that specifying an inflation rate may be overly prescriptive. Significantly, existing AMA policy in the drug pricing arena does not specify a specific inflation rate to be used, but there is precedent for referring to inflation generally in existing policy. Policy H-110.987 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 – a policy which has since become law. Therefore, your Reference Committee felt that the inclusion of “inflation” in the language of the third resolve was appropriate.

While concerns surrounding physician payment were raised in testimony on the fourth resolve of Resolution 113, many speakers were opposed. Testimony stressed that AMA policy historically has not dictated where savings from legislative proposals should be directed. And, such policy could preclude the AMA from supporting drug pricing proposals, even if such savings benefited physicians and physician practices in other ways, or instead were directed to our patients to help with cost-sharing, or to fund ACA improvements to cover the remaining uninsured. Finally, concerns around the optics of the fourth resolve were raised, in that the AMA could be seen as self-serving. Your

Reference Committee agrees, and did not include the fourth resolve in the alternate resolution presented, recommended to be adopted in lieu of Resolution 113.

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.

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.

Mister Speaker, this concludes the report of Reference Committee A. I would like to thank Anjalee W. Galion, MD; Barbara Hummel, MD; Rajadhar Reddy; Ezequiel Silva III, MD; Hugh Taylor, MD; Shannon Trotter, DO, and all those who testified before the Committee. I would also like to thank AMA staff: Courtney Perlino, MPP, and Jane Ascroft, MPA.

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