REPORTS OF THE COUNCIL ON MEDICAL SERVI CE

The following reports were presented by Sheila Rege, MD, Chair:

1. COUNCIL ON MEDICAL SERVICE SUNSET REVIEW OF 2014 HOUSE POLICIES

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: RECOMMENDATIONS ADOPTED
REMAINDER OF REPORT FILED

Policy G-600.110, "Sunset Mechanism for AMA Policy," calls for the decennial review of American Medical Association (AMA) policies to ensure that our AMA's policy database is current, coherent, and relevant. Policy G-600.010 reads as follows, laying out the parameters for review and specifying the procedures to follow:

1. As the House of Delegates adopts policies, a maximum ten-year time horizon shall exist. A policy will typically sunset after ten years unless action is taken by the House of Delegates to retain it. Any action of our AMA House that reaffirms or amends an existing policy position shall reset the sunset "clock," making the reaffirmed or amended policy viable for another ten years.

2. In the implementation and ongoing operation of our AMA policy sunset mechanism, the following procedures shall be followed: (a) Each year, the Speakers shall provide a list of policies that are subject to review under the policy sunset mechanism; (b) Such policies shall be assigned to the appropriate AMA councils for review; (c) Each AMA council that has been asked to review policies shall develop and submit a report to the House of Delegates identifying policies that are scheduled to sunset; (d) For each policy under review, the reviewing council can recommend one of the following actions: (i) retain the policy; (ii) sunset the policy; (iii) retain part of the policy; or (iv) reconcile the policy with more recent and like policy; (e) For each recommendation that it makes to retain a policy in any fashion, the reviewing council shall provide a succinct, but cogent justification; or (f) The Speakers shall determine the best way for the House of Delegates to handle the sunset reports.

3. Nothing in this policy shall prohibit a report to the HOD or resolution to sunset a policy earlier than its 10-year horizon if it is no longer relevant, has been superseded by a more current policy, or has been accomplished.

4. The AMA councils and the House of Delegates should conform to the following guidelines for sunset: (a) when a policy is no longer relevant or necessary; (b) when a policy or directive has been accomplished; or (c) when the policy or directive is part of an established AMA practice that is transparent to the House and codified elsewhere such as the AMA Bylaws or the AMA House of Delegates Reference Manual: Procedures, Policies and Practices.

5. The most recent policy shall be deemed to supersede contradictory past AMA policies.

6. Sunset policies will be retained in the AMA historical archives.

RECOMMENDATION

The Council on Medical Service recommends that the House of Delegates policies that are listed in the appendix to this report be acted upon in the manner indicated and the remainder of this report be filed.

APPENDIX – Recommended Actions

POLICY #	Title	Text	Recommendation
D-110.993	Reducing Prescription Drug Prices	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	Rescind. Superseded by Policy H-110.987. **Pharmaceutical Costs H-110.987**

POLICY #	Title	Text	Recommendation
		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.	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.

POLICY #	Title	Text	Recommendation
			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 ten percent 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 ten percent 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 adhdressing 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. 14. Our AMA supports legislation that limits Medicare annual drug price increases to the rate of inflation.

POLICY #	Title	Text	Recommendation
D-120.943	Review of Straddle Drug Pricing Rules for Medicare Part D Participants	Our AMA: (1) urges the Centers for Medicare and Medicaid Services (CMS) to examine how Medicare Part D plans are applying the straddle drug pricing rules and determine whether costs are being inappropriately shifted to beneficiaries whose drug spending totals span multiple coverage phases; and (2) will prepare a report explaining the straddle drug pricing rules and their potential impact on patients, incorporating information that is available from CMS regarding implementation by Part D plans.	Retain.
D-160.929	Patient Education Regarding the Medicare Chronic Care Management Fee	Our AMA will create a model letter that its members may use to explain the Medicare chronic care management fee to their patients.	Retain.
D-160.931	CMS Two Midnight Policy	Our AMA encourages the Centers for Medicare & Medicaid Services to educate the public and develop tools for physicians and patients that outline the financial impact of the two midnight policy.	Retain.
D-160.932	Medicare's Two-Midnight Rule	Our AMA will petition the Centers for Medicare & Medicaid Services to repeal the August 19 rules regarding Hospital Inpatient Admission Order and Certification.	Retain.
D-160.990	Identification of Health Care Providers	Our AMA will encourage all medical facilities to provide reliable identification of health care providers.	Retain.
D-165.937	Health System Reform Resources	Our AMA will continue to develop resources to help physician practices address the ongoing and emerging issues associated with expanding health insurance coverage under the Affordable Care Act.	Retain.
D-165.981	Transitional Issues in Moving Toward a System of Individually Selected and Owned Health Insurance	(1) Our AMA will inform individual physicians and group practice administrators why self-paying patients (e.g., those who have MSA-type coverage or are uninsured) may be at a significant price disadvantage in purchasing health care services.	Retain.
D-180.994	Rescinding Provisions Requiring Physicians to Have Hospital Admitting Privileges	Our AMA will work with the American Association of Health Plans, Health Insurance Association of America, and other appropriate organizations to rescind provisions requiring physicians to have hospital	Retain.

POLICY #	Title	Text	Recommendation
		medical staff privileges in order to participate in health plans.	
D-185.995	Health Plan Coverage of Prescription Drugs	Our AMA will: (1) advocate AMA policies related to health plan coverage of prescription drugs to pharmacy benefit managers, as well at to public and private sector payers; and (2) advocate for the enactment of legislation consistent with AMA policies related to health plan coverage of prescription drugs.	Retain.
D-230.986	Opposition to Proposed Revision of CMS Conditions of Participation that Limit the Autonomy, Self Governance and Quality Oversight of the Organized Medical Staff	1. Our AMA through appropriate means, including but not limited to a formal response during the current comment period for the proposed regulation on conditions of participation (CoP) or necessary legal action, including injunctive relief, will actively oppose any Centers for Medicare & Medicaid Services (CMS) policy that would bypass or remove the clinical quality and safety oversight, and credentialing and privileging responsibilities of the physician members of the Organized Medical Staff, or that would allow a practitioner to practice at a hospital without being a member of the medical staff. 2. Our AMA will actively educate our AMA physician members of the proposed revisions to the CoP by CMS, and the potential adverse effects of such proposals on the quality and safety of patient care, and encourage them to respond individually during the CMS comment period. 3. In the name of quality care and patient safety, our AMA will vigorously engage its members, the public, and interested stakeholders to advocate against the proposed revisions to the Medicare CoPs that would bypass or remove the clinical quality and safety oversight, and credentialing and privileging responsibilities of the physician members of the Organized Medical Staff, or that would allow a practitioner to practice at a hospital without being a member of the medical staff. 4. (a) Our AMA will update model hospital staff bylaws to address the problem of requiring board recertification to remain on staff; (b)	Retain.

POLICY #	Title	Text	Recommendation
		once our AMA develops these model hospital staff bylaw changes with regards to board recertification, they shall be made public in our AMA publications so physicians will recognize this problem of losing staff privileges that may be upon us in the near future; and (c) our AMA representatives to The Joint Commission will convey AMA Policies H-230.986 and H-230.997, which address board certification/recertification and hospital/health plan network privileges, to The Joint Commission.	
D-230.989	Reappointments to the Medical Staff	Our AMA will work with The Joint Commission to change the requirement for reappointments to medical staffs to every four years.	Retain.
D-240.993	Verbal Admission Order Signatures	Our AMA will work with the Centers for Medicare & Medicaid Services to allow authentication of verbal admission orders within 30 days, rather than prior to discharge.	Retain.
D-280.987	Analysis of Place-of-Service Code for Observation Services	Our AMA will advocate with the Centers for Medicare & Medicaid Services that the status of any observation patient who remains confined at a hospital for more than 24 hours be changed automatically to inpatient, and if they had spent a midnight in observation status, that midnight would be counted toward the three-day prior hospitalization requirement for Medicare coverage of skilled nursing facility care.	Retain.
D-280.989	Inclusion of Observation Status in Mandatory Three Day Inpatient Stay	1. Our AMA will continue to monitor problems with patient readmissions to hospitals and skilled nursing facilities and recoding of inpatient admissions as observation care and advocate for appropriate regulatory and legislative action to address these problems. 2. Our AMA will continue to advocate that the Centers for Medicare & Medicaid Services explore payment solutions to reduce the inappropriate use of hospital observation status.	Retain.
D-285.977	Excessive Telephone Wait Times for Physician Appeals of Managed Care Decisions on Patient Care	Our AMA advocates that managed care organizations be required to staff physician contact phone numbers concerning appeals for denied care sufficiently to maintain no more than a five minute average wait time.	Retain.

POLICY #	Title	Text	Recommendation
D-330.911	Generic Changes in Medicare (Part D) Plans	1. Our AMA will investigate the incidence and reasoning behind the conversion of one generic drug to another generic drug of the same class in Medicare Advantage drug plans. 2. Our AMA will request the Centers for Medicare & Medicaid Services to ensure that pharmaceutical vendors, when they do ask for generic transitions of drugs, list the drugs they believe are more cost effective along with their tier price and alternative drug names.	Retain-in-part. Rescind (1); accomplished with AMA participation in monthly CMS Medicare Part D Workgroup meetings.
D-330.921	Hospital Systems' Practices of Reclassification of Place of Service, Opting Not to Bill Medicare for Hospital and Aggressive Denial of Hospital Days in Reaction to Recovery Audits	1. Our American Medical Association will work with the Centers for Medicare & Medicaid Services, the Government Accountability Office, and other stakeholders to ensure that: (a) when hospitals make reclassifications based on screening criteria in proprietary databases, both the admitting physicians and the patient is immediately notified; (b) Recovery Audit Contractors, are precluded from making recoupments associated with "inappropriate admissions" and/or discrepancies between the hospital and physician's site of service; (c) physicians are intimately involved in the development of the data being used by proprietary databases; (d) a process is put in place whereby physicians can substitute their medical judgment for that of the software programs, and carriers and auditors will ensure that that judgment is considered and evaluated by physicians in the same state and specialty; and (e) the evidence underlying data programs and the processes being employed are completely transparent. 2. Our AMA will work with CMS to remove the requirement of linkage of Part A and Part B place of service so that admission or consultation documents that were done prior to a determination or reclassification of a place of service be recognized and not result in a rejection in claim for services.	Retain.
D-330.933	Restoring High Quality Care to the Medicare Part D	Our AMA will: a. work to eliminate prior authorizations under the Medicare Part D Prescription Drug Program which undermine a physician's best medical	Retain.

POLICY #	Title	Text	Recommendation
	Prescription Drug Program	judgment; b. work with the Centers for Medicare and Medicaid Services (CMS) to enforce the Medicare Part D Prescription Drug Program statutory requirement that all Part D plans include at least two drugs proven to be equally effective in each therapeutic category or pharmacologic class, if available, to be used by the physician in deciding the best treatment options for their patients; c. work with CMS to place reasonable copays in the Medicare Part D Prescription Drug Program; d. work with other interested parties to simplify the CMS prior authorization process such that a diagnosis or reason written on the prescription should be accepted as documentation for non-formulary request; and e. work with CMS to develop a one-page form for physicians and patients to utilize in appealing a prescription coverage denial.	
D-330.964	Update to Ambulatory Surgery Procedure List	Our American Medical Association urge the Centers for Medicare and Medicaid Services to immediately update the ambulatory surgery center list of covered procedures.	Rescind. The list of approved ASC procedures is now updated annually.
D-35.988	The Joint Commission Primary Care Home Initiative	1. Our AMA Commissioners to The Joint Commission will strongly advocate that the requirements for any primary care home or medical home initiative of The Joint Commission strictly meet the requirements of the *Joint Principles of the Patient-Centered Medical Home* and more specifically that (1) each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care and (2) that a personal physician lead a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients. The *Joint Principles of the Patient-Centered Medical Home* were developed by the American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, American Osteopathic Association and approved by the AMA. 2. Our AMA will continue to support	Rescind. Superseded by Policy H-160.919. **Principles of the Patient-Centered Medical Home H-160.919** 1. Our AMA adopts the American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians and the American Osteopathic Association "Joint Principles of the Patient-Centered Medical Home" as follows: Principles Personal Physician - Each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care. Physician Directed Medical Practice - The personal physician leads a team of individuals at the

POLICY #	Title	Text	Recommendation
		the concept of physician-led teams within the patient centered medical home (PCMH) as outlined in the Joint Principles of the Patient-Centered Medical Home. 3. Our AMA will respond to The Joint Commission's interpretation of its primary care medical home certification standards addressing non-physician-led PCMHs. 4. Our AMA will oppose any interpretation by The Joint Commission, or any other entity, of primary care medical home or patient centered medical home (PCMH) as being anything other than MD/DO physician led.	practice level who collectively take responsibility for the ongoing care of patients. Whole Person Orientation - The personal physician is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life; acute care; chronic care; preventive services; and end of life care. Care is coordinated and/or integrated across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (e.g., family, public and private community-based services). Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner. Quality and safety are hallmarks of the medical home: Practices advocate for their patients to support the attainment of optimal, patient-centered outcomes that are defined by a care planning process driven by a compassionate, robust partnership between physicians, patients, and the patient's family. Evidence-based medicine and clinical decision-support tools guide decision making. Physicians in the practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement.

POLICY #	Title	Text	Recommendation
			Patients actively participate in decision-making and feedback is sought to ensure patients' expectations are being met. Information technology is utilized appropriately to support optimal patient care, performance measurement, patient education, and enhanced communication. Practices go through a voluntary recognition process by an appropriate non-governmental entity to demonstrate that they have the capabilities to provide patient centered services consistent with the medical home model. Patients and families participate in quality improvement activities at the practice level. Enhanced access to care is available through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician, and practice staff. Payment appropriately recognizes the added value provided to patients who have a patient-centered medical home. The payment structure should be based on the following framework: It should reflect the value of physician and non-physician staff patient-centered care management work that falls outside of the face-to-face visit. It should pay for services associated with coordination of care both within a given practice and between consultants, ancillary providers, and community resources. It should support adoption and use of health information technology for quality improvement.

POLICY #	Title	Text	Recommendation
			It should support the provision of enhanced communication access such as secure e-mail and telephone consultation. It should recognize the value of physician work associated with remote monitoring of clinical data using technology. It should allow for separate fee-for-service payments for face-to-face visits. (Payments for care management services that fall outside of the face-to-face visit, as described above, should not result in a reduction in the payments for face-to-face visits). It should recognize case mix differences in the patient population being treated within the practice. It should allow physicians to share in savings from reduced hospitalizations associated with physician-guided care management in the office setting. It should allow for additional payments for achieving measurable and continuous quality improvements. 2. Our AMA supports the patient-centered medical home (as defined in Policy H-160.919) as a way to provide care to patients without restricting access to specialty care. 3. It is the policy of our AMA that medical home participation criteria allow any physician practice to qualify as a medical home, provided it can fulfill the principles of a patient-centered medical home. 4. Our AMA will work with The Joint Commission (TJC) to examine the structures of TJC-accredited medical homes and determine whether differences exist in patient satisfaction, quality, value, and patient safety, as

POLICY #	Title	Text	Recommendation
			reflected by morbidity and mortality outcomes, between physician-led (MD/DO) and non-physician-led medical homes. 5. Our AMA supports the physician-led patient-centered medical home and advocate for the public reporting/notification of the professional status (education, training, experience) of the primary care clinician who leads the primary care medical home.
D-390.954	Hospital-Based Physicians and the Value-Based Payment Modifier	Our AMA will continue to advocate that the Value-Based Payment Modifier program be repealed or significantly modified.	Rescind. The Merit-based Incentive Payment System (MIPS) under the Quality Payment Program replaced the Physician Feedback/Value-Based Payment Modifier program on January 1, 2019.
D-390.981	Medicare Payment for Services to Skilled Nursing Facility Residents in Physicians' Offices	Our AMA will: (1) inform the Centers for Medicare and Medicaid Services of the problems physicians and their patients experience as a result of the inclusion of the technical component of physicians' office-based services in the consolidated billing protocol for Medicare Skilled Nursing Facility residents; (2) urge the Centers for Medicare and Medicaid Services (CMS) to provide greater oversight of Medicare Skilled Nursing Facilities (SNFs) in meeting their obligations to pay physicians for the technical component of services those physicians provide in their offices to Medicare SNF residents; (3) advocate to Congress that it exclude from Medicare's Skilled Nursing Facility (SNF) consolidated billing protocol the technical component of medical services provided in physicians' offices to Medicare SNF residents, because of concern with the negative impact on care that could potentially occur; (4) urge the Centers for Medicare and Medicaid Services to require SNFs to clearly identify those patients who fall under the Medicare SNF consolidated billing program, as opposed to non-skilled extended care facility (ECF) patients, prior to sending patients to physicians' offices for care; and (5) communicate to physicians that in	Retain.

POLICY #	Title	Text	Recommendation
		order to assure payment whenever a SNF resident receives a service that is subject to SNF consolidated billing, the SNF and the physician are required to enter into an arrangement prior to providing services and the physician must look to the SNF for payment.	
D-390.984	Payment by Health Insurance Plans of Medicare Deductibles and Copayments	Our AMA will: (1) seek legislation to compel all insurers paying secondary to Medicare to be required to pay the deductibles and coinsurance owed after the Medicare payment is made; and (2) seek federal legislation to require that a secondary plan not manage the primary Medicare benefit by imposing limits as if it were primary.	Retain.
D-40.991	Acceptance of TRICARE Health Insurance	Our AMA: 1. Encourages state medical associations and national medical specialty societies to educate their members regarding TRICARE, including changes and improvements made to its operation, contracting processes and mechanisms for dispute resolution. 2. Encourages the TRICARE Management Activity to improve its physician education programs, including those focused on non-network physicians, to facilitate increased civilian physician participation and improved coordination of care and transfer of clinical information in the program. 3. Encourages the TRICARE Management Activity and its contractors to continue and strengthen their efforts to recruit and retain mental health and addiction service providers in TRICARE networks, which should include providing adequate reimbursement for mental health and addiction services. 4. Strongly urges the TRICARE Management Activity to implement significant increases in physician payment rates to ensure all TRICARE beneficiaries, including service members and their families, have adequate access to and choice of physicians. 5. Strongly urges the TRICARE Management Activity to alter its payment formula for vaccines for	Retain.

POLICY #	Title	Text	Recommendation
		routine childhood immunizations, so that payments for vaccines reflect the published CDC retail list price for vaccines. 6. Continues to encourage state medical associations and national medical specialty societies to respond to requests for information regarding potential TRICARE access issues so that this information can be shared with TRICARE representatives as they develop their annual access survey. 7. Continues to advocate for changes in TRICARE payment policies that will remove barriers to physician participation and support new, more effective care delivery models, including: (a) establishing a process to allow midlevel providers to receive 100 percent of the TRICARE allowable cost for services rendered while practicing as part of a physician-led health care team, consistent with state law; and (b) paying for transitional care management services, including payment of copays for services provided to TRICARE for Life beneficiaries receiving primary coverage through Medicare. 8. Continues to advocate for improvements in the communication and implementation of TRICARE coverage policies to ensure continued patient access to necessary services, including: (a) consistently approving full payment for services rendered for the diagnosis and treatment of common mental health conditions, regardless of the specialty of the treating physician; and (b) clarifying policies with respect to coverage for age appropriate doses of vaccines that have been recommended and adopted by the Advisory Committee on Immunization Practices.	
D-400.988	PLI-RVU Component of RBRVS Medicare Fee Schedule	Our AMA will: (1) continue its current activities to seek correction of the inadequate professional liability insurance component in the Resource-Based Relative Value Scale Formula; (2) continue its current activities to seek action from the Centers for Medicare & Medicaid Services to update the Professional Liability Insurance Relative Value Units (PLI-	Retain.

POLICY #	Title	Text	Recommendation
		RVU) component of the RBRVS to correctly account for the current relative cost of professional liability insurance and its funding; and (3) support federal legislation to provide additional funds for this correction and update of the PLI-RVU component of the RBRVS, rather than simply making adjustments in a budget-neutral fashion.	
D-450.961	Hospital-Based Physicians and the Value-Based Payment Modifier	Our AMA encourages national medical specialty societies to pursue the development of relevant performance measures that demonstrate improved quality and lower costs, and work with the Centers for Medicare & Medicaid Services to have those measures incorporated into the Value-Based Payment Modifier program and other quality measurement and improvement programs.	Rescind. The Merit-based Incentive Payment System (MIPS) under the Quality Payment Program replaced the Physician Feedback/Value-Based Payment Modifier program on January 1, 2019.
D-465.999	Critical Access Hospital Necessary Provider Designation	Our AMA: (1) will call on the Centers for Medicare & Medicaid Services to support individual states in their development of rural health networks; (2) opposes the elimination of the state-designated Critical Access Hospital (CAH) "necessary provider" designation; and (3) will pursue steps to require the federal government to fully fund its obligations under the Medicare Rural Hospital Flexibility Program.	Retain.
D-480.991	Access to Medical Care	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.	Retain.
D-70.965	Membership on RVS Update Committee (RUC) and CPT Coding Committee	Our AMA will request that representative societies send delegates or alternate delegates to the American Medical Association/Specialty Society Relative Value Scale Update Committee and the AMA Current Procedural Terminology Editorial Panel and Physician Advisory Committee who are currently engaged for a substantial portion of their professional activities with the practice of medicine either in active patient care or closely related activities.	Retain.

POLICY #	Title	Text	Recommendation
H-130.990	Freestanding Emergency Medical Care	(1) The AMA is concerned that the use of the term "emergency" in the title or description of a medical practice or a hospital center without maintaining specific emergency capabilities is not in the public interest since needed critical emergency service may be delayed. (2) The AMA firmly believes that the optimal provision of emergency care requires prompt physical access to the immediate resources of the hospital and that a freestanding emergency center without such access may delay definitive care of critical emergencies. (3) The AMA endorses the following criteria to aid in determining if a full range of emergency services is being offered: hours of operation, staffing and medical direction, relationship to the local emergency medical services system, ancillary service and equipment, protocols, private physician referrals, medical records, and payment for services.	Retain.
H-160.944	Defining "Observation Care"	1. The AMA will work with third party payers to establish a uniform definition of "observation care," including the following: (a) The patient should be designated as under "observation care" if the physician's intent for hospital stay is less than 24 hours. If the physician's intent and expectation is for a hospital stay of greater than 24 hours, then the stay should be considered inpatient. The use of 24 hours as a threshold for observation is a guideline. It is not unusual for observation to extend to a few hours beyond 24 hours or for patients to be admitted to inpatient status before 24 hours. (b) Patients classified as under "observation care" require hospital level-of-care. (c) The patient should be registered as under "observation care" after initial physician evaluation of the patient's signs and symptoms and appropriate testing. Post day surgical patients should be registered as under "observation care" if, after a normal recovery period, they continue to require hospital level-of-care as determined by a physician. 2. The AMA will establish policy on "observation care" and develop model	Retain.

POLICY #	Title	Text	Recommendation
		legislation to ensure that: (a) After initial approval of inpatient admission by insurers, there should be no retrospective reassignment to "observation care" status by insurers unless the original information given to insurers is incorrect. (b) Insurers should provide 60 days prior notice to providers of changes to "observation care" criteria or the application of those criteria with opportunity for comment. There should be no implementation of criteria or changes without first following these protocols. (c) Insurers' "observation care" policies should include an administrative appeal process to deal with all utilization and technical denials within a 60-day time frame for final resolution. An expedited appeal process should be available for patients in the admission process, allowing for a decision within 24 hours. (d) Insurers and HMOs should provide clearly written educational materials on "observation care" to subscribers highlighting differences between inpatient and "observation care" benefits and patient appeal procedures. 3. Our AMA will work with all appropriate governmental and non-governmental organizations to assure that both patients and physicians are treated fairly in the process of delineating the hospital admission status of patients, and to ensure that the process is transparent and administratively simple.	
H-160.983	Satellite and Commercial Medical Clinics	The AMA believes that (1) in principle, self-regulatory measures are preferable to mandatory state regulation as a mechanism to ensure quality of care in freestanding emergency and urgent care facilities; and (2) recently initiated self-regulatory programs applicable to freestanding facilities should be given ample opportunity to demonstrate their effectiveness in practice.	Retain.
H-165.829	The Future of Employer-Sponsored Insurance	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	Retain.

POLICY #	Title	Text	Recommendation
		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.	
H-165.865	Principles for Structuring a Health Insurance Tax Credit	(1) AMA support for replacement of the present exclusion from employees' taxable income of employer-provided health insurance coverage with tax credits will be guided by the following principles: (a) Tax credits should be contingent on the purchase of health insurance, so that if insurance is not purchased the credit is not provided. (b) Tax credits should be refundable. (c) The size of tax credits should be inversely related to income. (d) The size of tax credits should be large enough to ensure that health insurance is affordable for most people. (e) The size of tax credits should be capped in any given year. (f) Tax credits should be fixed dollar amounts for a given income and family structure. (g) The size of tax credits should vary with family size to mirror the pricing structure of insurance premiums. (h) Tax credits for families should be contingent on each member of the family having health insurance. (i)Tax credits should be applicable only for the purchase of health insurance, including all components of a qualified Health Savings Account, and not for out-of-pocket health expenditures. (j) Tax credits should be advanceable for low-income persons who could not afford the monthly out-of-pocket premium costs. (2) It is the policy of our AMA that in order to qualify for a tax credit for the purchase of individual health insurance, the health insurance purchased must provide coverage for hospital care, surgical and medical care, and catastrophic coverage of medical expenses as defined by Title 26 Section 9832 of the United States	Retain.

POLICY #	Title	Text	Recommendation
		Code. (3) Our AMA will support the use of tax credits, vouchers, premium subsidies or direct dollar subsidies, when designed in a manner consistent with AMA principles for structuring tax credits and when designed to enable individuals to purchase individually owned health insurance.	
H-180.951	Tax Treatment of Health Insurance: Comparing Tax Credits and Tax Deductions	Our AMA supports the use of appropriately structured and adequately funded tax credits as the most effective mechanism for enabling uninsured individuals to obtain health insurance coverage.	Retain.
H-180.953	Decreased Insurance Premiums for Nonsmokers	Our AMA: (1) encourages insurance companies to review and make public their current actuarial experience with respect to smokers and nonsmokers and to consider ways of making available to nonsmokers, at reduced rates, policies for accident, auto, life, homeowners, fire, and health insurance; and (2) supports the concept of health insurance contracts with lower premiums for nonsmokers, reflecting their decreased need for medical services and serving as a financial incentive for smokers (tobacco users) to discontinue this destructive habit.	Retain.
H-185.933	Patient Access to Penile Prosthesis as Legitimate Treatment for Erectile Dysfunction	Our AMA will work in concert with national specialty and state medical societies to advocate for patient access to the full continuum of care of evidence-based erectile dysfunction treatment modalities including oral pharmacotherapy, penile vasoactive injection therapy, vacuum erection device therapy and penile prosthetics.	Retain.
H-185.935	Reference Pricing	Our AMA supports the appropriate use of reference pricing as a possible method of providing health insurance coverage of specific procedures, products or services, consistent with the following principles: 1. Practicing physicians must be actively involved in the identification of services that are appropriate for a reference pricing system. 2. Appropriate reference pricing strategies may be considered for elective services or procedures for which there is evidence of a significant variation in cost that does not correspond to a variation in quality	Retain.

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		of care. Additional considerations include the relative complexity of the service, the potential for variation either across patients or during the course of a treatment, and the sufficient availability of providers in a geographic region. 3. Reference prices should be set at a level that reflects current market conditions and ensures that patients have access to a choice of providers. Prices should be reviewed annually and adjusted as necessary based on changes in market conditions. 4. Hospitals or facilities delivering services subject to reference pricing should avoid cost-shifting from one set of services to another. 5. Information about the services subject to reference pricing and the potential patient cost-sharing obligations must be fully transparent and easily accessible to patients and providers, both prior to and at the point of care. Educational materials should be made available to help patients and physicians understand the incentives and disincentives inherent in the reference pricing arrangement. 6. Insurance companies must notify patients of all services subject to reference pricing at the time of health plan enrollment. Patients must be indemnified against any additional charges associated with changes to reference pricing policies for the balance of the contract period. 7. Insurers that use reference pricing must develop and maintain systems that allow patients to effectively and appropriately compare prices among providers, including systems that help patients calculate their estimated costs for each provider prior to seeking care. 8. Plan sponsors should continually monitor and evaluate the effect of reference pricing policies on access to high quality patient care and ensure that procedures are in place to make plan modifications as necessary.	
H-185.941	Patient Cost-Sharing Requirements for Hospital Inpatient and	Our AMA will advocate that patients be subject to the same cost-sharing requirements whether they are admitted to a hospital as an inpatient, or for observation services.	Retain.

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	Observation Services		
H-185.75	Requiring Third Party Reimbursement Methodology be Published for Physicians	Our AMA: (1) urges all third party payers and self-insured plans to publish their payment policies, rules, and fee schedules; (2) pursues all appropriate means to make publication of payment policies and fee schedules a requirement for third party payers and self-insured plans; (3) will develop model state and federal legislation that would require that all third party payers and self-insured plans publish all payment schedule updates, and changes at least 60 days before such changes in payment schedules are enacted, and that all participating physicians be notified of such changes at least 60 days before changes in payment schedules are enacted. (4) seeks legislation that would mandate that insurers make available their complete payment schedules, coding policies and utilization review protocols to physicians prior to signing a contract and at least 60 days prior to any changes being made in these policies; (5) works with the National Association of Insurance Commissioners, develop model state legislation, as well developing national legislation affecting those entities that are subject to ERISA rules; and explore the possibility of adding payer publication of payment policies and fee schedules to the Patient Protection Act; and (6) supports the following requirements: (a) that all payers make available a copy of the executed contract to physicians within three business days of the request; (b) that all health plan EOBs contain documentation regarding the precise contract used for determining the reimbursement rate; (c) that once a year, all contracts must be made available for physician review at no cost; (d) that no contract may be changed without the physician's prior written authorization; and (e) that when a contract is terminated pursuant	Retain.

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		to the terms of the contract, the contract may not be used by any other payer.	
H-185.997	Insurance Coverage for Complete Maternity Care	Our AMA (1) reaffirms its policy of encouraging health insurance coverage for care of the newborn from the moment of birth; (2) urges the health insurance industry and government to include in their plans, which provide maternity benefits, coverage for normal obstetrical care, and all obstetrical complications including necessary intrauterine evaluation and care of the unborn infant; (3) urges the health insurance industry to offer such plans on the broadest possible basis; (4) urges the health insurance industry to make available, on an optional basis, coverage for treatment associated with voluntary control of reproduction; (5) will advocate for expanding coverage of maternity care to dependent women under the age of 26 on their parents' large group plans; and (6) will advocate that individual, small and large group health plans provide 60 days of newborn coverage for all newborns born to participants in the plan.	Retain.
H-190.965	Claims Denial and Payment Delays	Our AMA policy is that insurers should not deny payment on lost claims discovered beyond the required filing date when the physician has proof that the electronic or paper claim was filed in a timely manner.	Retain.
H-190.970	Status Report on the National Uniform Claim Committee and Electronic Data Interchange	The AMA advocates the following principles to improve the accuracy of claims and encounter-based measurement systems: (1) the development and implementation of uniform core data content standards (e.g., National Uniform Claim Committee (NUCC) data set); (2) the use of standards that are continually modified and uniformly implemented; (3) the development of measures and techniques that are universal and applied to the entire health care system; (4) the use of standardized	Retain.

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		terminology and code sets (e.g., CPT) for the collection of data for administrative, clinical, and research purposes; and (5) the development and integration of strategies for collecting and blending claims data with other data sources (e.g., measuring the performance of physicians on a variety of parameters in a way that permits comparison with a peer group).	
H-190.972	Strategy for Eliminating Delayed Payments to Physicians by Third Party Payers	It is the policy of our AMA that delayed payments to physicians and hospitals without justification by third party payers should be prohibited by law.	Retain.
H-190.975	Universality of CMS 1500 Form	The AMA will undertake the task of asking individual carriers and/or their representative organizations to maintain the universal contents and acceptance of specific data in the CMS 1500 Form so that it will remain as a truly universal form for the patient-doctor claim form.	Retain.
H-190.979	Insurance Company Filing Deadlines	Our AMA will work with the insurance industry so that where there is a specified filing deadline for services, this deadline is reset when insurance companies contend that they have either not received a filed claim or require additional supporting documentation.	Retain.
H-190.981	Required Timely Reimbursements by all Health Insurers	Our AMA will prepare and/or seek sponsorship of legislation calling for all health insurance entities and third-party payers--inclusive of not-for-profit organizations and health maintenance organizations--to pay for "clean" claims when filed electronically within 14 days and paper claims within 30 days, with interest accruing thereafter. These time periods should be considered ceilings, not floors or fixed differentials between paper and electronic claims.	Retain.
H-220.939	Activities of The Joint Commission	1. Our AMA supports continued active AMA participation as a corporate member of The Joint Commission. 2. Pursuant to Policy 220.949 (AMA Policy Database), our AMA: (a) Advocates accountability through voluntary, professionally	Retain.

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		directed quality assurance mechanisms as part of every system of health care delivery; (b) Monitors the effects of The Joint Commission standards, surveys, and other activities on the quality, cost, and outcomes of care; (c) Retains its current role in The Joint Commission and continue to evaluate that role on a regular basis; and (d) Continues to investigate additional methods to facilitate participation in voluntary accreditation mechanisms. 3. Our AMA establishes the following goals for AMA participation in The Joint Commission: (a) To assist The Joint Commission to define its mission, long-term goals, and role in the accreditation arena; (b) To assure continued physician involvement in medical decision-making by advocating a requirement for integrated medical delivery systems to have organized medical staffs; (c) To advocate the improvement of the quality and consistency of The Joint Commission accreditation process, surveyors, and survey reports; (d) To urge consideration of cost implications when revising The Joint Commission standards, developing and implementing other activities, and increasing the costs of surveys; (e) To work toward minimal revision of The Joint Commission standards, unless there is a clear need to change them to improve patient care or outcome, once the proposed medical staff standards for the 1996 AMH are finalized; (f) To urge The Joint Commission to focus on its accreditation activities and to provide accountability to the public for health services through private sector accreditation activities; and (g) To work toward The Joint Commission recognition as an accreditation body for integrated health care networks.	
H-220.946	Unreasonable Burden of The Joint Commission Standards and Surveys	The AMA requests The Joint Commission to study and consider the ability of small hospitals, particularly in rural areas, to bear the burden of the increasing demands on staff and financial resources in the implementation of the current and proposed standards; and urges The Joint Commission to eliminate	Retain.

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		standards that increase health care costs without demonstrably improving the quality of care.	
H-220.959	Compliance with The Joint Commission Accreditation Standards	The AMA Commissioners to The Joint Commission oppose the accreditation of hospitals that do not adhere to The Joint Commission standards prohibiting unilateral amendment of medical staff bylaws by either the governing body or the medical staff.	Retain.
H-220.983	The Joint Commission Standard IV Should Not Tie Clinical Privilege Termination to Contract	The AMA does not believe The Joint Commission standards should dictate specific provisions of individual contracts between physicians and hospitals that are mutually agreeable to the parties.	Retain.
H-225.989	AMA Opposes Forcing Medical Staffs to Repay Hill-Burton Obligations of Free Medical Care	The AMA (1) opposes attempts to create new and arbitrary requirements for hospital compliance with the Hill-Burton Act by shifting responsibility for these requirements to hospital medical staffs; (2) believes that a hospital's Hill-Burton Act obligations should be satisfied in a manner that does not interfere with the professional rights of its medical staff; and (3) endorses exploration of means to assure equal access to medical care for the people of the U.S.	Retain.
H-225.991	Communication and Cooperation Between Hospital Management and Medical Staff	The AMA encourages hospitals to make known to physicians the diagnostic codes which are recorded by medical records and business departments so the accuracy of these diagnoses can be confirmed.	Retain.
H-230.970	Proper Notification of a Physician Regarding Possible Loss of Medical Staff Membership or Privileges	Except in the instance of summary suspension, hospital notification of possible loss of medical staff membership and/or privileges must be sent by certified mail, return receipt requested, or its equivalent.	Retain.
H-235.971	Amending Medical Staff Bylaws	The AMA provides the assistance of its legal staff to hospital medical staffs and county and state medical associations when a hospital board of directors unilaterally changes, amends, or substitutes medical staff bylaws, or denies seats to duly elected medical staff officers.	Retain.

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H-235.976	Medical Staff Bylaws and Medical Staff Autonomy	Our AMA reaffirms that (1) medical staff bylaws are a contract between the organized medical staff and the hospital; and (2) application for medical staff appointment and clinical privileges should provide that each member of the medical staff, as well as the hospital, is bound by the terms of the medical staff bylaws, and the terms of the medical staff bylaws should be incorporated by reference into the application.	Retain.
H-235.987	Right of Committees of Medical Staffs to Meet in Executive Sessions	The AMA (1) supports the right of any hospital medical staff committee to meet in executive session, with only voting members of the medical staff present, in order to permit open and free discussion of issues such as peer review and to maintain confidentiality; and (2) encourages individual medical staffs to incorporate provisions in their bylaws to affirm this right.	Retain.
H-235.988	Non-Physicians Voting on the Medical Staff	The AMA opposes any regulation that would mandate voting privileges for non-physician members of medical staffs.	Retain.
H-240.961	Definition of a Hospital Day	Our AMA defines a Hospital Day as a 24-hour period that begins at the hour of admission.	Retain.
H-240.998	Preferential Hospital Rates	Our AMA (1) opposes hospital charge/cost arrangements granting unwarranted advantage to any group of patients; and (2) urges all health care payers, government and private, to pay their equitable share of costs incurred by hospitals and other facilities consistent with a reasonable definition of full financial requirements.	Retain.
H-260.980	Clinical Laboratory Improvement Act of 1988	1. It is the policy of the AMA to (a) continue and intensify its efforts to seek appropriate and reasonable modifications in the proposed rules for implementation of the Clinical Laboratory Improvement Amendments (CLIA) 88; (b) communicate to Congress and to the Centers for Medicare & Medicaid Services (CMS) the positive contribution of physician office laboratory testing to high quality, cost effective care so that through administrative revision of the regulations, clarification of Congressional intent and, if necessary, additional legislation, the negative	Retain-in-part. Rescind (2); accomplished by October 2015 sign-on letter to Congress.

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		impact of these proposed regulations on patient care and access can be eliminated; (c) continue to work with Congress, CMS, the Commission on Laboratory Assessment, and other medical and laboratory groups for the purposes of making the regulations for physicians' office laboratories reasonable, based on scientific data, and responsive to the goal of improving access to quality services to patients; (d) protest the reported high costs being considered for certification of laboratories and the limited number of laboratory categories proposed; (e) encourage all components of the federation to express to CMS and members of Congress their concerns about the effect of the proposed rules on access and cost of laboratory services; and (f) protest the very limited list of waivered tests. 2. Our AMA will send a letter to CMS stating that CLIA requirements regarding provider-performed microscopy procedures and annual competency assessments are overly burdensome for physicians and their practices.	
H-280.964	Medicare Certified Beds in Nursing Facilities	The AMA will work with CMS to eliminate any unnecessary requirements for designating by location Medicare Certified beds within a nursing facility, thus allowing each facility to flexibly apply the certified status to any appropriate bed within the facility.	Retain.
H-285.917	Stop Trial by Health Insurers	1. Our AMA opposes (a) any health insurer's efforts to make determinations regarding whether or not a physician has made a medical mistake; and (b) the practice of health plans using adverse event reporting data for purposes other than quality improvement and learning, as it could shift the focus of such reporting from improving patient safety to fostering a punitive environment. 2. Our AMA will (a) inform all health insurance companies that they are not the appropriate entity for determining medical mistakes; and (b) encourage physicians to be aware of contractual provisions that would allow insurers to deny payment in the event of a medical mistake.	Retain.

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H-285.918	Mandatory Subspecialty Consultation	Our AMA: (1) opposes the unilateral actions of hospitals and health care organizations to mandate specialty consultation for a patient with a specific disease state, when the mandate specifically denies the physician providing care the ability to determine medical necessity of the consultation and/or the consultation is not requested by the patient, and (2) discourages physicians from requesting hospital medical staff oversight committees, health plans and managed care organizations to mandate specialty consultations when the physician or physician group would gain financially from the mandatory consultation due to increased revenues from consultation billing, unless the consultation is required by law or regulation.	Retain.
H-285.943	Payment for Managed Care Administrative Services	Our AMA: (1) opposes managed care contract provisions that prohibit physician payment for the provision of administrative services; (2) encourages physicians entering into: (a) capitated arrangements with managed care plans to seek the inclusion of a separate capitation rate (per member per month payment) for the provision of administrative services, and (b) fee-for-service arrangements with managed care plans to seek a separate case management fee or higher level of payment to account for the provision of administrative services; and (3) supports the concept of a time-based charge for administrative duties (such as phone precertification, utilization review activities, formulary review, etc.), to be assessed to the various insurers.	Retain.
H-285.974	Residents Working with Managed Care Programs	The AMA encourages managed care plans to allow residents to care for patients under faculty supervision in the inpatient and outpatient setting.	Retain.
H-285.975	Consensus Opinions	Policy of the AMA is that all managed care programs must provide, or offer reimbursement for acquisition of, sufficient opinions necessary to reach a conclusion regarding the management of a given medical condition.	Rescind. Superseded by Policy H-390.917. **Consultation Follow-Up and Concurrent Care of Referral for Principal Care H-390.917** (1) It is the policy of the AMA that: (a) the completion of a consultation may require multiple

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			encounters after the initial consultative evaluation; and (b) after completion of the consultation, the consultant may be excused from responsibility of the care of the patient or may share with the primary care physician in concurrent care; he/she may also have the patient referred for care and thus become the principal care physician. (2) The AMA communicate the appropriate use of consultation, evaluation and management, and office medical services codes to third party payers and advocate the appropriate reimbursement for these services in order to encourage high quality, comprehensive and appropriate consultations for patients.
H-290.969	Medicaid Waivers and Maintenance of Effort Requirements	Our AMA opposes any efforts to repeal the Medicaid maintenance of effort requirements in the ACA and American Recovery and Reinvestment Act (ARRA), which mandate that states maintain eligibility levels for all existing adult Medicaid beneficiaries until 2014 and for all children in Medicaid and the Children's Health Insurance Program (CHIP) until 2019.	Rescind. No longer relevant.
H-290.984	Mandatory Enrollment of Medicare-Medicaid Patients in Managed Care Plans	The AMA, in keeping with its support for free market competition among all modes of health care delivery and financing, strongly opposes mandatory enrollment of Medicare and/or Medicaid patients in managed care plans.	Retain.
H-290.987	Medicaid Waivers for Managed Care Demonstration Projects	(1) Our AMA adopts the position that the Secretary of Health and Human Services should determine as a condition for granting waivers for demonstration projects under Section 1115(a) of the Medicaid Act that the proposed project: (i) assist in promoting the Medicaid Act's objective of improving access to quality medical care, (ii) has been preceded by a fair and open process for receiving public comment on the program, (iii) is properly funded, (iv) has sufficient provider reimbursement levels to secure adequate access to providers, (v) does not include provisions designed to coerce physicians and other providers into participation, such as those that link	Retain.

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		participation in private health plans with participation in Medicaid, and (vi) maintains adequate funding for graduate medical education. (2) Our AMA advocates that CMS establish a procedure which state Medicaid agencies can implement to monitor managed care plans to ensure that (a) they are aware of their responsibilities under EPSDT, (b) they inform patients of entitlement to these services, and (c) they institute internal review mechanisms to ensure that children have access to medically necessary services not specified in the plan's benefit package.	
H-315.968	Privacy Issues Regarding Insurance Company Explanation of Benefits	1. Our AMA advocates that electronic medical record (EMR) vendors be required to create user-triggered mechanisms that alert health care professionals of confidential medical information that should be safeguarded. 2. Our AMA encourages physicians to clearly identify health care information on both paper and electronic records that the patient has requested to be kept private. 3. Our AMA encourages physicians to develop individualized treatment plans for minors aged 12-17, in collaboration with parents or guardians, that outline expectations for the services provided and transitions toward increased privacy as the minor ages into adulthood. 4. Our AMA encourages physicians to inform their patients that they can request confidential communications from their office and health insurer by alternate means or locations than the policy holder's contact information, and to provide their patients with a Health Insurance Portability and Accountability Act (HIPAA) Privacy Rights Request Form. 5. Our AMA advocates that health insurers be required to develop a method of listing health care services on Explanation of Benefits statements that would preserve confidentiality for all insured individuals. 6. Our AMA advocates that health insurers be required to communicate clear procedures to all insured dependents on how to request	Retain.

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		confidential communications. 7. Our AMA advocates that health insurers be required to create privacy protections for all insured individuals on information that is contained on their Internet websites.	
H-315.992	Copying Records for Audits	Our AMA supports taking appropriate action to ensure that the financial responsibility for producing or copying patient records at the request of any regulatory agency having the authority to do so shall be borne entirely by the requesting agency and the request for said records shall be made at least 30 days in advance of any deadline.	Retain
H-320.956	Advance Directives and Utilization Review	The policy of the AMA is that: (1) the prior existence of advance directives (expressions of intent to forgo resuscitative, extraordinary, unwanted or other care highly unlikely to improve or stabilize health status) should not jeopardize the provision of medically appropriate care, if the care is consistent with agreed upon limits; (2) individual physicians should not be reprimanded by reviewing bodies for abiding by the wishes of patients when providing appropriate care to individuals who have exercised advance directives.	Retain.
H-320.965	Responsibility for Hospital Admissions	It is the policy of the AMA that the determination of the medical necessity for hospital admission should be made only by a Doctor of Medicine, or a doctor of osteopathy licensed in the same jurisdiction as the treating physician.	Retain.
H-330.944	New Durable Medical Equipment Requirements	The AMA will work with CMS to develop and implement an exemption policy for low-cost DME supplies that are dispensed by physicians through their offices, based on such factors as current Medicare payment amounts, whether the item is usually disposable, linkage to a particular physician treatment, and specialty society recommendations. Claim for such supplies under these circumstances would not be subject to CMS's DME regulatory requirements and would be submitted to the local Medicare carrier.	Retain.
H-335.973	Reimbursement Violations	Our AMA will urge physicians who experience problems with their Medicare carrier's application of	Retain

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		Medicare review criteria to report those problems, issues or concerns to their state medical association and state "Medicare Carrier Advisory Committee" for discussion and resolution.	
H-385.927	Additional Prompt Payment Advocacy	Our AMA continues to support state medical association and national medical specialty society efforts and work independently with federal and state legislators and agencies to provide for a percentage of the financial penalty and/or accrued interest to be paid directly to the physician in the cases where payers do not make payment within the specified time frame.	Retain.
H-385.948	Reasonable Charge for Preauthorization	The AMA strongly supports and advocates fair compensation for a physician's administrative costs when providing service to managed care patients.	Retain.
H-385.956	Payment for Ethics Consultations	The policy of the AMA is that physician provision of clinical ethics consultations for the guidance of individual patients or physicians, apart from and beyond their duties as members of hospital ethics committees, is an appropriately compensable medical service. Payment for these services should be made when they are reported with the appropriate existing CPT consultation codes (and prolonged physician service codes, if appropriate). The AMA recognizes that this does not address any aspect of payment for ethics consultations by non-physicians.	Retain.
H-385.959	Primary and Consultative Care	The AMA will promulgate policies to recognize the services of internists, pediatricians, family physicians and obstetrician/gynecologists as capable of providing both primary care and consultative care.	Retain.
H-390.867	Medical Rehabilitation Services	The AMA believes: (1) Rehabilitation criteria for reimbursement should be defined by medical needs of patients for rehabilitative care that includes functional, cognitive, social considerations, and cognitive status, specifically the so called "three-hour rule" is not a valid exclusion criterion for entry into a rehabilitation unit nor can it be the basis for denial of ongoing coverage in such a unit. (2)	Retain.

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		The severity of medical conditions, regardless of settings, must be accounted for, including a case-mix approach adjusted for regional variances to meet individual patient needs for high quality, cost effective medical, rehabilitation services.	
H-390.976	Delayed Payment of Medical Insurance Claims	Our AMA (1) expresses its concern and displeasure about CMS's practice of slowing payment of Medicare claims, which places an unwarranted financial burden upon the elderly and the practitioners and facilities which serve senior citizens; (2) supports model state legislation to establish incentives and/or penalties among private and public third party payers to rectify the problem of delayed insurance reimbursements; and (3) believes that reasonable interest should begin on uncontroverted claims not later than 30 days following receipt of a claim by the payer.	Rescind. Superseded by Policies H-190.959 and H-190.981 and AMA Model State Legislation. **Physician Reimbursement by Health Insurance and Managed Care Companies H-190.959** 1. Our AMA shall make it a top priority to seek regulatory and legislative relief to ensure that all health insurance and managed care companies pay for clean claims submitted electronically within fourteen days. 2. When electronic claims are deemed to be lacking information to make the claim complete, the health insurance and managed care companies will be required to notify the health care provider within five business days to allow prompt resubmission of a clean claim. 3. Our AMA shall advocate for heavy penalties to be imposed on health insurance and managed care companies, including their employees, that do not comply with laws and regulations establishing guidelines for claims payment. 4. Our AMA will continue to encourage regulators to enforce existing prompt pay requirements. **Required Timely Reimbursements by all Health Insurers H-190.981** Our AMA will prepare and/or seek sponsorship of legislation calling for all health insurance entities and third-party payers--inclusive of not-for-profit organizations and health maintenance organizations--to pay for "clean" claims when filed electronically within 14 days and paper claims within 30 days, with interest accruing thereafter.

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			These time periods should be considered ceilings, not floors or fixed differentials between paper and electronic claims.
H-390.985	CMS Consultation with Physicians	The AMA encourages CMS to consult with clinically experienced practicing physicians on all determinations affecting medical practice and patient care.	Retain.
H-390.987	Medicare Assignments and Laboratory Reimbursements	The AMA supports educational efforts to assist physicians in differentiating between procedural billing and professional billing, particularly as they relate to billing for the drawing of a specimen and billing for interpreting the laboratory test results.	Retain.
H-450.932	Public Reporting of Quality and Outcomes for Physician-Led Team-Based Care	1. Our AMA will advocate that internal reporting of quality and outcomes of team-based care should be done at both the team and individual physician level. 2. Our AMA will advocate that public reporting of quality and outcomes data for team-based care should be done at the group/system/facility level, and not at the level of the individual physician. 3. Our AMA reaffirms the intent of the codified mandate in the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA 2008) that public reporting of quality and outcomes data for team-based care should be done at the group/system level, and not at the level of the individual physician. 4. Our AMA will advocate that the current regulatory framework of public reporting for Meaningful Use also provide "group-level reporting" for medical groups/organized systems of care as an option in lieu of requiring MU reporting only on an individual physician basis.	Retain.
H-450.946	Ensuring Quality in Health System Reform	Our AMA: (1) will discuss quality of care in each of its presentations on health system reform; (2) will advocate for effective quality management programs in health system reform that: (a) incorporate substantial input by actively practicing physicians and physician organizations at the national, regional and local levels; (b) recognize and include key quality management initiatives that have been developed in	Rescind. Superseded by Policies H-450.966, H-450.970, H-450.994, and H-450.944. **Quality Management, H-450.966** (1) continues to advocate for quality management provisions

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		the private sector, especially those established by the medical profession; and (c) are streamlined, less intrusive, and result in real reduced administrative burdens to physicians and patients; and (3) will take a leadership role in coordinating private and public sector efforts to evaluate and enhance quality of care by maintaining a working group of representatives of private and public sector entities that will: (a) provide for an exchange of information among public and private sector quality entities; (b) oversee the establishment of a clearinghouse of performance measurement systems and outcomes studies; (c) develop principles for the development, testing, and use of performance/outcomes measures; and (d) analyze and evaluate performance/outcomes measures for their conformance to agreed upon principles.	that are consistent with AMA policy; (2) seeks an active role in any public or private sector efforts to develop national medical quality and performance standards and measures; (3) continues to facilitate meetings of public and private sector organizations as a means of coordinating public and private sector efforts to develop and evaluate quality and performance standards and measures; (4) emphasizes the importance of all organizations developing, or planning to develop, quality and performance standards and measures to include actively practicing physicians and physician organizations in the development, implementation, and evaluation of such efforts; (5) urges national medical specialty societies and state medical associations to participate in relevant public and private sector efforts to develop, implement, and evaluate quality and performance standards and measures; and (6) advocates that the following principles be used to guide the development and evaluation of quality and performance standards and measures under federal and state health system reform efforts: (a) Standards and measures shall have demonstrated validity and reliability. (b) Standards and measures shall reflect current professional knowledge and available medical technologies. (c) Standards and measures shall be linked to health outcomes and/or access to care. (d) Standards and measures shall be representative of the range of health care services commonly provided by those being measured. (e) Standards and measures shall be representative of episodes of care, as well as team-based care. (f) Standards and measures shall account for the range of settings and practitioners involved in health care delivery. (g) Standards and measures shall

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			recognize the informational needs of patients and physicians. (h) Standards and measures shall recognize variations in the local and regional health care needs of different patient populations. (i) Standards and measures shall recognize the importance and implications of patient choice and preference. (j) Standards and measures shall recognize and adjust for factors that are not within the direct control of those being measured. (k) Data collection needs related to standards and measures shall not result in undue administrative burden for those being measured. (BOT Rep. 35, A-94; Reaffirmed: CMS Rep. 10, I-95; Reaffirmed: CMS Rep. 7, A-05; Modified: CMS Rep. 6, A-13; Reaffirmed in lieu of Res. 714, A-14; Reaffirmed in lieu of Res. 814, I-14; Reaffirmed in lieu of Res. 208, A-15; Reaffirmed in lieu of Res. 223, A-15; Reaffirmed in lieu of Res. 203, I-15; Reaffirmed in lieu of. Res. 216, I-15; Reaffirmed: BOT Rep. 20, A-16; Reaffirmed: CMS Rep. 02, I-17; Reaffirmation: A-22) **Quality Management Principles, H-450.970** Our AMA (1) continues to support the concept that physicians and healthcare organizations should strive continuously to improve the quality of health care; (2) encourages the ongoing evaluation of continuous quality improvement models; (3) promotes implementation of effective quality improvement models; and (4) identifies the useful approaches for assisting physicians in implementing quality improvement procedures in their medical practices and office management. (BOT Rep. AA, A-92; Reaffirmed: CMS Rep. 9, I-00; Reaffirmed: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH

POLICY #	Title	Text	Recommendation
			Rep. 01, A-20) **Quality of Care – Essentials and Guidelines for Quality Assessment H-450.995** (1) Including favorable outcome as one characteristic, the AMA believes that medical care of high quality should: (a) produce the optimal possible improvement in the patient's physiologic status, physical function, emotional and intellectual performance and comfort at the earliest time possible consistent with the best interests of the patient; (b) emphasize the promotion of health, the prevention of disease or disability, and the early detection and treatment of such conditions; (c) be provided in a timely manner, without either undue delay in initiation of care, inappropriate curtailment or discontinuity, or unnecessary prolongation of such care; (d) seek to achieve the informed cooperation and participation of the patient in the care process and in decisions concerning that process; (e) be based on accepted principles of medical science and the proficient use of appropriate technological and professional resources; (f) be provided with sensitivity to the stress and anxiety that illness can generate, and with concern for the patient's overall welfare; (g) make efficient use of the technology and other health system resources needed to achieve the desired treatment goal; and (h) be sufficiently documented in the patient's medical record to enable continuity of care and peer evaluation. (2) The AMA believes that the following guidelines for quality assessment should be incorporated into any peer review system. (a) The criteria utilized to assess the degree to which medical care exhibits the essential elements of quality should be developed and concurred in by the professionals

POLICY #	Title	Text	Recommendation
			whose performance will be reviewed. (b) Such criteria can be derived from any one of the three basic variables of care: structure, process, or outcome. However, emphasis in the review process should be on statistically verifying linkages between specific elements of structure and process, and favorable outcomes, rather than on isolated examination of each variable. (c) To better isolate the effects of structure and process on outcome, outcome studies should be conducted on a prospective as well as a retrospective basis to the degree possible. (d) The evaluation of "intermediate" rather than "final" outcomes is an acceptable technique in quality assessment. (e) Blanket review of all medical care provided is neither practical nor needed to assure high quality of care. Review can be conducted on a targeted basis, a sampling basis, or a combination of both, depending on the goals of the review process. However, judgment as to performance of specific practitioners should be based on assessment of overall practice patterns, rather than solely on examination of single or isolated cases. By contrast, when general assessment of the quality of care provided by a given health care system or across systems is desired, random sampling of all care episodes may be the more appropriate approach. (f) Both explicit and implicit criteria are useful in assessing the quality of care. (g) Prior consultation as appropriate, concurrent and retrospective peer review are all valid aspects of quality assessment. (h) Any quality assessment program should be linked with a quality assurance system whereby assessment results are used to improve performance.

POLICY #	Title	Text	Recommendation
			(i) The quality assessment process itself should be subject to continued evaluation and modification as needed. (CMS Rep. A, A-86; Reaffirmed: CMS Rep. E, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CMS Rep. 7, A-11; Reaffirmed: BOT Action in response to referred for decision: Res. 718, A-17) **Quality Assurance in Health Care H-450.994** (1) Accountability through voluntary, professionally directed quality assurance mechanisms should be part of every system of health care delivery. The cost of quality assurance programs and activities should be considered a legitimate element in the cost of care. (Reaffirmed: Res. 711, A-94) (2) To fulfill their fundamental responsibility to maximize the quality of services, health care institutions should establish, through their governing bodies, a formal structure and process to evaluate and enhance the quality of their health care services. This should be accomplished by participation of the professional staff, management, patients and the general public. When appropriate, health care institutions should be urged by licensing and accrediting bodies to establish a formal committee to coordinate all quality assurance activities that occur among the various health care professions within the facility. (3) Voluntary accreditation programs with standards that exceed those of state licensure and that focus on quality-of-care issues should be offered to all health care facilities. Various agencies that accredit health care facilities should develop a formal interagency structure to coordinate their activities and to resolve any inter-organizational problems that may arise. (4) Public and private payment programs should limit their

POLICY #	Title	Text	Recommendation
			coverage for services provided in health care facilities to those that meet professionally acceptable standards of acceptable quality, should structure their reimbursement to support the improvement of quality, and should provide information on quality for the benefit of their subscribers. (5) Educational programs on quality assurance issues for health care professionals should be expanded through the inclusion of such material in health professions education programs, in preceptorships, in clinical graduate training and in continuing education programs. (6) Educational programs should be developed to inform the public about the various aspects of quality assurance. Health care facilities and national and local health care organizations should make information available to the public about the factors that determine the quality of care provided by health care facilities, and about the extent to which individual health care facilities meet professionally acceptable standards of quality. (7) Research should be undertaken to assess the effects of peer review programs and payment mechanisms on the overall quality of health care. (BOT Rep. NN, A-87; Modified: Sunset Report, I-97; Reaffirmed: CMS Rep. 9, A-07; Reaffirmed: BOT Rep. 20, A-16; Reaffirmed: BOT Action in response to referred for decision: Res. 718, A-17)
H-450.965	Medical Staff Leadership in Continuous Quality Improvement	The AMA will work with the AHA to assure that hospitals, in their continuous quality improvement/total quality management (CQI/TQM) programs, include practicing physicians in the development and implementation of such programs, especially the development of criteria sets and clinical indicators; provide feedback on CQI/TQM findings to physicians on a confidential basis; and inform all members of the medical	Retain.

POLICY #	Title	Text	Recommendation
		staff on the CQI/TQM programs developed.	
H-450.997	Quality Assurance and Peer Review for Hospital Sponsored Programs	The AMA urges hospital medical staffs to make certain that all hospital sponsored, initiated, or affiliated medical services have appropriate peer review and quality assurance programs.	Retain.

2. IMPROVING AFFORDABILITY OF EMPLOYMENT-BASED HEALTH COVERAGE

Reference committee hearing: see report of Reference Committee A.

HOUSE ACTION: REFERRED

At the June 2023 Annual Meeting, the House of Delegates referred Resolution 103, which was sponsored by the Medical Student Section and asked the American Medical Association (AMA) to: (1) recognize the inefficiencies and complexity of the employer-sponsored health insurance system and the existence of alternative models that better align incentives to facilitate access to high quality health care; (2) support movement toward a health care system that does not rely on employer-sponsored health insurance and enables universal access to high quality health care; (3) amend Policy H-165.828[1], "Health Insurance Affordability," by addition and deletion to read as follows:

> Health Insurance Affordability H-165.828[1]
> ~~1. 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 Affordable Care Act (ACA).~~ Our AMA advocates for the elimination of the employer-sponsored insurance firewall such that no individual would be ineligible for premium tax credits and cost-sharing assistance for marketplace coverage solely on the basis of having access to employer-sponsored health insurance.

and (4) amend Policy H-165.823[2] by deletion to read as follows:

> Options to Maximize Coverage Under the AMA Proposal for Reform H-165.823[2]
> 2. Our AMA will advocate that any public option to expand health insurance coverage must meet the following standards:
> a. The primary goals of establishing a public option are to maximize patient choice of health plan and maximize health plan marketplace competition.
> ~~b. Eligibility for premium tax credit and cost-sharing assistance to purchase the public option is restricted to individuals without access to affordable employer-sponsored coverage that meets standards for minimum value of benefits.~~
> b~~e~~. Physician payments under the public option are established through meaningful negotiations and contracts. Physician payments under the public option must be higher than prevailing Medicare rates and at rates sufficient to sustain the costs of medical practice.
> c~~d~~. Physicians have the freedom to choose whether to participate in the public option. Public option proposals should not require provider participation and/or tie participation in Medicare, Medicaid and/or any commercial product to participation in the public option.
> d~~e~~. The public option is financially self-sustaining and has uniform solvency requirements.
> e~~f~~. The public option does not receive advantageous government subsidies in comparison to those provided to other health plans.
> f~~g~~. The public option shall be made available to uninsured individuals who fall into the "coverage gap" in states that do not expand Medicaid – having incomes above Medicaid eligibility limits but below the federal poverty level, which is the lower limit for premium tax credits – at no or nominal cost.

The Board of Trustees assigned this item to the Council on Medical Service for a report back to the House of Delegates. This report discusses policy options for addressing employer-sponsored health insurance (ESI) affordability, summarizes relevant AMA policy, and presents recommendations.

BACKGROUND

Almost a decade and a half after enactment of the ACA, ESI continues to be the dominant source of health coverage for Americans under 65 years of age. In 2023, the Congressional Budget Office (CBO) estimated that 155 million people under age 65—or 57.3 percent of the nonelderly population—had health insurance coverage through their employer, a number the CBO predicts will remain steady through 2025 and increase in the years thereafter.[1] Although ESI is the most common type of health insurance, coverage varies significantly by income as well as race and ethnicity. While nearly all individuals with incomes at or above 400 percent of the federal poverty level (FPL) have ESI, it covers just over half of people with incomes between 150 to 400 percent FPL and fewer than one-quarter of individuals with incomes below 150 percent FPL.[2] Additionally, larger percentages of white and Asian people have ESI while individuals who are African American and Latino are less likely to have employer-based coverage, raising equity concerns.[3,4]

Overall, most Americans appear satisfied with employment-based coverage.[5] According to KFF's survey of consumer experiences with health insurance, in 2023, 80 percent of adults with ESI and 73 percent of those with marketplace coverage rated their health coverage as "excellent" or "good" although people in poorer health gave more negative ratings across all plan types. Regardless of health status, enrollees in marketplace plans were most likely to rate their experiences with health insurance as fair or poor.[6] Ninety-three percent of workers responding to a 2022 poll sponsored by the U.S. Chamber of Commerce expressed high rates of satisfaction with ESI, with a large majority (89 percent) expressing a preference for ESI over other types of coverage.[7] Eighty percent of respondents to this survey ranked health insurance as the most important workplace benefit provided to them, and a majority cited "affordability" and "high quality" as ESI's most critical features.[8]

Although ESI is popular, it has become increasingly costly for employers and employees, especially small firms and lower-income workers. According to 2023 data from the KFF's Employer Health Benefits Survey:

- Fifty-three percent of all firms offered health benefits, down slightly from five years ago (57 percent). Almost all (98 percent) large employers (those with 200 or more workers) offered coverage to at least some workers while just over half (53 percent) of smaller firms (those with three to 199 workers) did so.
- Seventy-five percent of eligible employees took up coverage when it was offered to them, a slight decrease from 2013 (80 percent) and a more sizeable decrease from 2003 (84 percent).[9]
- Annual health insurance premiums averaged $8,435 for individual coverage and $23,968 for family coverage, a seven percent increase over 2022. Notably, premiums for family coverage have increased on average 22 percent since 2018 and 47 percent since 2013. Workers pay, on average, $6,575 annually toward the cost of family premiums.
- Most (77 percent) firms offered only one type of plan, and PPOs were the most common plan type offered. Large employers were more likely than smaller firms to offer more than one plan.[10]

In addition to premium contributions, most workers with ESI are responsible for cost-sharing expenses, including plan deductibles, copayments, and coinsurance. According to KFF's 2023 Employer Health Benefits Survey, the average annual deductible for employees with single coverage was $1,735, a figure that has increased more than 50 percent over the course of 10 years.[11] Overall, nearly a third of employees had plan deductibles of $2,000 or more, including almost half (47 percent) of workers at small firms, whose average annual deductible was $2,434 compared to $1,478 for employees of larger firms.[12]

ESI Affordability

KFF has also highlighted the lack of affordable family coverage options for workers at smaller firms employing fewer than 200 people. These employees pay on average $8,334 towards family coverage premiums each year with a quarter paying at least $12,000 annually, not including deductibles and other cost-sharing expenses.[13] A KFF analysis of data from its 2023 survey of consumer experiences with health insurance found that adults with incomes below 200 percent FPL who have ESI were significantly more likely than higher-income peers to report difficulties paying for medical care; treatment delays and declines in health due to insurance problems, such as prior

authorization; dissatisfaction with the availability and quality of health providers in their plan's network; and more difficulty comparing plans and signing up for coverage.[14]

Several analyses have pointed out that workers with lower incomes are disproportionately burdened by ESI costs and usually pay a greater share of income toward employer plan premiums and other out-of-pocket expenses.[15] [16] [17] KFF research from 2022 found that, on average, families with incomes below 200 percent FPL pay approximately 10.4 percent of income toward health care premiums and out-of-pocket expenses (7.7 percent for premiums) while those with incomes at or above 400 percent FPL pay about 3.5 percent toward premiums and medical expenses (2.3 percent for premiums).[18] More workers (over 20 percent, according to a 2019 KFF survey) [19] are covered by high-deductible plans, which can present additional challenges to lower-income employees even if a health savings account or health reimbursement account option is available to them. Though employers could utilize health benefit design strategies to address affordability issues facing lower-income workers, few seem to do so; in 2022, 10 percent of large firms reportedly had programs that lowered premium costs for lower-income employees while only five percent reported programs to lower their cost-sharing expenses.[20] COBRA coverage may also be too costly for some workers who are leaving a job.

Though many workers mistakenly think otherwise, they—not the firms they work for—pay the majority of ESI costs, both directly through contributions and indirectly through wage adjustments made to cover employers' health care costs.[21] Building on the literature linking growth in health insurance costs to stagnant wages, a 2023 *JAMA* analysis suggests a likely association between increased premium costs for workers with ESI family coverage and decreased earnings and increased income inequality.[22] Because workers earning lower wages contribute a greater share of income toward ESI premiums, the analysis posits that making employer plans more affordable for lower-wage workers could help address earnings inequality. This study also identified large disparities in premium costs as a percentage of income by race (African American and Latino families paid higher percentages of earnings toward premium costs than white families), and found that over 30 years, families with ESI may have cumulatively lost, on average, more than $125,000 in earnings due to increases in premium costs.[23]

ACA Provisions on Affordability and Employer Shared Responsibility

Under the ACA, individuals are not eligible for marketplace premium tax credits if they are eligible for "minimum essential coverage," which is broadly defined to include Medicare, Medicaid, and other public programs as well as ESI. Accordingly, individuals with offers of coverage from an employer do not qualify for ACA marketplace subsidies unless their ESI offer is deemed either unaffordable or inadequate. In 2023, an employer plan was considered unaffordable if an employee's premium contribution exceeded 9.12 percent of that person's household income. This percentage threshold is adjusted annually for inflation and is 8.39 percent in 2024.[24] To be considered adequate, a plan must cover at least 60 percent of average costs (actuarial value); anything less is deemed inadequate.[25] The ACA provision making workers with affordable and adequate ESI offers ineligible to receive advance premium tax credits to purchase marketplace coverage is colloquially referred to as "the firewall." This affordability threshold was established to address multiple concerns with the landmark legislation; namely, to prevent disruption to the ESI market and prevent prohibitive increases in federal spending (for marketplace subsidies) while preserving ESI's position as the principal source of health coverage in this country.

As explained in a 2014 Council on Medical Service Report on the future of ESI, the ACA aimed to build upon the ESI framework and provide low-income, non-elderly individuals without access to ESI with either Medicaid coverage or subsidized private coverage offered through the nongroup marketplace. As such, provisions in the ACA statute included incentives and penalties intended to prevent disruption to the ESI market. For example, to incentivize employers to continue offering coverage, the ACA contained an "employer shared responsibility" provision, also called the "employer mandate," which requires employers with 50 or more full-time employees to either offer affordable minimum essential coverage to full-time employees and their dependents or pay a penalty to the Internal Revenue Service (IRS).[26] Under this provision, employers face two potential penalties:[27]

- If an employer does not offer minimum essential coverage to at least 95 percent of its full-time employees and dependents, and at least one employee receives a premium tax credit for coverage offered through an ACA exchange, the employer faces a penalty that is based on all full-time employees (except 30), including those who have ESI or coverage from another source. In 2024, the penalty is $2,970 per employee.[28]
- If an employer offers coverage to at least 95 percent of its employees but at least one employee obtains a premium tax credit for ACA coverage due to the employer's coverage not being "affordable" or

> "adequate," the employer must pay a penalty for each employee who receives the premium tax credit. In 2024, the penalty is $4,460 per employee.[29]

AMA Policy on the ACA Affordability Threshold

In the early years of ACA implementation, a 2015 Council on Medical Service report on health insurance affordability recommended making changes to how affordable coverage is defined under the law in order to provide more workers and their families with access to marketplace plans when those plans are more affordable than employer plans. This report established Policy H-165.828, which included several provisions calling for the ACA's "family glitch" to be fixed and capping the tax exclusion for ESI as a funding stream to improve insurance affordability. Policy H-165.828[1] as originally written (prior to being amended in 2021) established AMA support for:

> … modifying the eligibility criteria for premium credits and cost-sharing subsidies for those offered ESI 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 ACA.

In 2015 when this policy was adopted, individuals were deemed exempt from the ACA's individual mandate—which was repealed in 2017—if the lowest-priced coverage available to them cost more than 8.05 percent of their household income. The same year, individuals with employer coverage offers were eligible for ACA marketplace plan premium tax credits if their ESI premium contributions exceeded 9.56 percent of income. The aforementioned Policy H-165.828[1] was crafted to align the definitions of affordability with respect to being exempt from the individual mandate (>8.05 percent) and premium tax credit eligibility for individuals with ESI offers (>9.56 percent).

Policy H-165.828[1] was amended via adoption of the recommendations in a 2021 Council on Medical Service report to address new inconsistencies between the definition of affordability pertaining to premium tax credit eligibility and provisions in the American Rescue Plan Act of 2021 (ARPA), which extended eligibility for premium subsidies to people with incomes greater than 400 percent FPL and capped premiums for those with the highest incomes at 8.5 percent of their income. ARPA increased the generosity of premium tax credits and lowered the cap on the percentage of income individuals are required to pay for premiums of the benchmark (second-lowest-cost silver) plan for everyone. At the time the report was written, in 2021, employer coverage with an employee share of the premium less than 9.83 percent of income was considered "affordable." To open the door to premium tax credit eligibility to individuals with ESI premiums that were above the maximum affordability threshold applied to subsidized marketplace plans, Policy H-165.828[1] was amended to establish AMA support for:

> … modifying the eligibility criteria for premium credits and cost-sharing subsidies for those offered ESI by lowering the threshold that determines whether an employee's premium contribution is affordable to the level at which premiums are capped for individuals with the highest incomes eligible for subsidized ACA coverage.

Federal Subsidies for ACA Premium Tax Credits/Cost-Sharing and ESI Tax Benefits

In 2023, the federal government subsidized coverage obtained through the ACA marketplaces and the Basic Health Program (BHP) at a cost of $92 billion.[30] This figure includes ARPA federal subsidy enhancements for premium tax credits and cost-sharing reductions that were extended through 2025 by the Inflation Reduction Act (IRA). Prior to ARPA, required premium contribution percentages ranged from about two percent of household income for people with poverty level income to nearly 10 percent of income for people with incomes between 300 to 400 percent FPL; people earning more than 400 percent FPL were not eligible for premium tax credits.[31] This year, as shown in Table 1, required premium contribution percentages range from zero for people with less than 150 percent FPL to 8.5 percent for those making around 400 percent FPL or more.

Table 1: Required Individual Contribution Percentage for 2024[32,33]

Household income percentage of Federal poverty line:	% at start of range	% at top of range
Less than 150%	0.00%	0.00%
At least 150% but less than 200%	0.00%	2.00%
At least 200% but less than 250%	2.00%	4.00%
At least 250% but less than 300%	4.00%	6.00%
At least 300% but less than 400%	6.00%	8.50%
At least 400% and higher	8.50%	8.50%

Premium tax credits for ACA marketplace coverage are calculated by subtracting the required contribution from the actual cost of the "benchmark" plan, though the credit can be applied toward any marketplace plan except catastrophic coverage.[34] People with incomes below 250 percent FPL also receive subsidies for cost-sharing expenses that are based on income, so that people with incomes between 100 and 150 percent FPL receive the most generous subsidies.[35] These cost-sharing reductions are only available to those enrolled in silver plans. According to the CBO, in 2023 the average federal subsidy per ACA marketplace/BHP enrollee was $5,990.[36] The range of subsidy amounts is considerable, with small subsidy amounts provided to people with incomes around 400 or more percent of the FPL and subsidies worth around $15,000 for families with the lowest incomes.

The federal government subsidizes ESI via tax benefits provided to employers and employees that exclude premium contributions from federal income and payroll taxes. The amount of an individual's subsidy depends on that person's marginal tax rate that would be owed if employer-paid premiums were taxed as wages. Accordingly, people with greater incomes and higher marginal tax rates receive larger federal ESI subsidies than people with lower-incomes and lower tax rates.[37] According to the CBO, the average federal subsidy per ESI enrollee in 2023 was $2,170.[38]

In part due to the enhanced subsidies for marketplace enrollees established by ARPA and extended by the IRA, several analysts have observed the growing disparity between federal subsidies that help defray ACA marketplace plan costs, and subsidies for ESI coverage. To illustrate this expanding gap, a 2024 American Enterprise Institute (AEI) paper calculated the value of subsidies that would be received by a family of four with $75,000 in income, depending on whether they purchased ESI or marketplace coverage. According to AEI, if the family enrolled in an employer-based plan, their tax subsidy would be around $4,100, compared to the more than $15,000 in federal premium subsidies the family would be eligible for if enrolled in a marketplace plan.[39] Other analyses have noted that workers with lower incomes may be contributing more for an employer-based plan than they would pay for coverage under a subsidized marketplace plan, and that it would be financially advantageous for these workers to move to the marketplace.[40]

Some employees who would be financially incentivized to enroll in a marketplace plan if the firewall is repealed might opt to retain ESI coverage if they are satisfied with their plan and able to see the physicians they want in a timely manner. The Centers for Medicare & Medicaid Services (CMS) has previously acknowledged the proliferation of narrow networks among ACA exchange plans, and several studies have demonstrated varying degrees of challenges facing marketplace enrollees attempting to access in-network providers, most commonly mental health specialists. A 2020 *JAMA* study found that provider networks were broader in ESI plans and narrower in marketplace plans but that networks may also be limited in lower-quality employer plans.[41] The Council has previously observed that, while marketplace plans may be attractive to some people because their premium prices are lower, purchasers may not be aware that a plan's provider network could be narrower and that they may have trouble getting needed care from in-network physicians, hospitals, and other providers. Therefore, some workers with ESI coverage who would become newly eligible for marketplace subsidies if the firewall is repealed may decide to keep their employer plan to avoid possible care disruptions and to preserve relationships with their treating physicians. Depending on income and a range of other factors, this could be true for some employees who utilize more services and medications or who have a family member on their plan who has a health condition that requires timely access to specialty care.

POLICY OPTIONS ADDRESSING ESI AFFORDABILITY

During the development of this report, the Council reviewed papers from a broad spectrum of organizations and also met with subject matter experts who suggested a range of approaches to improving affordability in ESI and

nongroup markets. Review of the literature uncovered a handful of data analyses and a range of conflicting opinions on the best way forward. The studies generally agreed that lifting the firewall would increase access to lower cost insurance for people with low incomes. However, they differed in their assessment of the percent of the population that would move from ESI to the ACA marketplace, the impact of employer behavior, and their willingness to support increased federal health spending. These studies are summarized below in alphabetical order.

American Enterprise Institute (AEI): A 2020 paper published by AEI recognizes both the value of ESI to many Americans as well as its flaws, including rising costs for both employers and employees. AEI asserts that ESI is worth preserving and suggests tax reforms as the centerpiece of a framework for a more stable ESI system, including the provision of a tax benefit for employers that would be applied to employee premiums. According to AEI, such firm-level tax credits could provide greater support to lower-income employees but less support to those with higher incomes.[42]

Bipartisan Policy Center (BPC): A 2022 BPC report recognizes that ESI is less affordable for lower-wage workers but suggests that fully eliminating the firewall would be quite costly for the federal government. Instead, BPC recommends that Congress adjust the affordability threshold to align with the percentage cap on premium contributions for marketplace plans.[43]

Center on Budget and Policy Priorities (CBPP): A 2019 CBPP analysis acknowledged that eliminating the firewall would improve equity but concluded that a full repeal would be too costly to recommend. Instead, the CBPP suggested strengthening the standards for employer coverage offers, such as by raising the minimum value standard (from 60 to 70 percent) or establishing more robust benefit standards for ESI plans.[44]

Commonwealth Fund: A 2020 analysis found that, depending on marketplace subsidy amounts in place, between six and 13 percent of people with ESI would pay lower premium amounts if they were able to switch to marketplace plans. Importantly, the paper pointed out that people with the lowest incomes would benefit the most from lower marketplace premiums, as would African American, Latino, American Indian and Alaska Native individuals. According to the brief, much is unknown about potential employer responses to elimination of the firewall, including whether firms will incentivize sicker workers to move to exchange plans or stop offering coverage altogether.[45]

A 2024 Commonwealth Fund paper on automatic enrollment in health insurance posits that 1.2 million people with incomes below 150 percent of FPL and 6.5 million people with income between 150 percent and 200 percent of FPL would become eligible for marketplace subsidies if the firewall were eliminated. The analysis states that "most" of these newly eligible individuals currently have ESI although some are paying full premiums for nongroup plans.[46]

Congressional Budget Office (CBO): In 2020, the CBO estimated that approximately 25 percent of workers with ESI would become eligible for marketplace subsidies if the firewall was repealed. For 20 percent of those newly eligible, post-subsidy premiums for marketplace plans would be lower than ESI premiums, thus making the nongroup market an attractive option. The CBO maintained that, although firms would respond differently to a lifting of the firewall, most of the savings incurred would likely be passed on to employees and adverse selection would be minimized.[47]
Urban Institute: Data presented to the Council but not yet published at the time this report was written estimated that eliminating the firewall would decrease ESI coverage by two percent or less, increase federal spending by about $20 billion, decrease the number of uninsured individuals, slightly increase provider revenue, and decrease employer spending and household spending.[48]

RELEVANT AMA POLICY

Policy H-165.829 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. Among its many provisions, Policy H-165.920 supports:

- A system where individually owned health insurance is the preferred option but employer- provided coverage is still available to the extent the market demands it;

- An individual's right to select his/her health insurance plan and to receive the same tax treatment for individually purchased coverage, for contributions toward employer-provided coverage, and for completely employer-provided coverage; and
- A replacement of the present federal income tax exclusion from employee's taxable income of employer-provided insurance coverage with tax credits for individuals and families.

Under Policy H-165.851, the AMA supports incremental steps toward financing individual tax credits for the purchase of health insurance, including but not limited to capping the tax exclusion for employment-based health insurance. Policy H-165.843 encourages employers to promote greater individual choice and ownership of plans; enhance employee education regarding how to choose health plans that meet their needs; and support increased fairness and uniformity in the health insurance market. Policy H-165.881 advocates for equal-dollar contributions by employers irrespective of an employee's health plan choice. Policy H-165.854 supports Health Reimbursement Arrangements (HRAs)—account-based health plans that employers can offer to reimburse employees for their medical expenses—as one mechanism for empowering patients to have greater control over health care decision-making.

Policy H-165.824 supports improving affordability in health insurance exchanges by expanding eligibility for premium tax credits beyond 400 percent FPL; increasing the generosity of premium tax credits; expanding eligibility for cost-sharing reductions; and increasing the size of cost-sharing reductions. Policy H-165.828, which as previously noted addresses the affordability threshold (firewall), also supports capping the tax exclusion for employment-based health insurance as a funding stream to improve health insurance affordability.

Policy H-165.823 supports a pluralistic health care system and advocates that eligibility for premium tax credit and cost-sharing assistance to purchase a public option be restricted to individuals without access to affordable employer-sponsored coverage that meets standards for minimum value of benefits. This policy sets additional standards for supporting a public option and states that it shall be made available to uninsured individuals who fall into the "coverage gap" in states that do not expand Medicaid at no or nominal cost.

DISCUSSION

The AMA has long supported health system reform alternatives that are consistent with AMA policies concerning pluralism, freedom of choice, freedom of practice, and universal access for patients. To expand coverage to all Americans, the AMA has advocated for the promotion of individually selected and owned health insurance; the maintenance of the safety net that Medicaid and CHIP provide; and the preservation of employer-sponsored coverage to the extent the market demands it. As ESI continues to be the dominant source of health coverage for people under 65 years of age, most people who have employment-based coverage seem satisfied with it. Still, the Council acknowledges that because of shortcomings inherent to the ESI system—including equity and affordability concerns, and rising costs—it does not work well for everyone, especially workers with lower incomes and those at smaller firms paying for costly family coverage.

As explained in this report, people with higher earnings receive larger federal ESI subsidies than their lower-income peers and employees with lower incomes pay a greater share of earnings towards ESI expenses. The Council recognizes that federal tax benefits available to ESI subscribers most in need are not nearly as generous as the enhanced subsidies available to many low- and moderate-income individuals enrolled in ACA marketplace plans. Because the disparity between subsidy amounts for people with ESI and those with marketplace coverage has widened as marketplace subsidies have increased and ESI costs have continued to grow, the Council agrees that it is an appropriate time to revisit AMA policy on the firewall (Policy H-165.828[1]), which supports lowering the affordability threshold to the level at which premiums are capped for individuals with the highest incomes eligible for subsidized coverage (currently 8.5 percent).

During the development of this report, the Council reviewed the literature and heard from experts holding an array of views on the potential impacts of fully eliminating the firewall, which is the policy change requested by referred Resolution 103-A-23. Although the Council cannot estimate with certainty how many people would switch from ESI to exchange plans over time if the firewall was repealed, the impact on coverage patterns could be significant. Even less is known about potential employer responses to a repeal, which cannot be predicted and will likely vary, with some firms possibly shifting certain employees to the marketplace or ceasing to offer health coverage altogether, and without assurances that employer savings would be passed along to workers. Still, we understand

that the firewall is problematic for some employees, including lower-income workers who may be contributing more for an employer plan than they would pay for marketplace coverage and those whose firms offer little to no choice of health plans. Even among employees who would benefit financially from transitioning to the marketplace, some may opt to retain ESI coverage if they are satisfied with that plan, concerned about the network breadth of exchange plans, or interested in preserving relationships with their treating physicians.

The impact of eliminating the firewall on physician payment rates is also difficult to predict, since payment rates in the nongroup market tend to vary, though they are generally lower than rates paid in the ESI market. The Council's main concerns about eliminating the firewall abruptly and in full include the potential impacts on ESI stability, which may not be wholly understood, and the potential substantial costs that would be incurred by the federal government, which already spends upwards of $1.8 trillion on health insurance subsidies—across all coverage programs—each year.[49] Allowing all ESI enrollees access to ACA marketplace subsidies might prove to be prohibitively expensive. We cannot estimate the exact costs of eliminating the firewall, which would depend on how many workers ultimately move to exchange plans but the costs easily total tens of billions of dollars or more per year, especially if enhanced federal marketplace subsidies remain in place after 2025. We believe that budgetary considerations may make the full repeal option unrealistic, financially, and also politically since it would be unpopular with ESI proponents, including employers using health coverage offers as recruiting tools. For these reasons, the Council supports incrementally reducing the affordability threshold so that it benefits workers most in need, and then monitoring the effects of this change on coverage patterns, federal and consumer health spending, and employer behavior. Accordingly, the Council recommends amending Policy H-165.828[1] to support lowering the threshold that determines whether an employee's premium contribution is affordable to the maximum percentage of income they would be required to pay, after accounting for subsidies, towards premiums for an ACA benchmark plan (second-lowest-cost silver plan). The Council is optimistic that this change, if enacted, may also encourage some employers to offer more affordable coverage in order to keep attracting workers.

The Council also suggests additional recommendations that are intended to strengthen the quality and affordability of ESI. To help address the needs of ESI enrollees with lower incomes, who are more likely to report difficulties covering the costs of medical care and who may not know if they are firewalled, the Council recommends amending Policy H-165.843 to encourage employers to: 1) implement programs that improve affordability of ESI premiums and/or cost-sharing; 2) provide employees with user-friendly information regarding their eligibility for subsidized ACA marketplace plans based on their offer of ESI; and 3) provide employees with information regarding available health plan options, including the plans' cost, network breadth, and prior authorization requirements, which will help them choose a plan that meets their needs. The Council recognizes that employers are already required to provide employees with notice about the ACA marketplace and that, depending on income and ESI offer, they may be eligible for lower-cost coverage in the marketplace. However, it may be challenging for some employees to determine whether they are eligible for marketplace subsidies without tools to help them do so.

The Council also notes that large employers are subject to a 60 percent actuarial value standard compared to the 70 percent standard required of silver plans on the marketplace (an 80 percent actuarial standard is required for gold plans; 60 percent for bronze). Notably, marketplace plans are also subject to more rigorous essential health benefits standards. To address these disparities in standards, the Council recommends general support for efforts to strengthen employer coverage offerings, such as by requiring a higher minimum actuarial value or more robust benefit standards. Finally, the Council recommends reaffirmation of AMA policies most relevant to this report: Policy H-165.881, which directs the AMA to pursue strategies for expanding patient choice in the private sector by advocating for greater choice of health plans by consumers, equal-dollar contributions by employers irrespective of an employee's health plan choice, and expanded individual selection and ownership of health insurance; and Policy H-165.920, which supports principles related to individually purchased and owned health insurance coverage as the preferred option, although employer-provided coverage is still available to the extent the market demands it.

RECOMMENDATIONS

The Council on Medical Service recommends that the following recommendations be adopted in lieu of Resolution 103-A-23, and that the remainder of the report be filed.

1. That our American Medical Association (AMA) amend Policy H-165.828[1] by addition and deletion to read:

   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 the ~~level at which premiums are capped for individuals with the highest incomes eligible for subsidized coverage~~ maximum percentage of income they would be required to pay towards premiums after accounting for subsidies ~~in~~ for an Affordable Care Act (ACA) marketplace~~s~~ benchmark plan.

2. That our AMA amend Policy H-165.843 by addition and deletion to read:

   Our AMA encourages employers to:
   a) promote greater individual choice and ownership of plans;
   b) implement plans to improve affordability of premiums and/or cost-sharing, especially expenses for employees with lower incomes and those who may qualify for Affordable Care Act marketplace plans based on affordability criteria;
   c) ~~help employees determine if their employer coverage offer makes them ineligible or eligible for federal marketplace subsidies~~ provide employees with user-friendly information regarding their eligibility for subsidized ACA marketplace plans based on their offer of employer-sponsored insurance;
   b~~d~~) ~~enhance employee education regarding available health plan options and how to choose health plans that meet their needs~~ provide employees with information regarding available health plan options, including the plan's cost, network breadth, and prior authorization requirements, which will help them choose a plan that meets their needs;
   e~~e~~) offer information and decision-making tools to assist employees in developing and managing their individual health care choices;
   d~~f~~) support increased fairness and uniformity in the health insurance market; and
   e~~g~~) promote mechanisms that encourage their employees to pre-fund future costs related to retiree health care and long-term care.

3. That our AMA support efforts to strengthen employer coverage offerings, such as by requiring a higher minimum actuarial value or more robust benefit standards, like those required of nongroup marketplace plans.

4. That our AMA reaffirm Policy H-165.881, which directs the AMA to pursue strategies for expanding patient choice in the private sector by advocating for greater choice of health plans by consumers, equal-dollar contributions by employers irrespective of an employee's health plan choice and expanded individual selection and ownership of health insurance.

5. That our AMA reaffirm Policy H-165.920, which supports individually purchased and owned health insurance coverage as the preferred option, although employer-provided coverage is still available to the extent the market demands it, and other principles related to health insurance.

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APPENDIX - Policies Recommended for Amendment and Reaffirmation

Health Insurance Affordability H-165.828
1. 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 the level at which premiums are capped for individuals with the highest incomes eligible for subsidized coverage in Affordable Care Act (ACA) marketplaces.
2. 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 and household income.
3. Our AMA encourages the development of demonstration projects to allow individuals eligible for cost-sharing subsidies, who forego these subsidies by enrolling in a bronze plan, to have access to a health savings account (HSA) partially funded by an amount determined to be equivalent to the cost-sharing subsidy.
4. Our AMA supports capping the tax exclusion for employment-based health insurance as a funding stream to improve health insurance affordability, including for individuals impacted by the inconsistency in affordability definitions, individuals impacted by the "family glitch," and individuals who forego cost-sharing subsidies despite being eligible.
5. Our AMA supports additional education regarding deductibles and cost-sharing at the time of health plan enrollment, including through the use of online prompts and the provision of examples of patient cost-sharing responsibilities for common procedures and services.

6. Our AMA supports efforts to ensure clear and meaningful differences between plans offered on health insurance exchanges.
7. Our AMA supports clear labeling of exchange plans that are eligible to be paired with a Health Savings Account (HSA) with information on how to set up an HSA.
8. Our AMA supports the inclusion of pregnancy as a qualifying life event for special enrollment in the health insurance marketplace. (CMS Rep. 8, I-15 Reaffirmed in lieu of: Res. 121, A-16 Reaffirmation: A-17 Reaffirmed: CMS Rep. 09, A-19 Reaffirmed: CMS Rep. 02, A-19 Reaffirmed in lieu of: Res. 101, A-19 Reaffirmed: CMS Rep. 01, I-20 Reaffirmed: CMS Rep. 2, I-20 Modified: CMS Rep. 3, I-21 Appended: Res. 701, I-21)

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. (CMS Rep. 4, I-07 Reaffirmed: CMS Rep. 01, A-17)

Expanding Choice in the Private Sector H-165.881
Our AMA will continue to actively pursue strategies for expanding patient choice in the private sector by advocating for greater choice of health plans by consumers, equal-dollar contributions by employers irrespective of an employee's health plan choice and mexpanded individual selection and ownership of health insurance where plans are truly accountable to patients. (BOT Rep. 23,
A-97 Reaffirmed BOT Rep. 6, A-98 Reaffirmation A-02 Reaffirmed: CMS Rep. 4, A-12 Reaffirmation: A-19)

Individual Health Insurance H-165.920
Our AMA:
(1) affirms its support for pluralism of health care delivery systems and financing mechanisms in obtaining universal coverage and access to health care services;
(2) recognizes incremental levels of coverage for different groups of the uninsured, consistent with finite resources, as a necessary interim step toward universal access;
(3) actively supports the principle of the individual's right to select his/her health insurance plan and actively support ways in which the concept of individually selected and individually owned health insurance can be appropriately integrated, in a complementary position, into the Association's position on achieving universal coverage and access to health care services. To do this, our AMA will:
(a) Continue to support equal tax treatment for payment of health insurance coverage whether the employer provides the coverage for the employee or whether the employer provides a financial contribution to the employee to purchase individually selected and individually owned health insurance coverage, including the exemption of both employer and employee contributions toward the individually owned insurance from FICA (Social Security and Medicare) and federal and state unemployment taxes;
(b) Support the concept that the tax treatment would be the same as long as the employer's contribution toward the cost of the employee's health insurance is at least equivalent to the same dollar amount that the employer would pay when purchasing the employee's insurance directly;
(c) Study the viability of provisions that would allow individual employees to opt out of group plans without jeopardizing the ability of the group to continue their employer sponsored group coverage; and
(d) Work toward establishment of safeguards, such as a health care voucher system, to ensure that to the extent that employer direct contributions made to the employee for the purchase of individually selected and individually owned health insurance coverage continue, such contributions are used only for that purpose when the employer direct contributions are less than the cost of the specified minimum level of coverage. Any excess of the direct contribution over the cost of such coverage could be used by the individual for other purposes;
(4) will identify any further means through which universal coverage and access can be achieved;
(5) supports individually selected and individually-owned health insurance as the preferred method for people to obtain health insurance coverage; and supports and advocates a system where individually-purchased and owned health insurance coverage is the preferred option, but employer-provided coverage is still available to the extent the market demands it;

(6) supports the individual's right to select his/her health insurance plan and to receive the same tax treatment for individually purchased coverage, for contributions toward employer-provided coverage, and for completely employer provided coverage;
(7) supports immediate tax equity for health insurance costs of self-employed and unemployed persons;
(8) supports legislation to remove paragraph (4) of Section 162(l) of the US tax code, which discriminates against the self-employed by requiring them to pay federal payroll (FICA) tax on health insurance premium expenditures;
(9) supports legislation requiring a "maintenance of effort" period, such as one or two years, during which employers would be required to add to the employee's salary the cash value of any health insurance coverage they directly provide if they discontinue that coverage or if the employee opts out of the employer-provided plan;
(10) encourages through all appropriate channels the development of educational programs to assist consumers in making informed choices as to sources of individual health insurance coverage;
(11) encourages employers, unions, and other employee groups to consider the merits of risk-adjusting the amount of the employer direct contributions toward individually purchased coverage. Under such an approach, useful risk adjustment measures such as age, sex, and family status would be used to provide higher-risk employees with a larger contribution and lower-risk employees with a lesser one;
(12) supports a replacement of the present federal income tax exclusion from employees' taxable income of employer-provided health insurance coverage with tax credits for individuals and families, while allowing all health insurance expenditures to be exempt from federal and state payroll taxes, including FICA (Social Security and Medicare) payroll tax, FUTA (federal unemployment tax act) payroll tax, and SUTA (state unemployment tax act) payroll tax;
(13) advocates that, upon replacement, with tax credits, of the exclusion of employer-sponsored health insurance from employees' federal income tax, any states and municipalities conforming to this federal tax change be required to use the resulting increase in state and local tax revenues to finance health insurance tax credits, vouchers or other coverage subsidies; and
(14) believes that refundable, advanceable tax credits inversely related to income are preferred over public sector expansions as a means of providing coverage to the uninsured.
(15) Our AMA reaffirms our policies committed to our patients and their individual responsibility and freedoms consistent with our United States Constitution. (BOT Rep. 41, I-93 CMS Rep. 11,
I-94 Reaffirmed by Sub. Res. 125 and Sub. Res. 109, A-95 Amended by CMS Rep. 2, I-96 Amended and Reaffirmed by CMS Rep. 7, A-97 Reaffirmation A-97 Reaffirmed: CMS Rep. 5,
I-97 Res. 212, I-97 Appended and Amended by CMS Rep. 9, A-98 Reaffirmation I-98 Reaffirmation I-98 Res. 105 & 108, A-99 Reaffirmation A-99 Reaffirmed: CMS Rep. 5 and 7, I-99 Modified: CMS Rep. 4, CMS Rep. 5, and Appended by Res. 220, A-00 Reaffirmation I-00 Reaffirmed: CMS Rep. 2, I-01 Reaffirmed CMS Rep. 5, A-02 Reaffirmation A-03 Reaffirmed: CMS Rep. 1 and 3,
A-02 Reaffirmed: CMS Rep. 3, I-02 Reaffirmed: CMS Rep. 3, A-03 Reaffirmation I-03 Reaffirmation A-04 Consolidated: CMS Rep. 7, I-05 Modified: CMS Rep. 3, A-06 Reaffirmed in lieu of Res. 105, A-06 Reaffirmation A-07 Appended and Modified: CMS Rep. 5, A-08 Modified: CMS Rep. 8, A-08 Reaffirmation A-10 Reaffirmed: CMS Rep. 9, A-11 Reaffirmation A-11 Reaffirmed: Res. 239, A-12 Appended: Res. 239, A-12 Reaffirmed: CMS Rep. 6, A-12 Reaffirmed: CMS Rep. 9, A-14 Reaffirmed in lieu of: Res. 805, I-17)

3. REVIEW OF PAYMENT OPTIONS FOR TRADITIONAL HEALING SERVICES

Reference committee hearing: see report of Reference Committee A.

HOUSE ACTION: **ADOPTED AS FOLLOWS**
IN LIEU OF RESOLUTION 106-A-23
REMAINDER OF REPORT FILED
See Policies D-350.996, H-200.954, H-350.949, H-350.976 and H-350-977

At the 2023 Annual Meeting, the House of Delegates referred Resolution 106, which was sponsored by the Medical Student Section. Resolution 106-A-23 asked for the American Medical Association (AMA) to "study the impact of Medicaid waivers for managed care demonstration projects regarding implementation and reimbursement for traditional American Indian and Alaska Native (AI/AN) healing practices provided in concert with physician-led healthcare teams." Testimony was mixed for Resolution 106, with some recommending alternate language asking our AMA to support Medicaid payment for traditional healing services and encourage involved communities to adhere to a series of principles addressing traditional provider/facility arrangements, covered services, and qualified

providers. Others supported the resolution as written, albeit with further study to recognize the need for cultural relevance while ensuring patient safety. This report focuses on health equity and cultural competence in providing care for AI/AN populations, examines coverage considerations, summarizes relevant Medicaid Section 1115 waiver requests, and presents new policy recommendations.

BACKGROUND

The Office of Management and Budget (OMB) defines an AI/AN individual as "a person having origins in any of the original peoples of North and South America (including Central America) and who maintains Tribal affiliation or community attachment." American Indians and Alaska Natives are a United States (US) census-defined racial group that also has a specific political and legal classification. From 1778 to 1871, US relations with individual American Indian Nations indigenous to what is now the US were established through the treaty-making process. The treaties recognized unique sets of rights, benefits, and conditions for the Tribes who agreed to surrender millions of acres to the U.S. in return for its protection. The US-American Indian treaties are considered to be the foundation upon which federal Indian law and the federal Indian trust responsibility is based. In *Seminole Nation v. United States (1942)*, the US "charged itself with moral obligations of the highest responsibility and trust" toward Indian Tribes and accepted a legally enforceable fiduciary obligation to protect Tribal treaty rights, lands, assets, and resources, as well as a duty to carry out the mandates of federal law with respect to AI/AN Tribes and villages.[1]

In 1954, the Transfer Act moved responsibility for Indian health care from the Bureau of Indian Affairs to the United States Public Health Service in the former Department of Health, Education, and Welfare, currently known as the Department of Health and Human Services (HHS), creating the Indian Health Service (IHS). The IHS was formed to provide federal health care services to AI/AN populations based on the unique government-to-government relationship between the federal government and the Tribes established by treaties and codified in Article I, Section 8 of the US Constitution. IHS funds and delivers health services through a network of programs and facilities, providing services free of charge to eligible individuals. IHS provides an array of direct health care services at its facilities and also refers beneficiaries to private providers for care through the Purchased/Referred Care Program when needed services are not available at IHS facilities. Eligibility is generally restricted to members of federally recognized Tribes and their descendants who live within the geographic service area of an IHS or Tribally operated facility, typically on or near a reservation or other trust land area.

The Snyder Act of 1921 provided explicit legislative authorization for federal health programs for AI/AN individuals by mandating the expenditure of funds for "the relief of distress and conservation of health…(and) for the employment of…physicians…for Indian Tribes." The 1976 Indian Health Care Improvement Act (IHCIA) is the cornerstone legal authority for the provision of health care to AI/AN populations. It was permanently authorized in March 2010 as part of the Patient Protection and Affordable Care Act (ACA) with the goal to "promote traditional health care practices of the Indian Tribes served consistent with the Service standards for the provision of health care, health promotion, and disease prevention" and "fulfill special trust responsibilities and legal obligations to Indians…to ensure the highest possible health status for Indians and urban Indians and to provide all resources necessary to effect that policy."[2] The ACA included many AI/AN-specific provisions, such as greater flexibility in health insurance enrollment in the individual marketplace exchanges, limited or elimination of cost-sharing for health plans based on income, improved payment to IHS hospitals through Medicare, and promotion of traditional healing services. The legislation additionally facilitated the expansion of Medicaid, to the benefit of many AI/AN individuals. The Snyder Act and the permanent authorization of the IHCIA provide legislative authority for Congress to appropriate funds specifically for the health care of Indian people.

Since Indian Tribes are political entities, they are considered sovereign nations participating in a government-to-government relationship with the US separate from the state regulatory structure. The federal government honors this unique relationship by adhering to 2021 Executive Order 13175, which requires federal agencies to engage in meaningful Tribal consultation. As a result of the Executive Order, HHS and the Centers for Medicare & Medicaid Services (CMS) each have a Tribal consultation policy. Depending on the nature of the policy at issue, states are subject to varying levels of Tribal consultation requirements. For example, Section 5006 of the American Recovery and Reinvestment Act requires that states must seek advice from designees of Indian health programs and urban Indian organizations in the state when Medicaid and Children's Health Insurance Program (CHIP) matters have a direct effect on Indians, Indian health programs, or urban Indian programs. States are also required to describe the process for seeking advice from Indian health programs and urban Indian organizations in the Medicaid and CHIP state plans.

IHS does not provide insurance coverage or offer a defined benefit package. Further, because it is not an entitlement program, IHS offers services to the extent permitted by its annual federal appropriation and a limited amount of revenue from other sources (e.g., payment from insurers such as Medicaid). While IHS was previously the only federal health program without advance appropriations, HHS successfully secured advance appropriations for IHS starting in 2024, which means that the majority of IHS-funded programs, including Tribal health programs and urban Indian organizations, will remain funded and operational in the event of an expiration of appropriations. The Indian Health Manual sets forth the policies, standards, and procedures for determining who falls within the scope of the IHS health care program. Generally, in order to receive IHS services, an individual must be a member of a federally recognized Tribe or an Alaska Native Claims Settlement Act shareholder. Health care services unavailable at an IHS/Tribal/Urban facility can be provided by non-IHS health care facilities through the Purchased/Referred Care (PRC) program. Since PRC payments are authorized based on clearly defined guidelines subject to availability of funds, services obtained under PRC must be prioritized, with life-threatening illnesses or injuries being given highest priority. Although there are no deductibles, coinsurance, or copayments for IHS services, insurance allows coverage for things such as specialty care, services without IHS PRC authorization, and care when away from home.

AI/AN individuals who are eligible for health care through the IHS are also entitled to Medicaid/CHIP coverage if they meet the categorical and financial eligibility requirements of the Medicaid/CHIP program in the state in which they reside. When AI/AN individuals enroll in Medicaid/CHIP or a qualified health plan (QHP) available through the Marketplace, they can continue to receive services from their local Indian health care provider and can also access services from non-IHS providers that are participating providers in Medicaid/CHIP or the QHP provider network, respectively. IHS and Tribal providers can generally bill QHP issuers or Medicaid/CHIP for services provided to their patients, and these revenues can be used to pay for costs such as hiring health professionals, purchasing equipment, and meeting accreditation requirements. Medicaid plays a secondary but significant role in financing health services for the AI/AN population, as it provides health insurance coverage for many AI/AN people.[3] In 2020, over 1.8 million AI/AN individuals were enrolled in Medicaid, meaning almost one-fifth of the AI/AN population was covered by Medicaid.[4] Services provided by IHS and Tribal physicians are also subject to a 100 percent Federal Medical Assistance Percentage. As such, Medicaid is an essential source of revenue for the facilities and programs that make up the IHS health care delivery system.

AMERICAN INDIAN/ALASKA NATIVE TRADITIONAL HEALING SERVICES

The value of AI/AN traditional healing services is often measured against modern medicine, or allopathy. Allopathy is the treatment of disease by conventional means and translates to “other than the disease.” Traditional healing is holistic and spiritual, with a focus on well-being and the promotion of health through ceremony-assisted treatments. Many modern medicines and treatments have Indigenous equivalents (e.g., aspirin is closely related to salicin found in willow bark) and studies have found that traditional healing is currently in wide-spread use,[5] with documented effectiveness in diabetes mellitus populations.[6]

A scoping review of the literature provides robust data regarding the utilization of AI/AN traditional healing services, integration of traditional and Western medicine systems, ceremonial practice for healing, and traditional healer perspectives.[7] However, published systematic reviews appear limited to determining the effectiveness of AI/AN traditional healing in treating mental illness or substance use disorders. A 2016 systematic review searched four databases and reference lists for papers that explicitly measured the effectiveness of traditional healers on mental illness and psychological distress. While there was some evidence that traditional healers can provide an effective psychosocial intervention by helping to relieve distress and improve mild symptoms in common mental disorders such as depression and anxiety, they found little evidence to suggest that traditional healers change the course of severe mental illnesses such as bipolar and psychotic disorders.[8] A 2023 systematic review assessed the feasibility of AI/AN traditional ceremonial practices to address substance use disorders in both reservation and urban settings. Between September 2021, and January 2022, culturally specific review protocols were applied to articles retrieved from over 160 electronic databases, with 10 studies meeting the criteria for inclusion in the review. While all 10 studies reported some type of quantitative data showing a reduction of substance use associated with traditional ceremonial practices, the fact that the current status of the literature is emerging did not allow for meta-analysis of existing studies.[9]

For AI/AN communities, traditional healing practices are a fundamental element of Indian health care that helps individuals achieve wellness and restores emotional balance and one’s relationship with the environment. While

traditional healing services are recognized by the IHCIA, there is no statutory definition for traditional healing services. Some Tribes believe that a health problem is an imbalance between an individual and the community and there are seven natural ways of emotional discharge and healing to address that imbalance: shaking, crying, laughing, sweating, voicing (i.e., talking, singing, hollering, yelling, screaming), kicking, and hitting, all of which must be done in a constructive manner so as to not harm another spirit.[10] Accordingly, Traditional AI/AN healing services might include a range of services such as (but not limited to):

- Sweat lodges
- Healing hands
- Prayer
- Smudging and purification rituals
- Song and dance
- Use of herbal remedies
- Culturally sensitive and supportive counseling
- Shamanism

Traditional healers are often identified in their Tribal community by their innate gift of healing. They typically work informally but may continue to uncover their unique gift through apprenticeship and by observing more experienced healers. Many traditional healers do not charge for their services but are given gifts as an expression of gratitude. Some healers will not accept payment at all, especially when originating from a third-party.

HEALTH EQUITY CONSIDERATIONS

In 1883, the federal government established the Code of Indian Offenses to prosecute American Indians who participated in traditional ceremonies in order to replace them with Christianity.[11]
This was one of several methods utilized to restrict the cultural identity of American Indian Tribes throughout US history. In 1978, the American Indian Religious Freedom Act (AIRFA) was a pivotal turning point in addressing concerns regarding separation of church and state, legalizing traditional spirituality and ceremonies, and overturning local and state regulations that had banned AI/AN spiritual practices. In 1994, AIRFA was expanded to increase access to traditional healing services such that "when an Indian Health Service patient requests assistance in obtaining the services of a native practitioner, every effort will be made to comply…such efforts might include contacting a native practitioner, providing space or privacy within a hospital room for a ceremony, and/or the authorization of contract health care funds to pay for native healer consultation when necessary."

More recently, Congress recognized "provid[ing] the resources, processes, and structure that will enable Indian Tribes and Tribal members to obtain the quantity and quality of health care services and opportunities to eradicating health disparities between Indians and the general population of the United States," as a top national priority. After President Biden issued Executive Order 13985 in 2021 to establish equity as a cornerstone of Administration policy, the National Indian Health Board (NIHB), supported by CMS and the CMS Tribal Technical Advisory Group (TTAG), convened AI/AN leaders to consider what health equity means from a Tribal perspective. The resulting 2022 NIHB report similarly concluded that traditional healing is essential to advancing health equity. The federal government issued a second Executive Order in 2023, to further build equity into the business of government.

The 2022 NIHB report established that in pursuit of honoring Indigenous knowledge, traditional healing services should be paid utilizing paths to credentialing and billing that are Tribally led and approached with sensitivity and cultural humility. In September 2023, the CMS TTAG wrote to the CMS Administrator urging the Biden-Harris Administration to develop CMS policy in support of funding and payment for traditional healing, which would "allow Tribes to use the additional third-party revenue to expand traditional healing services, coordinate the services within the facility, hire additional healers as appropriate, and create a space for ceremonial practices."

LESSONS LEARNED IN FOSTERING CULTURAL COMPETENCE

In January 1952, two anthropologists and a physician from Cornell Medical College learned that tuberculosis raged untreated on the Navajo Reservation in Arizona. Recognizing a valuable opportunity for medical research, they designed and administered a ten-year demonstration to evaluate the efficacy of new antibiotics and test the power of modern medicine to improve the health conditions of a marginalized rural society. In 1970, they published a book detailing the demonstration and deeming the project a success, as it established a mechanism for effective, continued

community control and elicited full participation by community members who expressed satisfaction with the care they received.[12] A 2002 analysis of the demonstration drew different conclusions, where "researchers exploited the opportunities made possible by the ill-health of a marginalized population…(and) erected an intrusive system of outpatient surveillance that failed to reduce the dominant causes of morbidity and mortality…(where) every act of treatment became an experiment (and) risked undermining the trust on which research and clinical care depended."[13] However, the demonstration's exploration of AI/AN traditional healing is perhaps the only semiquantitative approach to the subject and provides insights that remain useful today, as the demonstration recognized that "First, it must be realized that this is not a situation of compromising alternatives. Rather, there is belief on the part of patients that both systems have something to offer, they both 'work.'"[14]

Humility, which is at the core of AI/AN traditional healing, requires commitment to cultural connectedness, particularly when traditional healing services are provided in concert with allopathic/osteopathic care. While validated cultural connectedness measurement scales are available,[15] there are tenets of traditional healing that can be successfully incorporated into any care coordination paradigm, such as providing multigenerational visits and home visits to reinforce the value of community-and family-based care or supporting a holistic approach to care through hands-on healing, physical body manipulation, and use of Indigenous diets to promote food as medicine. More AI/AN patients are embracing the opportunity to benefit from coordination between traditional healing and allopathic/osteopathic care. For example, in the Navajo Tribe, use of healers overlaps with use of medical providers for common medical conditions and patients rarely perceive conflict between the Native healer and conventional medicine.[16] If traditional healing services are allied with the health system, care can be coordinated to accommodate individuals' needs, leading to improved health outcomes.[17] Furthermore, coordination, open communication, and transparency are critical to overcoming medical mistrust in modern medicine among AI/AN individuals.

There are two areas where it is particularly important to further cultural sensitivity in the provision of traditional healing services:

(1) Collecting data: While Indigenous Peoples need health data to help identify populations at risk and monitor the effectiveness of programs, health care centers and public health institutions regularly overlook the AI/AN community when collecting data and conducting research. Because some AI/AN patients are hesitant to allow the collection of their health care data by non-Indigenous individuals due to a lack of trust in how it might be used, this underrepresentation can be magnified. Additionally, because Western research protocols do not prioritize providing benefits to the entire community, randomized clinical trials are often perceived as unacceptable and unfair as true randomization is difficult to apply when investigators have legacy relationships with certain individuals over others. The perception that control-group communities are receiving a lesser intervention, or none at all, can result in an ethical and cultural, and often stressful, struggle for both academic and community investigators.[18]

(2) Credentialing traditional healers: As non-AI/AN protocols cannot be easily applied in determining necessary qualifications when it comes to traditional healing services, many Tribes have established distinct processes for credentialing traditional healers. A Tribal credentialing process might involve a multi-level training program where applications are reviewed by Tribal Elders, who then interview candidates before being considered by the Council of Elders. Given the wide variation among Tribes, many agree that it would be impractical to standardize the credentialing process. Furthermore, if traditional healing is governmentally regulated and licensed, then licensing boards will tell traditional healers what conditions they can and cannot treat, what methods are acceptable, and determine who is qualified, possibly challenging Tribal sovereignty.

EFFORTS TO INTEGRATE TRADITIONAL HEALING SERVICES AND CONVENTIONAL MEDICINE

Due to the fact that traditional healing services exist outside the paradigm of conventional medicine and vary across Tribes, they do not necessarily adhere to a conventional evidence-based standard of care. Ensuring patient safety and quality of care through the delivery of evidence-based medicine remains a top priority for the AMA. Accordingly, when it comes to traditional healing services or integrative medicine services, it is important to distinguish between welcoming the benefits of culturally competent/sensitive care as adjunctive or supportive and full acceptance of non-evidence-based medicine practices as substitutes for evidence-based medicine-derived treatments. In Canada and the US, there is a growing movement toward combining traditional healing services with conventional medicine. The "wise practices" model incorporates local knowledge, culture, language, and values into program design, implementation, and evaluation. This ensures that the local context is a formal component of determining program success, allowing for improved community engagement and increased community acceptance of programs. Wise

practices allow Indigenous knowledge and principles to be incorporated into public health, academic, and policy settings.

In 2020, the University of North Dakota launched the first of its kind doctoral program in Indigenous health, offering students a deeper understanding of the unique health challenges faced by Indigenous communities. The training is focused on getting to know the community and its history to allow the provision of health care on reservations that is both evidence-based and culturally competent. That same year, KFF reported that IHS facilities were actively seeking job applicants for traditional healers toward rebuilding trust and recouping Indigenous expertise. In 2022, a Federal Indian Health Insurance Plan was proposed in *Preventive Medicine Reports* that would offer a culturally competent, comprehensive health insurance product that would include payment for traditional healing services and eliminate premiums and all other forms of cost-sharing regardless of income.[19] To-date, its legislative status is unknown.

LEARNING FROM PAST CONSIDERATIONS OF ALTERNATIVE TREATMENT OPTIONS

Developing an infrastructure to allow coverage for AI/AN traditional healing services could be informed by coverage considerations for other types of traditional healing services or integrative medicine services, which have varying degrees of success in being covered by insurance and differing evidence bases, many of which are still evolving as coverage expands.

Considerations surrounding coverage and payment for other types of alternative treatment include:

- Patient safety/quality and outcomes oversight
- Training, licensing, credentialing of providers
- Benefit design and payment structure
- Utilization uptake

Due to these and other considerations, insurance plans often have measures in place to ensure patient safety and clinical effectiveness in exchange for payment. For example, many plans only cover these services if prescribed by a physician or licensed practitioner as a demonstration of clinical benefit to the patient. Most insurance plans utilize a team of clinical experts to review which services meet their requirements for safety and effectiveness before offering coverage.

PURSUING PAYMENT FOR AI/AN TRADITIONAL HEALING SERVICES

Payment for the provision of AI/AN traditional healing services offers pathways for complementary practices, improvements in safety of care coordination, and trust-building between physicians and patients rooted in cultural sensitivity. Allowing payment for traditional healing services will likely increase access for AI/AN patients. In situations where traditional healers are unable to accept payment directly from patients, the payment can be given to the IHS facility, which can utilize the funds to procure medical supplies, invest in capital (e.g., build a Navajo Hogan), and pay the healers and other health care providers employed by the IHS.

During the August 2023 Traditional Medicine Global Summit, the World Health Organization (WHO) presented results from the third global survey on traditional medicine, which included questions on financing of traditional medicine, health of Indigenous Peoples, evidence-based traditional medicine, integration, and patient safety. In addition to informing the development of WHO's 2025-2034 traditional medicine strategy, these findings outline how standardization of traditional medicine condition documentation and coding in routine health information systems is a pre-requisite for effective implementation of traditional medicine in health care systems.

Payment for any health service usually requires establishing a coding infrastructure to allow reporting in a standardized manner. The infrastructure includes both procedural and diagnosis codes to answer the "what" and "why" of patient encounters, respectively. While there are currently no procedure codes for AI/AN traditional healing services, in May 2023, Blue Cross Blue Shield of Minnesota (BCBS MN) submitted an application for a Healthcare Common Procedural Coding System (HCPCS) Level II code to allow AI/AN Medicaid and dual-eligible members to receive and bill the health plan for traditional healing services. While approval of the code is currently pending a decision by CMS, BCBS MN will plan to pilot it with four Native-led clinics using an Indigenous evaluator to determine patient satisfaction, leaving it up to each clinic as to the level of physician involvement. Each

Native-led clinic will validate the traditional healing services through its Elder in Residence, Elders Council, or Elders Advisory Board. The HCPCS Level II code will be used to pay a capitated fee, viewed as administrative remuneration to offset the grant amount. BCBS MN is currently required to use an unlisted Current Procedural Terminology (CPT®) code to allow reporting of traditional healing services, which necessitates review of each paper claim submission. The HCPCS Level II nomenclature includes code *S9900, Services by a journal-listed Christian science practitioner for the purpose of healing, per diem*, which may serve as a precedent to assist CMS in its decision. Another option could be a standard encounter fee, such as the IHS All Inclusive Rate (AIR), which is the amount paid to IHS and Tribal facilities by CMS for Medicaid covered services per encounter (not per specific service). IHS reviews annual cost reports before submitting recommended rates to OMB for final approval through HHS. The approved AIRs are published in the *Federal Register* to allow annual updates to IHS systems. In lieu of a discrete HCPCS/CPT code, traditional healing services could be paid using an AIR.

The WHO's *International Classification of Diseases, 11th Edition* (ICD-11) allows reporting of traditional medicine diagnoses, representing a formative step for the integration of traditional medicine conditions into a classification standard used in conventional medicine. As a tool for counting and comparing traditional medicine conditions, the ICD-11 *Traditional Medicine Chapter* can provide the means for doing research and evaluation to establish efficacy of traditional medicine and collect morbidity data (e.g., payment, patient safety, research).[20]

Additionally, the *International Classification of Diseases, 10th Edition, Clinical Modification* (ICD-10-CM), which is the Health Insurance Portability & Accountability Act diagnosis code set standard, includes social determinants of health (SDOH)-related Z codes (Z55-Z65). The Z codes can be reported when documentation specifies that a patient has an associated problem or risk factor that influences their health (e.g., housing insecurity or extreme poverty), thereby helping to improve equity in health care delivery and research by:

- Empowering physicians to identify and address health disparities (e.g., care coordination and referrals)
- Supporting planning and implementation of social needs interventions
- Identifying community and population needs
- Monitoring SDOH intervention effectiveness for patient outcomes
- Utilizing data to advocate for updating and creating new policies

Payment processes for traditional healing services should be culturally sensitive, to allow individuals to "recover one's wholeness." The Anti-Deficiency Act prevents the IHS from participating in risk-based contracts, as it prohibits expenditures in excess of amounts available in appropriations. Furthermore, a bundled payment model would not be logical as healers cannot be put at risk based on outcomes in an environment where collection of demographic-based outcome data is suspect. There are several possible options for a payment model, including:

- Standard Encounter Fee: IHS, Tribal, or Urban Indian health facilities paid at the AIR per encounter rate available for Medicaid inpatient and outpatient hospital services for covered traditional healing services, with hospital services billed on a Uniform Billing Form (UB-04) at the OMB AIR using with the current rate published in the *Federal Register*.
- Fee-for-Service: Payment based on traditional healing services provided to an individual AI/AN patient and reported by a HCPCS/CPT code(s) (e.g., BCBS MN pilot)
- Member Benefit Allowance: Each eligible AI/AN patient receives an added value benefit to be spent on traditional healing services at their determination. This option could circumvent some Tribes' inability to accept payment from a third party. The self-directed community benefit is currently utilized by the New Mexico Centennial Care 2.0 Medicaid Section 1115 waiver. Native American Healers is among the specialized therapies under the member-managed annual $2,000 budget, allowing Tribal members to have access to an annual sum to use for traditional healing services.
- Medicaid Section 1115 Waivers.

MEDICAID SECTION 1115 WAIVER REQUESTS

Medicaid Section 1115 waivers may provide another path forward for payment of traditional healing services through conventional health care systems. While federal officials have called for state Medicaid programs to improve their ability to provide culturally competent services to AI/AN beneficiaries[21] and Congress granted IHS the ability to bill Medicaid, traditional healing services are not currently a Medicaid nationally covered service. However, Section 1115(a) of the Social Security Act (SSA) authorizes the Secretary of HHS to waive provisions of

Section 1902 of the SSA and grant expenditure authority to treat demonstration costs as federally matchable expenditures under Section 1903 of the SSA. The Secretary's approval of experimental, pilot, or demonstration projects is discretionary and must be based on a finding that the demonstration is likely to assist in promoting the objectives of the Medicaid program.

Medicaid Section 1115 waivers are initially approved for five years and renewable for three years at a time. The waivers are required to be budget-neutral, meaning that federal spending under the waiver cannot exceed what it would have been in absence of the waiver. Although not defined by federal statue or regulations, this requirement has been in practice for many years. Over time, CMS has allowed states to calculate budget neutrality in multiple ways, although in 2018 it provided states with additional information on agency policies regarding calculating budget neutrality.

To date, four states (i.e., Arizona, California, New Mexico, and Oregon) have pursued Medicaid Section 1115 demonstration authority to cover traditional healing services furnished by Indian health providers to AI/AN Medicaid beneficiaries. In general, the waiver requests seek that the maximum amount of discretion be given to Native and Indigenous communities to establish relevant programs for each community, while allowing HHS to enact certain federal oversight requirements to ensure patient safety and program requirements are being met (e.g., background checks, verification of training, etc.) upon approval of the requests. The Center for Medicaid & CHIP Services (CMCS) is the agency charged with reviewing the state waiver requests with the goal of supporting cultural alignment of providers and patients toward reducing health disparities in the AI/AN community. CMCS has acknowledged the importance of incorporating Tribal leadership into the review process since traditional healing services vary across Tribes. Below is a summary of the current status of each state's waiver application request.

Arizona

It is expected that the Arizona waiver application will be considered by CMCS first – and then serve as the template for the other three states. The Arizona Health Care Cost Containment System (AHCCCS) initially submitted its waiver request in 2015 and then again in 2020, consulting with Tribal leadership prior to each submission. AHCCCS is requesting permission to pay for traditional healing services using Title 19 dollars, maximizing individual Tribal communities' discretion to define traditional healing services and qualifications for traditional healers. The request limits services to individuals served by the IHS and urban Indian facilities and proposes paying the AIR, which is annually established by the federal government. It also includes specific service parameters toward maximizing patient benefit and safety.

California

The California Department of Health Care Services (DHCS) has requested authority to cover Traditional Healer and Natural Helper services under the Drug Medi-Cal Organized Delivery System (DMC-ODS) in 2017, 2020, and again in 2021. The most recent request includes Traditional Healer and Natural Helper services under the DMC-ODS as part of the comprehensive California Advancing and Innovating Medi-Cal initiative. The purpose of the request is to provide culturally appropriate options and improve access to substance use disorder (SUD) treatment for AI/AN Medi-Cal members receiving SUD treatment services through Indian health care providers. Meanwhile, DHCS provides funding and technical assistance resources to Tribal and urban Indian health programs through the Tribal MAT Project, including the Tribal and Urban Indian Community Defined Best Practices program. Described by its lead entities as "a unified response to the opioid crisis in California Indian Country," the Tribal MAT Project was designed to meet the specific opioid use disorder prevention, treatment, and recovery needs of California's Tribal and Urban Indian communities with special consideration for Tribal and urban Indian values, culture, and treatments.

New Mexico

Since 2019, New Mexico's Centennial Care 2.0 Section 1115 demonstration has provided a self-directed community budget for specialized therapies to members with a nursing-facility level of care need (NF LOC) and who receive home and community-based services (HCBS). Native American Healing is among the specialized therapies under the member-managed annual $2,000/member budget. All Tribal members with an NF LOC need are mandatorily enrolled in a health plan. Tribal members ineligible for HCBS and who have enrolled in a health plan may have access to an annual sum to use for traditional healing services; this arrangement is considered a "value-added service"[22] subject to the health plan to provide or place parameters on the benefit. In 2022, the New Mexico Human Services Department (HSD) submitted a waiver renewal application seeking federal approval to renew and enhance the Centennial Care 2.0 waiver to expand the availability of culturally competent, traditional healing benefits to

AI/AN members enrolled in managed care, up to $500/member for traditional healing services to each Tribal member enrolled in managed care and lacking an NF LOC need. HSD has hosted Tribal Listening Sessions to gather feedback on the new Member-Directed Traditional Healing Benefits for Native Americans.

Oregon
In 2022, the Oregon Health Plan (OHP) submitted a Section 1115 waiver request to continue foundational elements of the OHP with a substantial refocus on addressing health inequities, including expanding benefits for AI/AN OHP members to include Tribal-based practices as a covered service, and waive prior authorization criteria for Tribal members. The Oregon Health Authority and the Oregon Tribes implemented a process by which Tribal-based practices are developed and approved by the Tribal-Based Practice Review Panel, which is comprised of Tribal representatives.

In reviewing the applications across the four states, CMCS' goal is to identify commonality of services that can be covered under Medicaid, provided by traditional healers who have been credentialed within their communities. CMCS plans to pay for traditional healing services through certified IHS facilities, who will then decide how the traditional healers are paid. It is not anticipated that traditional healing will require a referral or prior authorization, as this limits access to the service. CMCS is currently undergoing robust consultation with Tribes and IHS to identify common traditional healing services, facilities where those services are being provided, and providers who will provide them. Pending approval of the waivers, CMCS has expressed that it would require each state to develop and report on benchmarks to demonstrate how it is improving outcomes and reducing disparities, thereby requiring demonstration of value while allowing for variation by state and by Tribe.

AMA POLICY

AMA Policy H-290.987 generally supports Section 1115 waivers that assist in promoting the goals of the Medicaid program and have sufficient payment levels to secure adequate access to providers.

Policy H-350.949 encourages Medicaid managed care organizations to follow the CMS TTAG's recommendations to improve care coordination and payment agreements with Indian health care providers.

The AMA has several policies outlining the integral and culturally necessary role that traditional healing services play in delivering health care to AI/AN individuals, including:

- Policy H-350.948, which advocates for increased funding to the IHS Purchased/Referred Care Program and the Urban Indian Health Program to enable the programs to fully meet the health care needs of AI/AN patients;
- Policy H-350.976, which recognizes the "medicine man" as an integral and culturally necessary individual in delivering health care to American Indians and Alaska Natives; and
- Policy H-350.977, which supports expanding the role of the American Indian in their own health care and increased involvement of private practitioners and facilities in American Indian care.

The AMA has long-standing policy identifying, evaluating, and working to close health care disparities, including:

- Policy D-350.995, which calls for a study of health system opportunities and barriers to eliminating racial and ethnic disparities in health care;
- Policy D-350.996, which calls for the AMA to continue to identify and incorporate strategies specific to the elimination of minority health care disparities in its ongoing advocacy and public health efforts;
- Policy H-200.954, which supports efforts to quantify the geographic maldistribution of physicians and encourages medical schools and residency programs to consider developing admissions policies and practices and targeted educational efforts aimed at attracting physicians to practice in underserved areas and to provide care to underserved populations; and
- Policy H-350.974, which encourages the development of evidence-based performance measures that adequately identify socioeconomic and racial/ethnic disparities in quality and supports the use of evidence-based guidelines to promote the consistency and equity of care for all persons.

Further, Policy H-480.973 encourages the National Center for Complementary and Integrative Health to determine by objective and scientific evaluation the efficacy and safety of practices and procedures of unconventional medicine.

DISCUSSION

Resolution 106-A-23 calls for the AMA to study the impact of using Medicaid Section 1115 waivers for demonstration projects regarding payment for AI/AN traditional healing services. The Council recognizes the value of traditional healing services for AI/AN patients and understands the need for state flexibility to design Medicaid programs that best respond to the health care needs of their enrollees. The purpose of Section 1115 waivers, which give states additional flexibility to design and improve their Medicaid programs, is to demonstrate and evaluate state-specific policy approaches to better serving that state's unique population of Medicaid enrollees, including AI/AN individuals. The Council acknowledges the importance of cultural competence, particularly with regard to understanding traditional healing and its economic impact in the Section 1115 waiver program, as it requires regular monitoring and independent evaluation of outcomes, which is challenging to do while respecting Tribal data sovereignty. Additionally, it is uncertain how generalizable outcomes might be given the vast differences among Tribes.

The Council understands the importance of distinguishing between culturally competent/sensitive care as adjunctive or supportive and full acceptance of non-evidence-based medicine practices as substitutes for evidence-based medicine-derived treatments. Further, with the Medicaid Section 1115 waiver demonstrations, we may find novel programs that are based on evidence. While support of guidelines for coordinating traditional healing services as part of the physician-led health care team was requested by Resolution 106-A-23 and is consistent with AMA policy, decisions should be made in concert with Tribes in order to ensure inclusive and culturally relevant care. Experts with whom the Council agrees have recommended that each Tribe be responsible for verifying that valid traditional healing services have been performed by credentialed healers, taking into account the "medical necessity" of the service along with the appropriate site of service (e.g., hogan versus hospital).

With many AI/AN patients utilizing traditional healing services,[23] patient safety will be maximized if there is care coordination between Indigenous healers and physicians. The Council appreciates the value of traditional healing services for AI/AN patients when provided in coordination with evidence-based conventional medicine, and believes such coordination may allow the culturally competent physician-led health care team to address Tribal social determinants of health while building trust in conventional care systems among the AI/AN community. What cannot be overlooked, however, is the substantial shortage of physicians identifying as AI/AN. As of 2021, fewer than 3,000 physicians – or 0.4 percent of total physicians – identified as American Indian or Alaska Native, according to the latest statistics from the Association of American Medical Colleges Physician Specialty Data Report. The US Government Accountability Office published a report outlining an average vacancy rate for IHS physicians, nurses, and other care providers of 25 percent. There would need to be more physicians who identify as AI/AN if the U.S. is to provide culturally sensitive care implemented by a physician-led team utilizing a traditional healing model.

AI/AN traditional healing represents a spiritual tradition tied to lifestyle, community, sovereignty issues, and land and culture preservation not easily explained by Western medicine. The history of AI/AN Tribes in the US involves dislocation and upheaval followed by sustained disregard for effective Indigenous practices based on a historic preference for conventional evidence-based medicine. Barriers to care have been created by a lack of cultural competence among systems of care that fail to question how evidence is defined.

It is critically important to remember that the US has a special responsibility to AI/AN populations due to treaty obligations and sovereign nation status which differentiate AI/AN traditional healing from other forms of traditional healing. The IHCIA and resulting creation of the IHS establish clear federal law plus a mandate to ensure the highest possible health status and to provide all resources necessary for AI/AN populations.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 106-A-23, and the remainder of the report be filed:

1. That our American Medical Association (AMA) amend Policy H-350.976 by addition and deletion, and modify the title by addition, as follows:

   Improving Health Care of American Indians and Alaska Natives H-350.976
   (1) Our AMA recommends that: (1) All individuals, special interest groups, and levels of government recognize the American Indian and Alaska Native people as full citizens of the US, entitled to the same equal rights and privileges as other US citizens.
   (2) The federal government provide sufficient funds to support needed health services for American Indians and Alaska Natives.
   (3) State and local governments give special attention to the health and health-related needs of nonreservation American Indians and Alaska Natives in an effort to improve their quality of life.
   (4) American Indian and Alaska Native religious and cultural beliefs be recognized and respected by those responsible for planning and providing services in Indian health programs.
   (5) Our AMA recognize practitioners of Indigenous medicine as an integral and culturally necessary individual in delivering health care to American Indians and Alaska Natives.
   (6) Our AMA monitor Medicaid Section 1115 waivers that recognize the value of traditional American Indian and Alaska Native healing services as a mechanism for improving patient-centered care and health equity among American Indian and Alaska Native populations when coordinated with physician-led care.
   (7) Our AMA support consultation with Tribes to facilitate the development of best practices, including but not limited to culturally sensitive data collection, safety monitoring, the development of payment methodologies, healer credentialing, and tracking of traditional healing services utilization at Indian Health Service, Tribal, and Urban Indian Health Programs.
   (~~6~~8) Strong emphasis be given to mental health programs for American Indians and Alaska Natives in an effort to reduce the high incidence of alcoholism, homicide, suicide, and accidents.
   (~~7~~9) A team approach drawing from traditional health providers supplemented by psychiatric social workers, health aides, visiting nurses, and health educators be utilized in solving these problems.
   (~~8~~10) Our AMA continue its liaison with the Indian Health Service and the National Indian Health Board and establish a liaison with the Association of American Indian Physicians.
   (~~9~~11) State and county medical associations establish liaisons with intertribal health councils in those states where American Indians and Alaska Natives reside.
   (~~10~~12) Our AMA supports and encourages further development and use of innovative delivery systems and staffing configurations to meet American Indian and Alaska Native health needs but opposes overemphasis on research for the sake of research, particularly if needed federal funds are diverted from direct services for American Indians and Alaska Natives.
   (~~11~~13) Our AMA strongly supports those bills before Congressional committees that aim to improve the health of and health-related services provided to American Indians and Alaska Natives and further recommends that members of appropriate AMA councils and committees provide testimony in favor of effective legislation and proposed regulations.

2. That our AMA reaffirm Policy D-350.996, which states that the AMA will continue to identify and incorporate strategies specific to the elimination of minority health care disparities in its ongoing advocacy and public health efforts.

3. That our AMA reaffirm Policy H-200.954, which supports efforts to quantify the geographic maldistribution of physicians and encourages medical schools and residency programs to consider developing admissions policies and practices and targeted educational efforts aimed at attracting physicians to practice in underserved areas and to provide care to underserved populations.

4. That our AMA reaffirm Policy H-350.949, which encourages state Medicaid agencies to follow the Centers for Medicare & Medicaid Services Tribal Technical Advisory Group's recommendations to improve care coordination and payment agreements between Medicaid managed care organizations and Indian health care providers.

5. That our AMA reaffirm Policy H-350.977, which supports expanding the American Indian role in their own health care and increased involvement of private practitioners and facilities in American Indian health care through such mechanisms as agreements with Tribal leaders or Indian Health Service contracts, as well as normal private practice relationships.

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Council on Medical Service Report 3-A-24
Review of Payment Options for Traditional Healing Services
Policy Appendix

Strategies for Eliminating Minority Health Care Disparities D-350.996
Our American Medical Association (AMA) will continue to identify and incorporate strategies specific to the elimination of minority health care disparities in its ongoing advocacy and public health efforts, as appropriate.
Res. 731, I-02 Modified: CCB/CLRPD Rep. 4, A-12 Reaffirmed: CCB/CLRPD Rep. 1, A-22

US Physician Shortage H-200.954
Our AMA:
(1) explicitly recognizes the existing shortage of physicians in many specialties and areas of the US;
(2) supports efforts to quantify the geographic maldistribution and physician shortage in many specialties;
(3) supports current programs to alleviate the shortages in many specialties and the maldistribution of physicians in the US;
(4) encourages medical schools and residency programs to consider developing admissions policies and practices and targeted educational efforts aimed at attracting physicians to practice in underserved areas and to provide care to underserved populations;
(5) encourages medical schools and residency programs to continue to provide courses, clerkships, and longitudinal experiences in rural and other underserved areas as a means to support educational program objectives and to influence choice of graduates' practice locations;
(6) encourages medical schools to include criteria and processes in admission of medical students that are predictive of graduates' eventual practice in underserved areas and with underserved populations;
(7) will continue to advocate for funding from public and private payers for educational programs that provide experiences for medical students in rural and other underserved areas;
(8) will continue to advocate for funding from all payers (public and private sector) to increase the number of graduate medical education positions in specialties leading to first certification;
(9) will work with other groups to explore additional innovative strategies for funding graduate medical education positions, including positions tied to geographic or specialty need;
(10) continues to work with the Association of American Medical Colleges (AAMC) and other relevant groups to monitor the outcomes of the National Resident Matching Program; and
(11) continues to work with the AAMC and other relevant groups to develop strategies to address the current and potential shortages in clinical training sites for medical students.
(12) will: (a) promote greater awareness and implementation of the Project ECHO (Extension for Community Healthcare Outcomes) and Child Psychiatry Access Project models among academic health centers and community-based primary care physicians; (b) work with stakeholders to identify and mitigate barriers to broader implementation of these models in the United States; and (c) monitor whether health care payers offer additional payment or incentive payments for physicians who engage in clinical practice improvement activities as a result of their participation in programs such as Project ECHO and the Child Psychiatry Access Project; and if confirmed, promote awareness of these benefits among physicians.
(13) will work to augment the impact of initiatives to address rural physician workforce shortages.
(14) supports opportunities to incentivize physicians to select specialties and practice settings which involve

delivery of health services to populations experiencing a shortage of providers, such as women, LGBTQ+ patients, children, elder adults, and patients with disabilities, including populations of such patients who do not live in underserved geographic areas
Res. 807, I-03 Reaffirmation I-06 Reaffirmed: CME Rep. 7, A-08 Appended: CME Rep. 4, A-10 Appended: CME Rep. 16, A-10 Reaffirmation: I-12 Reaffirmation A-13 Appended: Res. 922, I-13 Modified: CME Rep. 7, A-14 Reaffirmed: CME Rep. 03, A-16 Appended: Res. 323, A-19 Appended: CME Rep. 3, I-21 Reaffirmation: I-22 Appended: Res. 105, A-23 Reaffirmed: BOT Rep. 11, A-23

Medicaid Waivers for Managed Care Demonstration Projects H-290.987
(1) Our AMA adopts the position that the Secretary of Health and Human Services should determine as a condition for granting waivers for demonstration projects under Section 1115(a) of the Medicaid Act that the proposed project: (i) assist in promoting the Medicaid Act's objective of improving access to quality medical care, (ii) has been preceded by a fair and open process for receiving public comment on the program, (iii) is properly funded, (iv) has sufficient provider reimbursement levels to secure adequate access to providers, (v) does not include provisions designed to coerce physicians and other providers into participation, such as those that link participation in private health plans with participation in Medicaid, and (vi) maintains adequate funding for graduate medical education. (2) Our AMA advocates that CMS establish a procedure which state Medicaid agencies can implement to monitor managed care plans to ensure that (a) they are aware of their responsibilities under EPSDT, (b) they inform patients of entitlement to these services, and (c) they institute internal review mechanisms to ensure that children have access to medically necessary services not specified in the plan's benefit package. (BOT Rep. 24, A-95; Reaffirmation A-99; Reaffirmation A-00; Reaffirmation I-04; Modified: CMS Rep. 1, A-14)

Medicaid Managed Care for Indian Health Care Providers H-350.949
Our AMA will: (1) support stronger federal enforcement of Indian Health Care Medicaid Managed Care Provisions and other relevant laws to ensure state Medicaid agencies and their Medicaid managed care organizations (MCO) are in compliance with their legal obligations to Indian health care providers; and (2) encourage state Medicaid agencies to follow the Centers for Medicare and Medicaid Services Tribal Technical Advisory Group's recommendations to improve care coordination and payment agreements between Medicaid managed care organizations and Indian health care providers.
Res. 208, A-23

Improving Health Care of American Indians H-350.976
Our AMA recommends that: (1) All individuals, special interest groups, and levels of government recognize the American Indian people as full citizens of the US, entitled to the same equal rights and privileges as other U.S. citizens.
(2) The federal government provide sufficient funds to support needed health services for American Indians.
(3) State and local governments give special attention to the health and health-related needs of nonreservation American Indians in an effort to improve their quality of life.
(4) American Indian religious and cultural beliefs be recognized and respected by those responsible for planning and providing services in Indian health programs.
(5) Our AMA recognize the "medicine man" as an integral and culturally necessary individual in delivering health care to American Indians.
(6) Strong emphasis be given to mental health programs for American Indians in an effort to reduce the high incidence of alcoholism, homicide, suicide, and accidents.
(7) A team approach drawing from traditional health providers supplemented by psychiatric social workers, health aides, visiting nurses, and health educators be utilized in solving these problems.
(8) Our AMA continue its liaison with the Indian Health Service and the National Indian Health Board and establish a liaison with the Association of American Indian Physicians.
(9) State and county medical associations establish liaisons with intertribal health councils in those states where American Indians reside.
(10) Our AMA supports and encourages further development and use of innovative delivery systems and staffing configurations to meet American Indian health needs but opposes overemphasis on research for the sake of research, particularly if needed federal funds are diverted from direct services for American Indians.
(11) Our AMA strongly supports those bills before Congressional committees that aim to improve the health of and health-related services provided to American Indians and further recommends that members of appropriate AMA councils and committees provide testimony in favor of effective legislation and proposed regulations.

CLRPD Rep. 3, I-98 Reaffirmed: Res. 221, A-07 Reaffirmation A-12 Reaffirmed: Res. 233, A-13 Reaffirmed: BOT Rep. 09, A-23

Indian Health Service H-350.977

The policy of the AMA is to support efforts in Congress to enable the Indian Health Service to meet its obligation to bring American Indian health up to the general population level. The AMA specifically recommends: (1) Indian Population: (a) In current education programs, and in the expansion of educational activities suggested below, special consideration be given to involving the American Indian and Alaska native population in training for the various health professions, in the expectation that such professionals, if provided with adequate professional resources, facilities, and income, will be more likely to serve the tribal areas permanently; (b) Exploration with American Indian leaders of the possibility of increased numbers of nonfederal American Indian health centers, under tribal sponsorship, to expand the American Indian role in its own health care; (c) Increased involvement of private practitioners and facilities in American Indian care, through such mechanisms as agreements with tribal leaders or Indian Health Service contracts, as well as normal private practice relationships; and (d) Improvement in transportation to make access to existing private care easier for the American Indian population.

(2) Federal Facilities: Based on the distribution of the eligible population, transportation facilities and roads, and the availability of alternative nonfederal resources, the AMA recommends that those Indian Health Service facilities currently necessary for American Indian care be identified and that an immediate construction and modernization program be initiated to bring these facilities up to current standards of practice and accreditation.

(3) Manpower: (a) Compensation for Indian Health Service physicians be increased to a level competitive with other Federal agencies and nongovernmental service; (b) Consideration should be given to increased compensation for service in remote areas; (c) In conjunction with improvement of Service facilities, efforts should be made to establish closer ties with teaching centers, thus increasing both the available manpower and the level of professional expertise available for consultation; (d) Allied health professional staffing of Service facilities should be maintained at a level appropriate to the special needs of the population served; (e) Continuing education opportunities should be provided for those health professionals serving these communities, and especially those in remote areas, and, increased peer contact, both to maintain the quality of care and to avert professional isolation; and (f) Consideration should be given to a federal statement of policy supporting continuation of the Public Health Service to reduce the great uncertainty now felt by many career officers of the corps.

(4) Medical Societies: In those states where Indian Health Service facilities are located, and in counties containing or adjacent to Service facilities, that the appropriate medical societies should explore the possibility of increased formal liaison with local Indian Health Service physicians. Increased support from organized medicine for improvement of health care provided under their direction, including professional consultation and involvement in society activities should be pursued.

(5) Our AMA also support the removal of any requirement for competitive bidding in the Indian Health Service that compromises proper care for the American Indian population.

(6) Our AMA will advocate that the Indian Health Service (IHS) establish an Office of Academic Affiliations responsible for coordinating partnerships with LCME- and COCA-accredited medical schools and ACGME-accredited residency programs.

(7) Our AMA will encourage the development of funding streams to promote rotations and learning opportunities at Indian Health Service, Tribal, and Urban Indian Health Programs.

CLRPD Rep. 3, I-98 Reaffirmed: CLRPD Rep. 1, A-08 Reaffirmation A-12 Reaffirmed: Res. 233, A-13 Appended: Res. 305, A-23 Reaffirmed: BOT Rep. 09, A-23

4. HEALTH SYSTEM CONSOLIDATION

Informational report; no reference committee hearing.

HOUSE ACTION: FILED

At the 2023 Annual Meeting, the House of Delegates adopted Policy D-160.907, Health System Consolidation, which directed the American Medical Association (AMA) to: 1) assess and report annually on nationwide health system and hospital consolidation, as well as payer consolidation, to assist policymakers and the federal government; 2) that the annual report on nationwide hospital consolidation be modeled after the "Competition in Health Insurance: A comprehensive study of U.S. Markets" in its comprehensiveness to include for example data and analyses as: a) a review of the current level of hospital and/or health system consolidation at the level of all metropolitan statistical areas, state, and national markets; b) a list of all mergers and acquisition transactions valued above a set threshold amount resulting in hospital and/or health system consolidation; c) analyses of how each transaction has changed or is expected to change the level of competition in the affected service and geographic markets; and d) analyses of how health care costs and price have changed in affected markets after large consolidation transaction has taken place; 3) that the AMA report the initial findings of this study to the House of Delegates by the 2024 Annual Meeting; and 4) that the AMA report the findings of this study to its members and stakeholders, including policymakers and legislators, to inform future health care policy.

The Board of Trustees assigned only the third Resolve clause of Policy D-160.907 to the Council for a report back at the 2024 Annual Meeting. The balance of the directive was assigned to AMA staff to implement (i.e., the AMA's Division of Economic and Health Policy Research). Data were used primarily from the American Hospital Association (AHA) to assess competition in hospital markets. As directed by Policy D-160.907, the requested analysis was modeled after the AMA's Competition in Health Insurance study.

This informational Council report serves as notice to the House of Delegates regarding the report from the AMA's Division of Economic and Health Policy Research. Here we share topline findings from the Policy Research Perspective titled: "Competition in Hospital Markets, 2013-2021" and encourage interested members to reference the full analysis for a more robust discussion of the findings.

BACKGROUND

The economic study was conducted using the AHA's 2013, 2017, and 2021 Annual Survey Databases. These databases were used to calculate shares and concentration levels in markets across the United States. The Herfindahl-Hirschman Index (HHI) indicates the level of market concentration and was calculated for each Metropolitan Statistical Area (MSA). The HHI is calculated as a sum of the squared market shares for all firms found within a market. A higher HHI indicates higher concentration. For example, if a market consisted of four firms and each firm held a 25 percent share, the HHI for that market would be 2,500:

$$25^2 + 25^2 + 25^2 + 25^2 = 2{,}500$$

If the number of firms in a market increased, the HHI would generally decrease, and vice versa.

Appendices A1 and A2 show that in the majority of MSA-level markets, hospitals (or systems) have large market shares. In 97 percent of markets, at least one hospital (system) had a market share of 30 percent or greater in 2021, and 77 percent of markets had one hospital (system) with a share of 50 percent or more in 2021 – up from 70 percent or more in 2013. In 43 percent of markets, a single hospital (system) had a market share of 70 percent or more in 2021 – an increase from 37 percent in 2013. The fraction of hospitals that are a part of a system has also been increasing over time, increasing from 70 percent in 2013 to 76 percent in 2017 to 78 percent in 2021.

Appendix B shows that, on average, hospital markets are highly concentrated and market concentration has been increasing over time. Virtually all hospital markets (99 percent) are highly concentrated.

A complete list of the two largest hospitals' (or systems') market shares and the HHIs by MSA can be found in the full analysis.

AMA POLICY

The AMA has several policies, and the Council has presented several recent reports to the House of Delegates on hospital consolidation and health care mergers and acquisitions.

CMS Report 8-A-23, Impact of Integration and Consolidation on Patients and Physicians, recommended that the AMA: 1) continue to monitor the impact of hospital-physician practice and hospital-hospital mergers and acquisitions on health care prices and spending, patient access to care, potential changes in patient quality outcomes, and physician wages and labor; 2) continue to monitor how provider mix may change following mergers and acquisitions and how non-compete clauses may impact patients and physicians; 3) broadly support efforts to collect relevant information regarding hospital-physician practice and hospital-hospital mergers and acquisitions in states or regions that may fall below the Federal Trade Commission (FTC)/Department of Justice review threshold; 4) encourage state and local medical associations, state specialty societies, and physicians to contact their state's attorney general with concerns of anticompetitive behavior; and encourage physicians to share their experiences with mergers and acquisitions, such as those between hospitals and/or those between hospitals and physician practices, with the FTC via their online submission form.

CMS 2-I-22, Corporate Practice of Medicine, recommended that the AMA: 1) acknowledge that the corporate practice of medicine has the potential to erode the patient-physician relationship; 2) acknowledge that the corporate practice of medicine may create a conflict of interest between profit and best practices in residency and fellowship training; and 3) amend Policy H-160.891 by addition of two new clauses stating that each individual physician should have the ultimate decision for medical judgment in patient care and medical care processes, including the supervision of non-physician practitioners and physicians should retain primary and final responsibility for structured medical education inclusive of undergraduate and graduate medical education including the structure of the program, program curriculum, selection of faculty and trainees, as well as educational and disciplinary issues related to these programs.

CMS 3-I-22, Health System Consolidation, was an informational report and the first in a series the Council has on this and related topics. CMS 3-I-22 shared background information on vertical and horizontal mergers and acquisitions and highlighted notable transactions from 2020. The Council will continue its work on this issue and provide additional reports for the consideration of the House of Delegates when appropriate.

Policy D-160.907, established by the adoption of Resolution 727-A-23 as amended, states that the AMA will: assess and report annually on nationwide health system and hospital consolidation as well as payer consolidation, to assist policymakers and the federal government; model this report on nationwide hospital consolidation after the "Competition in Health Insurance" study in its comprehensiveness to include for example, data and analyses such as: a) a review of the current level of hospital and/or health system consolidation at the level of all metropolitan statistical areas, state, and national markets; a list of all mergers and acquisition transactions valued above a set threshold amount resulting in hospital and/or health system consolidation; analyses of how each transaction has changed or is expected to change the level of competition in the affected service and geographic markets; analyses of how health care costs and prices have changed in affected markets after a large consolidation transaction has taken place.

Policy H-160.884 states that the AMA opposes not-for-profit firm immunity from FTC competition policy enforcement in the health care sector, supports appropriate transaction value thresholds, including cumulative transaction values, for merger reporting in health care sectors to ensure that vertical acquisitions in health care do not evade antitrust scrutiny, and supports health care-specific advocacy efforts that will strengthen antitrust enforcement in the health care sector through multiple mechanisms.

Policy H-215.960 states that the AMA: affirms that a) health care entity mergers should be examined individually, taking into account case-specific variables of market power and patient needs; b) the AMA strongly supports and encourages competition in all health care markets; c) the AMA supports rigorous review and scrutiny of proposed mergers to determine their effects on patients and providers; and d) antitrust relief for physicians remains a top AMA priority. The AMA will continue to support actions that promote competition and choice, including (a) eliminating state certificate of need laws; (b) repealing the ban on physician-owned hospitals; (c) reducing administrative burdens that make it difficult for physician practices to compete; and (d) achieving meaningful price transparency; and (3) will work with interested state medical associations to monitor hospital markets, including

rural, state, and regional markets, and review the impact of horizontal and vertical health system integration on patients, physicians, and hospital prices.

Policy H-215.969 states that it is the policy of the AMA that, in the event of a hospital merger, acquisition, consolidation, or affiliation, a joint committee with merging medical staffs should be established to resolve at least the following issues: a) medical staff representation on the board of directors; b) clinical services to be offered by the institutions; c) process for approving and amending medical staff bylaws; d) selection of the medical staff officers, medical executive committee, and clinical department chairs; e) credentialing and recredentialing of physicians and limited licensed providers; f) quality improvement; g) utilization and peer review activities; h) presence of exclusive contracts for physician services and their impact on physicians' clinical privileges; i) conflict resolution mechanisms; j) the role, if any, of medical directors and physicians in joint ventures; k) control of medical staff funds; l) successor-in-interest rights; m) that the medical staff bylaws be viewed as binding contracts between the medical staffs and the hospitals; and that the AMA will work to ensure, through appropriate state oversight agencies, that where hospital mergers and acquisitions may lead to restrictions on reproductive health care services, the merging entity shall be responsible for ensuring continuing community access to these services.

Policy D-215.984 states that the AMA will study nationwide health system and hospital consolidation in order to assist policymakers and the federal government in assessing health care consolidation for the benefit of patients and physicians who face an existential threat from health care consolidation and regularly review and report back on these issues to keep the House of Delegates apprised on relevant changes that may impact the practice of medicine, with the first report no later than the 2023 Annual meeting.

Policy D-225.995 states that the AMA will continue to monitor and report on current numbers of mergers and break-ups of mergers of hospitals in this country. Policy D-383.980 states that the AMA will study the potential effects of monopolistic activity by health care entities that may have a majority of market share in a region on the patient-doctor relationship and develop an action plan for legislative and regulatory advocacy to achieve more vigorous application of antitrust laws to protect physician practices which are confronted with potentially monopolistic activity by health care entities.

DISCUSSION

As expected, the majority of markets in the United States are characterized by hospitals with large market shares. Virtually all hospital markets are highly concentrated, and, on average, this concentration has been increasing over time.

REFERENCES

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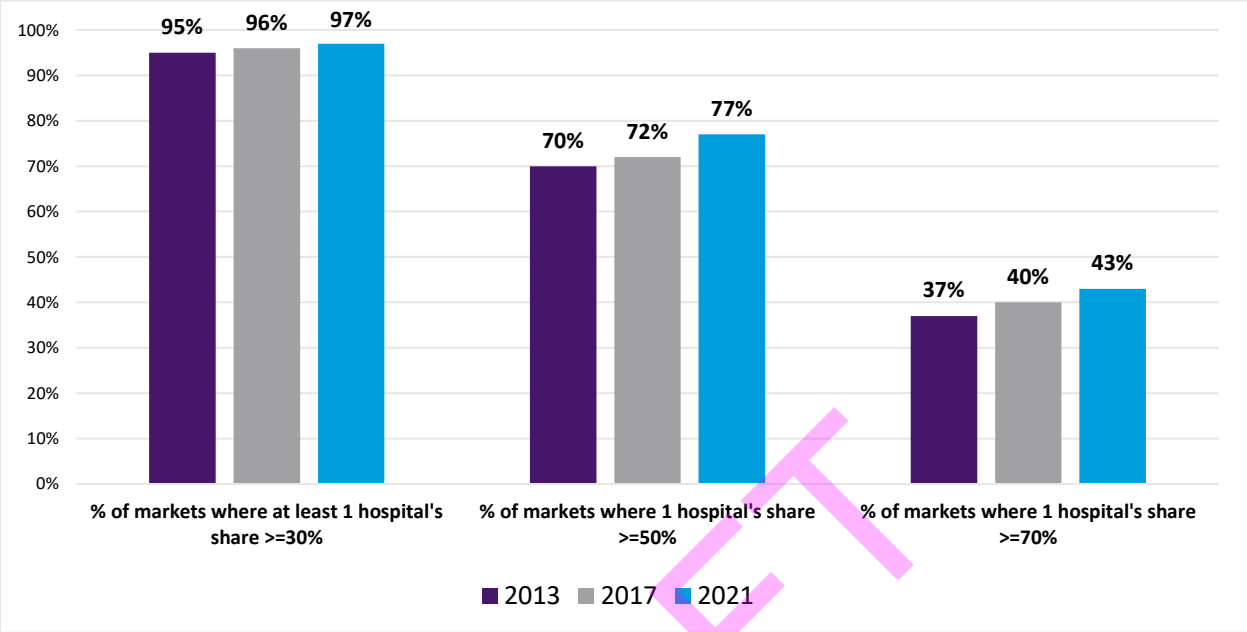
Appendix A1 - Hospital Market Shares and System Membership, 2013-2021

Variable	2013	2017	2021
% of Markets where at least 1 hospital's share >=30%	95%	96%	97%
% of Markets where 1 hospital's share >=50%	70%	72%	77%
% of Markets where 1 hospital's share >=70%	37%	40%	43%
% of Hospitals that are members of systems	70%	76%	78%
Number of hospitals	1946	2021	2002
Number of systems	276	273	268
Number of markets	363	387	389

1. Source: Author's calculations of data from the 2013, 2017 and 2021 American Hospital Association Annual Surveys.
2. This paper defines geographic markets as metropolitan statistical areas (MSAs). For MSAs that are very large (e.g. New York, Chicago), markets are defined as smaller parts of those MSAs called metropolitan divisions.
3. A "hospital" in the first three rows of this Exhibit relating to market shares can either refer to a hospital or a hospital system. Some hospitals belong to systems, while others do not. If there is more than 1 one hospital belonging to the same system in an MSA, the admissions are aggregated up to the system level. Market shares

are calculated from system-wide admissions in an MSA. In those cases, the "hospital's" market share here refers to the system's share.

Appendix A2 - Hospital Market Shares, 2013-2021



1. Source: Author's calculations of data from the 2013, 2017 and 2021 American Hospital Association Annual Surveys.
2. This paper defines geographic markets as metropolitan statistical areas (MSAs). For MSAs that are very large (e.g. New York, Chicago), markets are defined as smaller parts of those MSAs called metropolitan divisions.
3. A "hospital" in the first three rows of this Exhibit relating to market shares can either refer to a hospital or a hospital system. Some hospitals belong to systems, while others do not. If there is more than one hospital belonging to the same system in an MSA, the admissions are aggregated up to the system level. Market shares are calculated from system-wide admissions in an MSA. In those cases, the "hospital's" market share here refers to the system's share.

Appendix B - Hospital Market Concentration, 2013-2021

Variable	2013	2017	2021
Weighted average HHI	3722	3853	4062
% of Markets that are highly concentrated	97%	98%	99%
Number of markets	363	387	389

1. Source: Author's calculations of data from the 2013, 2017 and 2021 American Hospital Association Annual Surveys.
2. This paper defines geographic markets as metropolitan statistical areas (MSAs). For MSAs that are very large (e.g. New York, Chicago), markets are defined as smaller parts of those MSAs called metropolitan divisions.
3. HHI is the Herfindahl-Hirschmann Index, which is a measure of market concentration. The average HHI is weighted by metropolitan-area population.

Relevant AMA Policy
Health System Consolidation

Health System Consolidation, D-160.907
1. Our American Medical Association (AMA) will assess and report annually on nationwide health system and hospital consolidation, as well as payer consolidation, to assist policymakers and the federal government.

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

Strengthening Efforts Against Horizontal & Vertical Consolidation, H-160.884
1. Our AMA opposes not-for-profit firm immunity from FTC competition policy enforcement in the health care sector.
2. Our AMA supports appropriate transaction value thresholds, including cumulative transaction values, for merger reporting in health care sectors to ensure that vertical acquisitions in health care do not evade antitrust scrutiny.
3. Our AMA supports health care-specific advocacy efforts that will strengthen antitrust enforcement in the health care sector through multiple mechanisms.
(Res. 813, I-23)

Hospital Consolidation, H-215.960
Our AMA: (1) affirms that: (a) health care entity mergers should be examined individually, taking into account case-specific variables of market power and patient needs; (b) the AMA strongly supports and encourages competition in all health care markets; (c) the AMA supports rigorous review and scrutiny of proposed mergers to determine their effects on patients and providers; and (d) antitrust relief for physicians remains a top AMA priority; (2) will continue to support actions that promote competition and choice, including: (a) eliminating state certificate of need laws; (b) repealing the ban on physician-owned hospitals; (c) reducing administrative burdens that make it difficult for physician practices to compete; and (d) achieving meaningful price transparency; and (3) will work with interested state medical associations to monitor hospital markets, including rural, state, and regional markets, and review the impact of horizontal and vertical health system integration on patients, physicians, and hospital prices.
(CMS Rep. 07, A-19; Reaffirmation, I-22)

Hospital Merger Study, H-215.969
1. It is the policy of the AMA that, in the event of a hospital merger, acquisition, consolidation, or affiliation, a joint committee with merging medical staffs should be established to resolve at least the following issues:
(A) medical staff representation on the board of directors;
(B) clinical services to be offered by the institutions;
(C) process for approving and amending medical staff bylaws;
(D) selection of the medical staff officers, medical executive committee, and clinical department chairs;
(E) credentialing and recredentialing of physicians and limited licensed providers;
(F) quality improvement;
(G) utilization and peer review activities;
(H) presence of exclusive contracts for physician services and their impact on physicians' clinical privileges;
(I) conflict resolution mechanisms;
(J) the role, if any, of medical directors and physicians in joint ventures;
(K) control of medical staff funds;
(L) successor-in-interest rights;
(M) that the medical staff bylaws be viewed as binding contracts between the medical staffs and the hospitals; and
2. Our AMA will work to ensure, through appropriate state oversight agencies, that where hospital mergers and acquisitions may lead to restrictions on reproductive health care services, the merging entity shall be responsible for ensuring continuing community access to these services.
(CMS Rep. 4, I-01; Reaffirmed: CMS Rep. 7, A-11; Appended: Res. 3, I-13; Reaffirmed: CMS Rep. 07, A-19)

Health System Consolidation, D-215.984
Our AMA will: (1) study nationwide health system and hospital consolidation in order to assist policymakers and the federal government in assessing health care consolidation for the benefit of patients and physicians who face an existential threat from health care consolidation; and (2) regularly review and report back on these issues to keep the House of Delegates apprised on relevant changes that may impact the practice of medicine, with the first report no later than the 2023 Annual meeting.
(Res. 702, A-22)

Hospital Merger Study, D-225.995
Our AMA will: (1) urge its AMA Commissioners to the Joint Commission to seek the inclusion of a standard in The Joint Commission hospital accreditation program requiring a medical staff successor-in-interest standard in the hospital medical staff bylaws; (2) seek inclusion of medical staff bylaw successor-in-interest provisions in the Medicare Conditions of Participation and in the rules and regulations of other public and private hospital accreditation agencies; and (3) continue to monitor and report on current numbers of mergers and break-ups of mergers of hospitals in this country.
(CMS Rep. 7, I-00; Modified: CMS Rep. 6, A-10; Reaffirmed: CMS Rep. 01, A-20)

Health Care Entity Consolidation, D-383.980
Our AMA will (1) study the potential effects of monopolistic activity by health care entities that may have a majority of market share in a region on the patient-doctor relationship; and (2) develop an action plan for legislative and regulatory advocacy to achieve more vigorous application of antitrust laws to protect physician practices which are confronted with potentially monopolistic activity by health care entities. (BOT Rep. 8, I-15)

5. PATIENT MEDICAL DEBT

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS IN LIEU OF RESOLUTION 710-A-23 AND RESOLUTION 712-A-23 REMAINDER OF REPORT FILED
See Policy H-373.990

At the 2023 Annual Meeting, the House of Delegates referred Resolutions 710 and 712. Resolution 710-A-23, introduced by the Michigan delegation, asked the American Medical Association (AMA) to work with the appropriate national organizations to address the medical debt crisis by advocating for robust policies at the federal and state levels that prevent medical debt, help consumers avoid court involvement, and ensure that court involved cases do not result in devastating consequences to patient's employment, physical health, mental wellbeing, housing, and economic stability. Resolution 712-A-23, introduced by the New Jersey delegation, asked the AMA to study the causes of medical bankruptcy in the United States and draft a report for presentation at the 2024 Annual House of Delegates meeting, with such a report to include recommendations to the House of Delegates to severely reduce the problem of medical debt.

BACKGROUND

An estimated 100 million people in the United States (41 percent of adults) have debt related to unpaid medical bills, totaling between $195-220 billion.[1] Of this 100 million, approximately 20 million people owe money directly to their physician, hospital, or other non-physician provider.[2] The remaining 80 million people reflect those that have other debts associated with their health care (i.e., credit card debt, loans from family and friends, etc.) The Consumer Financial Protection Bureau (CFPB) estimates that $88 billion of total medical debt is reflected on Americans' credit reports.[3] A 2021 Census Bureau analysis estimated that 15 percent of households in the United States owed medical debt.[4] Medical debt is the leading cause of bankruptcy in the United States and can take many forms, including past due payments owed directly to a physician or hospital, ongoing payment plans, money owed to a bank or collections that has been assigned or sold the debt, credit card debt, and/or money borrowed from family or friends.[5] Medical debt can often be masked as other forms of debt when someone falls behind on other expenses (i.e., food, housing, household goods) to pay down their medical bills.[6] Those with unaffordable medical bills are

more likely to skip or delay needed care, cut back on basic household expenses, take money out of retirement or college savings, or increase credit card debt.[7]

Medical debt occurs across demographic groups, but is more likely if a patient has disabilities, is in worse health, is poor or near poor, is Black, lives in the South, lives in a non-Medicaid expansion state, or is middle aged. Women are more likely to report having medical debt than men (11 percent vs. 8 percent), which is likely due to childbirth-related expenses and lower average incomes.[8]

COVID-19 exacerbated several hardships associated with increased medical debt, including downstream effects of contracting COVID-19, losing employer-sponsored health insurance, or losing income. The Commonwealth Fund completed a study that found that half of all people ages 19-64 affected by COVID-19 had medical debts or issues tangentially related to medical debt during the study period. COVID-19 hospitalizations and treatment also contributed to individuals' debt.[9]

Besides negative financial impacts, other consequences patients face include being contacted by collectors or negative credit score impacts, which makes it difficult to buy a vehicle, get a job, or buy or rent a home. Additionally, there are consequences associated with care: one in seven adults with health care debt say they have been denied care due to unpaid medical bills.[10]

Causes of Medical Debt in the United States

According to a KFF study, 72 percent of patients with medical debt claim the bills were from an unexpected acute event while 27 percent of those with debt claim that the expenses built up over time from treatments for chronic conditions.[11] Conversely, the Commonwealth Fund reports that the source of debt for many people is chronic conditions and that about half of adults with debt said it was the result from treatment received for ongoing health problems.[12] The discrepancy in these findings indicates that medical debt clearly impacts both patients who experience a one-time acute care event and those with chronic medical conditions.

Approximately 23 million people owe "significant" medical debt, which is considered to be anything $250 or greater, according to both KFF and the Survey of Income and Program Participation.[13] In 2020, the average amount of medical debt was $429.[14] Among single-person, privately insured households in 2019, 32 percent did not have liquid assets over $2,000 and among multi-person households, 20 percent did not have liquid assets over $2,000. Sixteen percent of privately insured adults say they would need to take on credit card debt to meet an unexpected $400 expense, while seven percent would need to borrow money from friends or family.[15]

Adults who are uninsured for six months or more out of the year are more likely to report having significant medical debt. However, medical debt burden does not solely impact those without health insurance. Over 90 percent of Americans have some form of health insurance. Even those with private health insurance may have insufficient liquid assets to meet high deductibles or other cost-sharing expenses.[16] Many working age adults surveyed by the Commonwealth Fund said it was very or somewhat difficult to afford their health care, including 43 percent of those with employer-sponsored coverage, 57 percent with Affordable Care Act (ACA) Marketplace or individual plans, 45 percent with Medicaid, and 51 percent with Medicare.[17]

Insurance coverage does not shield individuals from taking on debt. A substantial portion of people with insurance still have medical debt including 30 percent of people with employer-sponsored coverage, 37 percent enrolled in an ACA Marketplace or individual plan, 21 percent covered by Medicaid, and 33 percent covered by Medicare.[18] Among those in employer plans, those with low incomes especially struggled. Fifty-six percent of those with debt enrolled in employer-sponsored plans had incomes under 200 percent of the federal poverty line (FPL) and reported difficulty in paying for their health care.[19] Additionally, those in employer-sponsored plans with incomes below 400 percent FPL reported much higher rates of delaying or forgoing needed care due to the cost. More than half of these individuals reported that their health problem had gotten worse as a result of skipping care.

One concern with Medicaid specifically is estate recovery for those using Medicaid long-term care. Medicaid beneficiaries over the age of 55 that have used long-term services, such as a nursing home or home care, are subject to estate recovery after their death. State agencies will come after any assets, including the individual's home, in order to recoup the money spent on long-term care for the patient. In 2019, states collected $733 million in estate recovery, which is about 0.5 percent of Medicaid's total long-term care expenditures. Patient's families who do not

have the assets to pay the expenses owed back to Medicaid are often forced to sell the patient's home to cover the costs. These homes are often the last assets a family has and can further exacerbate existing poverty.[20]

Medical debt is a uniquely American problem as nearly half of all working-age Americans struggle with health care costs.[21] The Commonwealth Fund compared the performance of the United States' health system to those of other high-income countries and ranked it last among 11 nations in several categories including access, efficiency, equity, and health outcomes.[22] Health expenditures per person in the United States totaled $12,555 in 2022, which was over $4,000 more than any other high-income nation. The average amount spent on health per person in comparable countries is about half of what the United States spends per person ($6,651).[23] Americans also tend to be unhealthier than those in other countries. However, the comparison is limited due to the variance in health systems in each of the countries that were compared. America's global counterparts either have government health plans (i.e., Britain and Canada) or rely on subsidized private insurers (i.e., Germany and the Netherlands).[24] In addition, it would be unfair to compare the health care costs between America and its global counterparts due to the different tax burdens in each of these countries and how that impacts the total paid for health care. While the discrepancies between how these various systems work and serve patients may be of interest, this report specifically focuses on addressing American medical debt within the current health care system.

Impact on Physicians

An article in the *AMA Journal of Ethics* states that physicians have a responsibility to reduce debt, especially given the impact of patients forgoing care if they are unable to pay. At a minimum, physicians should be aware of their institution's charity care policy or reduced bill payment options.[25] However, physicians cannot continue providing care to patients if they are not paid, especially those working in small private practices. Asking patients to pay outstanding and overdue bills is increasingly difficult if there are reduced financial consequences to patients who fail to pay. According to Medscape's 2022 Physician Compensation Report, physicians react in the following ways when patients do not pay their outstanding bills: 43 percent continue to treat the patients and develop a payment plan; 13 percent send outstanding bills to third-party collection agencies; 12 percent continue to provide care and write off the balance; 25 percent choose other actions; and eight percent drop patients if they continue not to pay.[26]

Physicians are encouraged to have an established payment policy, presented in writing to all patients. These agreements should be clear and easy for all patients to understand. When possible, physicians should try to collect payment at the time of service and provide transparent pricing to patients. This could include explaining that costs for prescribed services (e.g., tests, imaging, medications) are often dictated by the patient's insurance plan and out of the control of the prescribing physician. In the event that unpaid accounts need to be turned over to a third-party collection agency, physicians should be mindful to select agencies that charge reasonable fees, noting that some charge a fee that is 30 to 40 percent of the total amount of debt they collect.

Physician responsibilities regarding patient medical debt and the cost of care are further codified in the following AMA Code of Ethics opinions: 11.1.1, 11.1.4, 11.2.1, 11.2.2, 11.2.4, and 11.3.3.

Patient Financing Programs

Medical financing products, such as medical credit cards and installment plans, can be offered to patients through hospitals or physicians' offices, but they are often serviced through third-party financial services companies. Historically, uninsured and low-income patients have been provided installment plans with zero or low interest rates directly from hospitals or physicians' offices where they received their care. Notably, as more physicians become employed, there is less control and awareness of the debt collection practices of their employers. In recent years, some hospitals and physicians' offices have partnered with financial service or private equity companies to offer more structured loan arrangements, which tend to charge market-level or higher interest rates. Some even target patients with low credit scores, while others target specific services, such as fertility treatments.

Patient financing is a multi-billion-dollar business that includes private equity and banks buying patient debt from hospitals, physicians, and non-physician providers. Hospitals, physicians, and other non-physician providers, who have traditionally put patients in interest free payment plans, have embraced the patient financing model and have entered into contracts with these lenders. Many of these financing plans offer a promotional period where no interest is charged, but if a patient does not pay off the full amount owed during this time, interest is then charged. These loans can deepen inequities. For example, lower income patients without the means to make large monthly payments

can face higher interest rates while wealthier patients who are able to take on larger monthly payments can secure lower interest rates. Additionally, patients with higher incomes can usually pay off the debt during the promotional period and avoid accruing any interest.[27]

Across the United States, approximately 50 million people are on a financing plan to pay off a medical or dental bill and about 25 percent of these individuals are paying interest. A portion of the interest collected may be kept by financing companies who contract with hospitals to collect outstanding debt. Many hospitals are reluctant to share specific details on their agreements with these companies but have cited the need to offset the cost of offering financing options to patients as a reason why they enter into these partnerships.[28]

If patients are unable to keep up with payments to the financing companies, their debt may be sent into collections or returned to the hospital or physician's office where further action may be taken. For example, one of these financing companies, AccessOne, returns patient accounts to the hospital if payments are missed. The hospital can then sue the patient, report them to credit bureaus, or take other collection action. Such actions could also include referring unpaid bills to the state revenue department, which can garnish tax refunds.[29] Medical credit cards may also be offered to patients. These accounts tend to charge patients interest rates higher than regular credit cards if patients are unable to pay their balances during the promotional period. In addition, when a patient uses a medical credit card, a physician's office may charge a fee at the time payment is disbursed. One such company, Alphaeon Credit, markets directly to ophthalmology, plastic surgery, dermatology, and dental practices. As an example, in the fine print of their offer to ophthalmology patients, Alphaeon Credit notes that "minimum payments are not guaranteed to pay the promotional plan balance within the promotional period…you may have to pay more than the minimum payment to avoid accrued interest charges." The annual percentage rate (APR) that a patient is charged if they do not pay off their balance within the promotional period is 31.99 percent, well above the average for a typical credit card.[30]

Hospital Charity Care

Charity care is offered at most hospitals in the United States. Nonprofit hospitals must provide financial aid as a condition of their tax-exempt status, which is something that saves the hospitals billions of dollars each year. However, standards for aid vary widely across hospitals. Aid at some hospitals is limited to patients below the FPL, while at other hospitals, patients with incomes that are five to six times the FPL can receive assistance. Applying for aid can be complicated for patients, requiring lots of personal financial information and documentation. A Kaiser Health News analysis of tax filings found that nearly one half of nonprofit medical systems were billing patients with incomes low enough to qualify for charity care.[31]

Problems associated with charity care are important and closely related to the broader issue of patient medical debt. Notably, the Council will be preparing a report for the 2024 Interim Meeting specifically on charity care and any associated recommendations will be included in the forthcoming report.

Recent Federal and State Efforts

In July 2023, the Biden Administration, CFPB, the Department of Health and Human Services (HHS), and the Treasury Department issued a Request for Information (RFI) on medical credit cards and other high-cost specialty financing products to understand their prevalence, patients' experience with them, and incentives driving physicians and other non-physician providers to offer these products. In the RFI, the agencies cite that hospitals and financial service companies might not be making reasonable efforts to determine when a patient is eligible for financial assistance before offering a medical financing product.[32]

Additionally, the RFI indicates that a typical APR for a medical credit card is 27 percent, while a typical consumer credit card has an average APR of about 16 percent. With medical credit cards, if a patient is unable to pay the balance within the no- or low-interest promotional period, the patient will then owe interest on the entire amount, not just the remaining balance. As a result, patients incurred a total of about $1 billion in deferred interest on health care purchases between 2018-2020.[33]

Although national credit reporting agencies agreed not to report medical debts that are less than a year old or under $500 on Americans' credit reports, using a medical financing product can impact patient credit scores more directly through "hard" credit checks, increased credit line utilization, decreased account age, or eventual account closure.[34]

A benefit for hospitals, physicians, and non-physician providers utilizing medical financing products is being paid within days of providing a service and not having to handle disputes, billing, or other administrative work.

In addition to the RFI, in September 2023, CFPB released a notice that it is developing a rule to bar credit reporting companies from including medical debt in consumer credit reports. CFPB is seeking to prohibit lenders from using medical collections information when evaluating a borrower's application. The agency plans to issue a Notice of Proposed Rulemaking in 2024,[35] which was not available at the time that this report was written. As of November 2023, CFPB released a notice stating that it is taking steps to ensure medical debt collectors follow the law, including the Fair Debt Collection Practices Act and the Fair Credit Reporting Act. Specifically, these steps include supervision and enforcement efforts, reminding entities about their obligations, support for state-level action, and education and outreach. Although the Fair Debt Collection Practices Act limits how aggressive debt collectors can be by restricting the ways and times they can contact debtors, it does not limit or prohibit the use of legal remedies like wage garnishment or foreclosure. [36] Further, the Fair Debt Collection Practices Act currently only applies to debt collectors and does not include hospitals or other health care entities.

In addition to recent federal efforts, several states have created policies to protect patients from the consequences of having medical debt. A detailed overview, including maps of which states fall into each category can be found here.[37]

A summary of recent state actions include:

- Charging interest on medical debt
  - Eight states have laws prohibiting or limiting interest on all medical debt.
  - Some states have set a ceiling for interest on all medical debt. Others prohibit charging interest to patients who are at or below 250 percent FPL and are ineligible for public insurance programs.
- Regulations on sending medical bills to collections
  - Thirty-seven states do not regulate when a hospital can send a bill to collections. However, unlike hospitals, debt collectors do not have a relationship with patients and can be more aggressive when collecting on the debt.
  - Connecticut prohibits hospitals from sending bills of certain low-income patients to collections and Illinois requires hospitals to offer a reasonable payment plan first.
  - Maryland and Colorado require hospitals to report debt collection actions with demographic data and New Mexico and Colorado extended the requirements that are applicable to nonprofit hospitals to urgent care clinics, freestanding Emergency Departments, and outpatient clinics.38
- Sale of medical debt
  - Maryland, New Mexico, and Vermont prohibit the sale of medical debt while California and Colorado regulate debt buyers instead. California prohibits debt buyers from charging interest and Colorado prohibits them from foreclosing on a patient's home.
  - California also recently restricted when hospitals could sell patient debt or report patients to credit bureaus.39 Debt collection is prohibited for 180 days, regardless of financial status.40
- Liens and foreclosures
  - Thirty-three states do not limit hospitals, collection agencies, or debt buyers from placing a lien or foreclosing on a patient's home to recover unpaid medical bills. However, almost all states provide a homestead exemption, which protects some equity in a patient's home from being seized during bankruptcy.
  - Eleven states prohibit or set limits on liens and foreclosures for medical debt.
  - New York and Maryland fully prohibit both liens and foreclosures because of medical debt, while California and New Mexico only prohibit them for certain low-income populations.
- Wage garnishment
  - Under federal law, the amount of wages garnished each week may not exceed the lesser of 25 percent of the employee's disposable earnings or the amount by which an employee's disposable earnings are greater than 30 times the federal minimum wage.
  - Twenty-one states exceed the federal ceiling for wage garnishment.
  - New York fully prohibits wage garnishment to recover medical debt for all patients, yet California only extends protections for certain low-income populations.
  - New Hampshire does not prohibit wage garnishment, but it does require the creditor to keep going back to court every pay period to garnish wages, which significantly limits creditors' ability to garnish wages in practice.

AMA POLICY AND ADVOCACY

AMA policy is limited on the issue of patient medical debt directly. Tangentially related policies address uncompensated care, controlling costs of care, price transparency, patient cost-sharing generally, and expanding coverage and improving affordability of coverage.

Policy D-155.987 states that our AMA: 1) encourages physicians to communicate information about the cost of their professional services to individual patients, taking into consideration the insurance status of the patient or other relevant information where possible; 2) advocates that health plans provide plan enrollees or their designees with complete information regarding plan benefits and real time cost-sharing information associated with both in-network and out-of-network provider services or other plan designs that may affect patient out-of-pocket costs; 3) will actively engage with health plans, public and private entities, and other stakeholder groups in their efforts to facilitate price and quality transparency for patients and physicians, and help ensure that entities promoting price transparency tools have processes in place to ensure the accuracy and relevance of the information they provide; 4) will work with states and the federal government to support and strengthen the development of all-payer claims databases; 5) encourages electronic health record vendors to include features that assist in facilitating price transparency for physicians and patients; 6) encourages efforts to educate patients in health economics literacy, including the development of resources that help patients understand the complexities of health care pricing and encourage them to seek information regarding the cost of health care services they receive or anticipate receiving; and 7) will request that the Centers for Medicare & Medicaid Services expand its Medicare Physician Fee Schedule Look-up Tool to include hospital outpatient payments.

Policy H-165.846 states that our AMA supports the following principles to guide in the evaluation of the adequacy of health insurance coverage options: a) any insurance pool or similar structure designed to enable access to age-appropriate health insurance coverage must include a wide variety of coverage options from which to choose; b) existing federal guidelines regarding types of health insurance coverage (e.g., Title 26 of the US Tax Code and Federal Employees Health Benefits Program regulations) should be used as a reference when considering if a given plan would provide meaningful coverage; c) provisions must be made to assist individuals with low-incomes or unusually high medical costs in obtaining health insurance coverage and meeting cost-sharing obligations; and d) mechanisms must be in place to educate patients and assist them in making informed choices, including ensuring transparency among all health plans regarding covered services, cost-sharing obligations, out-of-pocket limits, and lifetime benefit caps, and excluded services. Policy H-165.846 also advocates that the Early and Periodic Screening, Diagnostic, and Treatment program be used as the model for any essential health benefits package for children and that the AMA: a) opposes the removal of categories from the essential health benefits (EHB) package and their associated protections against annual and lifetime limits, and out-of- pocket expenses; and b) opposes waivers of EHB requirements that lead to the elimination of EHB categories and their associated protections against annual and lifetime limits.

Policy D-180.979, which comes from CMS Report 9-A-19, states that the AMA will: 1) support the development of sophisticated information technology systems to help enable physicians and patients to better understand financial obligations; 2) encourage states and other stakeholders to monitor the growth of high deductible health plans and other forms for cost-sharing in health plans to assess the impact of such plans on access to care, health outcomes, medical debt, and provider practice sustainability; 3) advocate for the inclusion of health insurance contract provisions that permit network physicians to collect patient cost-sharing financial obligations (e.g., deductibles, co-payments, and co-insurance) at the time of service; and 4) monitor programs wherein health plans and insurers bear the responsibility of collecting patient co-payments and deductibles.

Policy H-373.996 states that our AMA supports the principles contained in the Medical Debt Relief Act as drafted and passed by the US House of Representatives to provide relief to the American consumer from a complicated collections process and supports medical debt resolution being portrayed in a positive and productive manner.

Policy H-160.923 states that our AMA: 1) supports the transitional redistribution of disproportionate share hospital payments for use in subsidizing private health insurance coverage for the uninsured; 2) supports the use of innovative federal- or state-based projects that are not budget neutral for the purpose of supporting physicians that treat large numbers of uninsured patients, as well as the Emergency Medical Treatment and Active Labor Act-directed care; and 2) encourages public and private sector researchers to utilize data collection methodologies that

accurately reflect the amount of uncompensated care (including both bad debt and charity care) provided by physicians.

Policy H-165.838 states that the AMA is committed to working with Congress, the Administration, and other stakeholders to achieve enactment of health system reforms that include the following seven critical components: health insurance coverage for all Americans; insurance market reforms that expand choice of affordable coverage and eliminate denials for pre-existing conditions or due to arbitrary caps; assurance that health care decisions will remain in the hands of patients and their physicians, not insurance companies or government officials; investments and incentives for quality improvement and prevention and wellness initiatives; repeal of the Medicare physician payment formula that triggers steep cuts and threaten seniors' access to care; implementation of medical liability reforms to reduce the cost of defensive medicine; and streamline and standardize insurance claims processing requirements to eliminate unnecessary costs and administrative burdens.

DISCUSSION

Medical debt is a huge burden on many Americans across all demographic groups. Patients face negative outcomes associated with debt, including worse health outcomes, stress from being contacted by debt collectors and negative credit score impacts, and the downstream effects of difficulty getting a job or buying or renting a home.

Medical debt is accrued by patients with long-term, chronic conditions, as well as those with acute conditions or those suffering from an accident. Insurance coverage does not automatically protect patients from debt. Even with insurance coverage many patients struggle with high cost-sharing and deductibles offered by their insurance plans. Improved patient education on the cost of care and plan details could help patients better prepare for unexpected medical costs. Both insured and uninsured patients have reported delaying or forgoing needed care due to costs, further exacerbating health concerns.

The growth of high-deductible health insurance plans, which are increasingly offered to patients, have been shown to require deductibles too high for many Americans. In 2021, the average annual deductible for a single worker with employer-based coverage was over $1,400, which is almost four times greater than it was in 2006. Family deductibles can exceed $10,000.[41] Out-of-pocket maximums also prove to be too high for many Americans. For example, although the ACA caps out-of-pocket spending for those on Marketplace plans, in 2024, the out-of-pocket maximum for those on a Marketplace plan is $9,450 for an individual and $18,900 for a family.[42,43]

Many patients are unaware of reduced cost options offered by their hospital or physician's office. These plans should be easy for patients to access and should be discussed with patients at the time of payment. This includes sharing details about interest rates, timelines for payment, and anything else that may impact the patient financially. While physicians should be aware of the charity care policy in their office or institution, it must be understood that physicians cannot continue providing care to patients if they are not paid. This is made more difficult if penalties are reduced for patients who are unable or unwilling to pay their bills. The Council believes that physicians have the opportunity to educate patients on the charity care policy offered by their institution but should be mindful when partnering with third-party collection agencies, especially those who place wage garnishments and property liens on low-wage patients. If possible, physicians should try to handle debts with patients directly, by requiring payment prior to providing services (for non-emergent care), offering flexible payment plans, or forgiveness of debt altogether. Additionally, if a patient's medical bill is part of an ongoing dispute, hospitals and physicians should try to refrain from sending this bill to collections or to a third-party collection agency until the dispute is resolved.

The Council believes that recent efforts by the Biden Administration, CFPB, HHS, and Treasury Department to explore the causes of and solutions to medical debt provide the AMA with an opportunity to support amendments to laws, such as the Fair Debt Collection Practices Act, to strengthen standards and provide additional clarity to patients about medical billing.

Several states, counties, and cities have taken a creative approach to managing medical debt for their residents. For example, New York City and Cook County (Chicago) in Illinois have recently partnered with RIP Medical Debt, a nonprofit organization that purchases and forgives medical debt from low-wage individuals. At the time that this report was written, Cook County and RIP Medical Debt have used $12 million of federal funds granted by the American Rescue Plan to forgive up to $1 billion in medical debt for residents.[44] New York City is also partnering with RIP Medical Debt and investing $18 million to purchase and forgive $2 billion in medical debt for

approximately half a million New York residents.[45] To qualify for relief in both Cook County and New York, a resident must have an annual household income below 400 percent FPL or have medical debt equal to five percent or more of their annual household income. Other states and cities are exploring similar grants and partnerships. The AMA has an opportunity to be further educated on these and other initiatives to reduce medical debt for patients and explore ways to support the missions of these organizations.

Medical debt impacts many patients in the United States, causing negative health outcomes from delayed or denied care to stress from financial pressures from unpaid bills. When possible, the Council believes that physicians should support patient education on the cost of care, including potential downsides for alternative options for paying down debt, such as high interest rates or penalties for missing payments with third-party collection agencies. Understanding both the serious issue of medical debt for patients and that physicians need to be paid to continue providing care, physicians should be thoughtful when navigating this issue by encouraging patients to be informed about their insurance coverage and to take advantage of charity care when they qualify to reduce the burden of the cost of their care.

RECOMMENDATIONS

The Council on Medical Service recommends that the following recommendations be adopted in lieu of Resolution 710-A-23 and Resolution 712-A-23, and the remainder of the report be filed:

1) That our American Medical Association (AMA) encourage health care organizations to manage medical debt with patients directly, considering several options including but not limited to discounts, payment plans with flexibility and extensions as needed, or forgiveness of debt altogether, before resorting to third-party debt collectors or any punitive actions.
2) That our AMA supports innovative efforts to address medical debt for patients, including sliding-scale, interest-free payment plans before collection or litigation activities and public and private efforts to eliminate medical debt, such as purchasing debt with the intent of cancellation.
3) That our AMA support amending the Fair Debt Collection Practices Act to include hospitals and strengthen standards within the Act to provide clarity to patients about whether their insurance has been or will be billed, which would require itemized debt statements to be provided to patients, thereby increasing transparency, and prohibiting misleading representation in connection with debt collection.
4) That our AMA opposes wage garnishments and property liens being placed on low-wage patients due to outstanding medical debt at levels that would preclude payments for essential food and housing.
5) That our AMA support patient education on medical debt that addresses dimensions such as:
    a. Patient financing programs that may be offered by hospitals, physicians offices, and other non-physician provider offices;
    b. The ramifications of high interest rates associated with financing programs that may be offered by a hospital, physician's office, or other non-physician provider's office;
    c. Potential financial aid available from a patient's hospital and/or physician's office; and
    d. Methods to reduce high deductibles and cost-sharing.

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Relevant AMA Policy
Patient Medical Debt

Price Transparency, D-155.987
1. Our AMA encourages physicians to communicate information about the cost of their professional services to individual patients, taking into consideration the insurance status (e.g., self-pay, in-network insured, out-of-network insured) of the patient or other relevant information where possible.
2. Our AMA advocates that health plans provide enrollees or their designees with complete information regarding plan benefits and real-time cost-sharing information associated with both in-network and out-of-network provider services or other plan designs that may affect patient out-of-pocket costs.
3. Our AMA will actively engage with health plans, public and private entities, and other stakeholder groups in their efforts to facilitate price and quality transparency for patients and physicians and help ensure that entities promoting price transparency tools have processes in place to ensure the accuracy and relevance of the information they provide.
4. Our AMA will work with states and the federal government to support and strengthen the development of all-payer claims databases.
5. Our AMA encourages electronic health records vendors to include features that assist in facilitating price transparency for physicians and patients.
6. Our AMA encourages efforts to educate patients in health economic literacy, including the development of resources that help patients understand the cost of health care services they receive or anticipate receiving.
7. Our AMA will request that the Centers for Medicare and Medicaid Services expand its Medicare Physician Fee Schedule Look-up Tool to include hospital outpatient payments.
(CMS Rep. 4, A-15; Reaffirmed in lieu of: Res. 121, A-16; Reaffirmed in lieu of: Res. 213, I-17; Reaffirmed: BOT Rep. 14, A-18; Reaffirmed in lieu of: Res. 112, A-19; Modified: Res. 213, I-19; Reaffirmation: A-23)

Adequacy of Health Insurance Coverage Options, H-165.846
1. Our AMA supports the following principles to guide in the evaluation of the adequacy of health insurance coverage options:
a. Any insurance pool or similar structure designed to enable access to age-appropriate health insurance coverage must include a wide variety of coverage options from which to choose.
b. Existing federal guidelines regarding types of health insurance coverage (e.g., Title 26 of the US Tax Code and Federal Employees Health Benefits Program [FEHBP] regulations) should be used as a reference when considering if a given plan would provide meaningful coverage.
c. Provisions must be made to assist individuals with low-incomes or unusually high medical costs in obtaining health insurance coverage and meeting cost-sharing obligations.
d. Mechanisms must be in place to educate patients and assist them in making informed choices, including ensuring transparency among all health plans regarding covered services, cost-sharing obligations, out-of-pocket limits and lifetime benefit caps, and excluded services.
2. Our AMA advocates that the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program be used as the model for any essential health benefits package for children.
3. Our AMA: (a) opposes the removal of categories from the essential health benefits (EHB) package and their associated protections against annual and lifetime limits, and out-of-pocket expenses; and (b) opposes waivers of

EHB requirements that lead to the elimination of EHB categories and their associated protections against annual and lifetime limits, and out-of-pocket expenses.
(CMS Rep. 7, A-07; Reaffirmation: I-07; Reaffirmation: A-09; Reaffirmed: Res. 103, A-09; Reaffirmation: I-09; Reaffirmed: CMS Rep. 3, I-09; Reaffirmed: CMS Rep. 2, A-11; Appended: CMS Rep. 2, A-11; Reaffirmed in lieu of Res. 109, A-12; Reaffirmed: CMS Rep. 1, I-12; Reaffirmed: CMS Rep. 3, A-13; Reaffirmed in lieu of Res. 812, I-13; Reaffirmed: CMS Rep. 6, I-14; Reaffirmed: CMS Rep. 6, I-15; Appended: CMS Rep. 04, I-17; Reaffirmed in lieu of: Res. 101, A-19)

Health Plan Payment of Patient Cost-Sharing, D-180.979
Our AMA will: (1) support the development of sophisticated technology systems to help enable physicians and patients to better understand financial obligations; (2) encourage states and other stakeholders to monitor the growth of high deductible health plans and other forms of cost-sharing in health plans to assess the impact of such plans on access to care, health outcomes, medical debt, and provider practice sustainability; (3) advocate for the inclusion of health insurance contract provisions that permit network physicians to collect patient cost-sharing financial obligations (e.g., deductibles, co-payments, and co-insurance) at the time of service; and (4) monitor programs wherein health plans and insurers bear the responsibility of collecting patient co-payments and deductibles.
(CMS Rep. 09, A-19)

Exclusion of Medical Debt that Has Been Fully Paid or Settled, H-373.996
Our AMA supports the principles contained in The Medical Debt Relief Act as drafted and passed by the US House of Representatives to provide relief to the American consumer from a complicated collections process and supports medical debt resolution being portrayed in a positive and productive manner.
(Res. 226, I-10; Reaffirmed: BOT Rep. 04, A-20)

Offsetting the Costs of Providing Uncompensated Care, H-160.923
Our AMA: (1) supports the transitional redistribution of disproportionate share hospital (DSH) payments for use in subsidizing private health insurance coverage for the uninsured; (2) supports the use of innovative federal- or state-based projects that are not budget neutral for the purpose of supporting physicians that treat large numbers of uninsured patients, as well as EMTALA-directed care; and (3) encourages public and private sector researchers to utilize data collection methodologies that accurately reflect the amount of uncompensated care (including both bad debt and charity care) provided by physicians.
(CMS Rep. 8, A-05; Reaffirmation: A-07; Modified: CMS Rep. 01, A-17)

Health System Reform Legislation, H-165.838
1. Our American Medical Association is committed to working with Congress, the Administration, and other stakeholders to achieve enactment of health system reforms that include the following seven critical components of AMA policy:
a. Health insurance coverage for all Americans
b. Insurance market reforms that expand choice of affordable coverage and eliminate denials for pre-existing conditions or due to arbitrary caps
c. Assurance that health care decisions will remain in the hands of patients and their physicians, not insurance companies or government officials
d. Investments and incentives for quality improvement and prevention and wellness initiatives
e. Repeal of the Medicare physician payment formula that triggers steep cuts and threaten seniors' access to care
f. Implementation of medical liability reforms to reduce the cost of defensive medicine
g. Streamline and standardize insurance claims processing requirements to eliminate unnecessary costs and administrative burdens
2. Our American Medical Association advocates that elimination of denials due to pre-existing conditions is understood to include rescission of insurance coverage for reasons not related to fraudulent representation.
3. Our American Medical Association House of Delegates supports AMA leadership in their unwavering and bold efforts to promote AMA policies for health system reform in the United States.
4. Our American Medical Association supports health system reform alternatives that are consistent with AMA policies concerning pluralism, freedom of choice, freedom of practice, and universal access for patients.
5. AMA policy is that insurance coverage options offered in a health insurance exchange be self-supporting, have uniform solvency requirements; not receive special advantages from government subsidies; include payment rates established through meaningful negotiations and contracts; not require provider participation; and not restrict enrollees’ access to out-of-network physicians.

6. Our AMA will actively and publicly support the inclusion in health system reform legislation the right of patients and physicians to privately contract, without penalty to patient or physician.
7. Our AMA will actively and publicly oppose the Independent Medicare Commission (or other similar construct), which would take Medicare payment policy out of the hands of Congress and place it under the control of a group of unelected individuals.
8. Our AMA will actively and publicly oppose, in accordance with AMA policy, inclusion of the following provisions in health system reform legislation:
a. Reduced payments to physicians for failing to report quality data when there is evidence that widespread operational problems still have not been corrected by the Centers for Medicare and Medicaid Services
b. Medicare payment rate cuts mandated by a commission that would create a double-jeopardy situation for physicians who are already subject to an expenditure target and potential payment reductions under the Medicare physician payment system
c. Medicare payments cuts for higher utilization with no operational mechanism to assure that the Centers for Medicare and Medicaid Services can report accurate information that is properly attributed and risk-adjusted
d. Redistributed Medicare payments among providers based on outcomes, quality, and risk-adjustment measurements that are not scientifically valid, verifiable and accurate
e. Medicare payment cuts for all physician services to partially offset bonuses from one specialty to another
f. Arbitrary restrictions on physicians who refer Medicare patients to high quality facilities in which they have an ownership interest
9. Our AMA will continue to actively engage grassroots physicians and physicians in training in collaboration with the state medical and national specialty societies to contact their Members of Congress, and that the grassroots message communicates our AMA's position based on AMA policy.
10. Our AMA will use the most effective media event or campaign to outline what physicians and patients need from health system reform.
11. AMA policy is that national health system reform must include replacing the sustainable growth rate (SGR) with a Medicare physician payment system that automatically keeps pace with the cost of running a practice and is backed by a fair, stable funding formula, and that the AMA initiate a "call to action" with the Federation to advance this goal.
12. AMA policy is that creation of a new single payer, government-run health care system is not in the best interest of the country and must not be part of national health system reform.
13. AMA policy is that effective medical liability reform that will significantly lower health care costs by reducing defensive medicine and eliminating unnecessary litigation from the system should be part of any national health system reform.
(Sub. Res. 203, I-09; Reaffirmation A-10; Reaffirmed in lieu of Res. 102, A-10; Reaffirmed in lieu of Res. 228, A-10; Reaffirmed: CMS Rep. 2, I-10; Reaffirmed: Sub. Res. 222, I-10; Reaffirmed: CMS Rep. 9, A-11; Reaffirmation A-11; Reaffirmed: CMS Rep. 6, I-11; Reaffirmed in lieu of Res. 817, I-11; Reaffirmation I-11; Reaffirmation A-12; Reaffirmed in lieu of Res. 108, A-12; Reaffirmed: Res. 239, A-12; Reaffirmed: Sub. Res. 813, I-13; Reaffirmed: CMS Rep. 9, A-14; Reaffirmation A-15; Reaffirmed in lieu of Res. 215, A-15; Reaffirmation: A-17; Reaffirmed in lieu of: Res. 712, A-17; Reaffirmed in lieu of: Res. 805, I-17; Reaffirmed: CMS Rep. 03, A-18; Reaffirmed: CMS Rep. 09, A-19; Reaffirmed: CMS Rep. 3, I-21; Reaffirmation: A-22; Reaffirmed: CMS Rep. 02, I-23)

6. ECONOMICS OF PRESCRIPTION MEDICATION PRIOR AUTHORIZATION

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: RECOMMENDATIONS ADOPTED
REMAINDER OF REPORT FILED
See Policies D-120.933, H-110.963, H-120.916, H-120.919, H-125.979, H-125.986 and H-320.945

At the 2023 Annual Meeting, the House of Delegates referred Resolution 725-A-23, The Economics of Prior Authorization, which was sponsored by the Organized Medical Staff Section. This resolution asked;

> That our American Medical Association advocate to the federal government that third party payers and surrogates include economic information on the net costs of medication denied prior authorization and, where

applicable, comparative net costs of alternative approved or suggested medications for each rejected prior authorization.

In response to the resolution, this report provides an overview of prior authorization and factors that contribute to prescription medication prior authorization specifically, including formularies, rebates, and drug pricing. The Council also explores that real-time benefit tools (RTBT) have the potential to help solve this issue. The Council presents policy recommendations consistent with the intent of Resolution 725-A-23.

BACKGROUND

The Council commends the sponsors of Resolution 725-A-23 for bringing forward this important topic and believes that the spirit of the resolution has the potential to positively impact both physicians and patients. Prior authorization is a complex and often frustrating process that physicians face on a regular basis. While additional information in denial letters is warranted, as suggested in the original resolution, the Council emphasizes that resources like RTBTs have the potential to improve the prior authorization process faced by patients and physicians. These tools allow physicians to access detailed information about the coverage of a prescription medication before the prescription is written, which could reduce the number of denial letters, increase the information accessible to physicians, and allow physicians to focus on patient care instead of appeals. To fully understand prior authorization, its economic impact, and how RTBTs could assist care delivery and workflow, it is necessary to understand some of the factors that contribute to the complexity, such as formularies, rebates, and the lack of prescription drug price transparency.

Formularies, or the list of prescription drugs covered by a payer, are created via consultation with experts, often supported or directed by pharmacy benefit managers (PBMs) and typically based on clinical outcomes and the relative costs.[1,2] Formularies are premised on reducing costs and ensuring the appropriate use of pharmaceuticals.[3] However, they often have negative impacts on patients and physicians. Specifically, research has demonstrated that among studied formularies at least half of all patient health care utilization and economic outcomes were not beneficial to patients.[3] Drugs on a formulary are typically divided into different tiers based on the drug's price and the formulary designer's preference. A drug's tier position depends on a multitude of factors and can differ significantly between payers; however, one of the primary factors influencing any drug's tier placement is the financial arrangement between the payer and the drug manufacturer for that drug. Unfortunately, a drug's efficacy or its appropriateness for a particular patient, and its cost-effectiveness are often secondary considerations compared to the financial implications of the drug.

Manufacturers offer rebates that are typically negotiated between PBMs and the drug manufacturer and are typically based on the list price of the drug. Along with prior authorization, rebates are generally used to encourage a payer to include favorable placement or inclusion on a formulary.[4] Increased rebates are sometimes used to incentivize placement on a preferred formulary tier.[5] Rebates are relied on heavily by PBMs and other payers to negotiate more lucrative deals, and to protect these financial positions, it is critical to PBMs and payers that the specific details of these arrangements remain confidential. Without access to more detailed information about rebates and other financial incentives, it is impossible for physicians to fully understand how much a drug truly costs.

Payers often use prior authorization as a tool to discourage physicians from prescribing medications that are not on the payer's preferred formulary tier. If a payer prefers that a physician prescribe one drug over another within the same drug class, the payer can simply apply a prior authorization requirement to the non-preferred medication. By placing prior authorization on non-preferred drugs, payers can drive utilization in their desired direction. It is often challenging for physicians to determine whether a prior authorization is required at all, let alone what the specific requirements are. The prior authorization process is often so opaque that physicians may not be notified that a prior authorization is required until they receive a denial letter from the payer, or the patient is turned away at the pharmacy counter, which can lead to delays and significant interruptions in ongoing care as well as disruptions to patient adherence. Although these payer coverage determination delays and/or issues are rarely the physician's fault, patients may blame the physician, undermining the patient's trust in the physician and potentially impacting the patient-physician relationship long-term.

Physicians are often prescribing without access to drug cost and coverage information at the point of prescribing, making it almost impossible to avoid prescribing a drug that may be unaffordable under that specific patient's plan. This can cause the physician to unknowingly prescribe a more expensive medication when a lower-cost and equally beneficial medication is available and can cause significant harm to patient outcomes. Specifically, more expensive

medications have been linked to lower treatment adherence, and, in extreme cases, increases in morbidity and/or mortality.[6] While there have been efforts from federal regulators and legislators to mitigate some of the negative impacts from medication prior authorization, the process remains opaque and complicated and, as a result, patients may not be able to readily access lower-cost alternative medications. Additionally, there is very little transparency from PBMs and payers regarding rebates, formulary makeup, and drug costs.[6] Rebate information is considered proprietary data and as such is not accessible for scrutiny, making it incredibly difficult for any regulating body to have accurate data leading to challenges in effective regulation.

PRIOR AUTHORIZATION DENIALS

The roots of prior authorization can be traced back to the original Medicare and Medicaid legislation from the 1960s which introduced utilization review, or the process of verifying the need for treatment, often hospital stays, for a confirmed diagnosis.[7] Over time, this process has expanded to include the coverage of prescription medications and to what is now recognized as prior authorization.[7] When introduced, prior authorization was touted as a method to restrict significant increases in the cost of prescription drugs, however this process has become one that is burdensome for both patients and physicians.[8] Prior authorization has resulted in several adverse consequences ranging from increased administrative burden to patient inability to access necessary medications.[8] Additionally, the prior authorization process can undermine the patient-physician relationship. Physicians and patients frequently have limited knowledge if prior authorization will be required for a medication, hindering the ability for physicians to ensure affordable, timely access to the medication they deem the most appropriate.[9]

Today, prior authorization has become pervasive throughout the health care system. A recent report found that 99 percent of Medicare Advantage (MA) plans require prior authorization for at least some services; most often for Part B drugs.[10] Additionally, a study investigating MA plans found that prior authorizations are submitted, on average, 1.5 times for each enrollee, adding up to approximately 35 million requests in one year.[11] Of the submitted requests in MA plans this study found that six percent, or approximately 2 million, were denied. However, this denial rate ranged greatly among payers with some denial rates as high as double the average. Importantly, this study found that only 11 percent of denied prior authorizations were appealed by either the patient or provider. The vast majority of appeals were successful with 82 percent resulting in a full or partial overturning of the denial. Similar to rates of denials, some payers saw much higher rates of appeal, some reaching 20 percent of all denials. Further, for some payers, appeals were successful as much as 94 percent of the time.[11] While this study is helpful in beginning to understand the rates of prior authorization denials, the researchers did not have access to disaggregated data showing the service type of prior authorization requests and were unable to access reasoning for each denial or information on the timeliness of requests or appeals. Additionally, these statistics were only based on MA plans; private plans were not included. It is important to note that physicians who are forced to appeal prior authorization denials often face significant administrative costs. Physicians and their offices are often required to hire additional staff and/or spend personal time managing authorizations and appeals.

Legislators and regulators have introduced rules and regulations that are designed to minimize the struggles that plague the prior authorization process. For example, a recent final regulation from the Centers for Medicare & Medicaid Servicecs (CMS) requires that as of January 1, 2027, payers, including MA, Medicaid, Children's Health Insurance Program, and Qualified Health Plans on the Federally Facilitated Exchange are required to maintain a prior authorization application programming interface (API). This API must include information on covered items and services, identification of documents required for prior authorization, be supportive of prior authorization requests and payer responses, and communicate approvals, denials, or requests for additional information.[12] Effective January 1, 2026, payers will be required to report metrics and follow a stricter response timeline.[13] While this rule will improve the regulation of prior authorization, it does not extend to prescription drug prior authorization requests.

One of the biggest issues with prior authorization is the opaque and extensive denial process. Not only is this a frustrating process for the patient looking to access treatment, but it is also exasperating for physicians who are attempting to support their patients. When a denial letter is sent out, it may not include effective information to understand and/or appeal the denial itself. For example, physicians and patients may simply be informed that a medication has not been approved without providing justification as to why the denial took place or an alternative treatment option. Without clear information regarding the clinical rationale for the denial, patients and physicians are often left to the frustrating process of guess work in attempting to find a treatment covered by the patient's plan.

In order to improve the quantity and quality of information provided in denial letters, CMS has implemented basic requirements for all Medicare health plans.[14] These requirements, outlined in CMS-10003-Notice of Denial of Medical Coverage or Payment form are in place for all medical services and prescription drug denials. Specifically, in denial letters, plans must provide the patient/physician with detailed information as to why the request was denied. Plans are required to include a "specific and detailed" explanation for the denial, applicable coverage rules or plan policies cited in the denial, and specific information as to what needs to be done to approve coverage.[14] These requirements ensure that the Medicare beneficiaries and their physicians are able to have an understanding of the full scope of the denial via the notification letter.

REAL-TIME BENEFIT TOOL

To address the underlying concerns of Resolution 725-A-23, the Council worked to better understand available data and what could feasibly be provided to physicians and patients. Not only are there issues related to a lack of transparency due to prior authorization, at present, prior authorization denial systems are not capable of producing specific net cost information on denials. The Council believes that advocacy efforts supporting the betterment of alternative solutions, like RTBTs, instead of the expansion of prior authorization systems better serve physicians and their patients. One potential solution to the challenges faced due to prior authorization are RTBTs, which allow patients and prescribers to access real-time information about coverage, including formularies and benefit information at the point of prescribing.[15] These tools simplify prescribing with real-time information during an appointment. RTBTs allow prescribers to enter prescription details, like type, amount, and intended pharmacy, and be informed, prior to writing the prescription, of the cost and prior authorization requirements. RTBTs also allow physicians and other prescribers to view alternative medications that may be lower cost to the patient and/or not require prior authorization, thus allowing the prescriber to identify and prescribe the most appropriate and accessible medication for a patient.[16]

RTBTs present an opportunity to improve the care delivery process by presenting prescribers with critical prescription coverage and cost information at the point of prescribing. The current prior authorization system relies heavily on relaying information to the patient/prescriber after a prescription has been written and the patient has attempted to get that prescription filled. These "post-prescription written denials," usually delivered to prescribers via letters, often lead to additional work for prescribers and their staff and result in immense administrative practice burdens. In addition to increased work for physicians and their staff, the current prior authorization process also often leads to patient care delays and adherence issues. RTBTs present all of the cost, coverage, and other pertinent benefit information within the prescriber's typical prescribing workflow and allow the prescriber to not only identify prior authorization requirements prior to writing the prescription, but also submit the prior authorization request directly to the payer sooner.

By providing information at the beginning of the prescribing process, RTBTs allow prescribers to identify care delivery impediments earlier so they avoid any unexpected utilization management delays. RTBTs have the potential to mitigate the impact of prior authorization denial letters by informing prescribers of alternative, therapeutically equivalent medications that do not require prior authorization at the point of care. RTBTs allow physicians to see which medications would be covered and thus prior authorizations, and subsequent denial letters, should only be necessary if the prescriber determines that the alternative, covered medication is not clinically appropriate. With fewer denial letters, physicians can spend more time caring for patients and less time on appeals.

Current CMS regulation requires that all Medicare Part D plans provide at least one RTBT. In practice, for physicians and qualified providers to have access to RTBT information for all patients, they may need to support and integrate multiple RTBT and Electronic Health Records (EHR) systems. This is burdensome and complicated for all physicians to implement, and nearly impossible for smaller practices. Managing multiple systems is not only expensive and complex, it also may lead to confusion on RTBTs. In response to the complications that arose with the need to manage and support multiple RTBT and EHR systems, CMS has proposed a rule that would require Part D plans to implement a standardized system.[17] This standard, the National Council for Prescription Drug Programs RTPB Standard Version 13 would allow for standardized formulary and benefit data in a manner that is reliable, detailed, and effectively integrated into systems.[18] The AMA has been vocal in advocating for and supporting this proposed rule.[19] Should the proposed rule be implemented, starting January 2027, this standardized system would allow for increasingly efficient physician access to clear information at the time of prescribing. Of note, this requirement would not extend to private insurers, however the requirement of this standard system by CMS could lead to future implementation in the private sector.

AMA ADVOCACY

The AMA's extensive advocacy efforts work to address each of the systemic factors cited by Resolution 725-A-23, including prior authorization, formularies, rebates, prescription drug pricing transparency, and RTBTs. Regarding prior authorization, the AMA has an ongoing grassroots campaigns "Fix Prior Auth" to address the harm incurred by patients and physicians by prior authorization,[20] and TruthinRx, which aims to educate patients, physicians, providers, and legislators about the issues that arise from the lack of price transparency.[21] TruthinRx advocates for transparency from PBMs, payers, and manufacturers around formularies and rebates. The goals of these campaigns are to spread awareness, create legislative changes, and serve as an extensive resource for patients, physicians, and employers on these high priority issues.

Additionally, the AMA conducts regular surveys to track and report the impact of prior authorization on patients and physicians. The survey includes questions aimed at better understanding the impact of prior authorization for generic medication. In addition to this work, AMA advocacy has commented on prior authorization via letters and testimony to state legislators, Congress, and federal agencies 35 times in 2023 alone and has already been active in advocating for these issues in 2024.

AMA advocacy has commented on relevant transparency issues through 21 letters and testimonies to state legislators, Congress, and federal agencies in 2023. Finally, to support the implementation of RTBTs, AMA advocacy has sent 18 letters and testimonies in 2023 to Congress and federal agencies. Efforts have already been made, and continue to be made, in 2024 to advocate on these issues. Each of these factors contribute to the issues raised in Resolution 725-A-23 and are clearly on the AMA advocacy's ongoing agenda.

AMA POLICY

Underscoring the extensive advocacy work on these issues is a robust body of AMA policy aimed at ensuring that prior authorization is monitored and minimized, PBMs are monitored and regulated, the process is transparent, and to support the implementation of adequate RTBT tools.

Policy H-125.991 outlines the standards that both formulary systems and Pharmacy and Therapeutic Committees should meet. For example, this policy outlines that formulary systems should include oversight from organized medical staff. This policy is reinforced by similar guidelines in Policy H-285.965, which, among other things, outlines that both physicians and patients should have access to clear information about a payer's formulary and that these formularies should be created and maintained with the input of physicians. In addition to these policies dealing directly with the creation and maintenance of formularies, Policy H-110.981 details advocacy efforts to ensure that PBMs and regulatory bodies make rebate and discount reports available to the public, ideally, assisting in disentangling the influence rebates have on the complex and opaque process that is formulary creation.

AMA policy also deals directly with efforts to ensure that PBMs are monitored and that there is an increase in transparency regarding their operation. Specifically, Policy D-110.987 outlines the advocacy efforts that the AMA continues to implement to ensure that PBMs are required to increase transparency in their operating procedures and that they are adequately regulated on both a state and federal level. Additionally, Policy H-125.986 encourages physician engagement in reporting issues with PBMs and indicates efforts to increase PBM oversight and reduce PBM overreach in medical practice. Policy H-110.963 expands the coverage of regulation and monitoring to third-party PBMs. Each of these policies aim to implement adequate oversight of PBMs. Finally, Policies H-125.986 and D-120.933 outline the AMA's support to ensure that PBMs' actions do not impede or negatively impact the patient-physician relationship.

In addition to AMA policy on contributing factors to prior authorization, the AMA has extensive policy on prior authorization and increasing physician access to real time prescribing information. Policy H-125.979 specifies AMA efforts to work with appropriate parties to ensure that physicians have access to real-time formulary data when prescribing a medication. Additionally, Policy H-120.919 outlines AMA efforts to support the implementation of RTBT tools that are helpful to prescribers and accurate at the time of prescribing. Finally, Policy H-320.945 outlines AMA opposition to prior authorization abuses and outlines the requirement for payers to report accurate statistics on approvals and denials.

DISCUSSION

Prior authorization is a tool that was initially introduced to save money and ensure that care given to patients was medically necessary. However, in the years since its introduction it has been overutilized and is now a burden for physicians as well as a barrier to patients accessing care. The opaqueness of both rebates and formularies contribute greatly to the confusion and subsequent frustration that results from denied prior authorization. The AMA continues to make significant efforts on multiple fronts to address this issue and ensure that prior authorization is fixed for patients and physicians.

Resolution 725-A-23 asked that the AMA work to encourage the inclusion of economic information when prescription drugs are denied prior authorization. The Council believes that this concept would be beneficial to physicians and that alternative solutions, like RTBT tools, should be supported in order to mitigate the need for some prior authorizations. In the spirit of Resolution 725-A-23, and to address the confusion that can arise from prior authorization denial letters, the Council recommends that a new policy be adopted to support working with appropriate parties to ensure that denial letters include information that is helpful to physicians and patients in understanding the full scope of denial. Such a policy will benefit ongoing and future AMA advocacy letters and testimony.

The AMA has worked, and continues to work, extensively on ensuring that the burden of prior authorization is lessened for both physicians and patients. One aspect of this ongoing work has been rooted in policy outlining the AMA's support for RTBT tools. This work advocates for physicians to be able to access systems that are effective, efficient, and accurate. Accordingly, the Council suggests amending Policy H-120.919 to better align the standards and language with CMS policy, and to ensure that these tools provide a justification for the prior authorization requirement, offer alternative(s), and that coverage determinations from the RTBT are honored.

Finally, the Council recommends that Policies H-110.963; Third-Party Pharmacy Benefit Administrators; H-125.979; Private Health Insurance Formulary Transparency; H-320.945; Abuse of Preauthorization Procedures; H-125.986 Pharmaceutical Benefit Management Companies; and D-120.933 Pharmacy Benefit Managers Impact on Patients be reaffirmed. These policies outline the AMA's efforts to ensure that all PBMs are monitored, regulated, and do not harm the physician-patient relationship, that health insurers are required to be transparent about the creation and maintenance of formularies, and that prior authorization is not abused by payers.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 725-A-23, and the remainder of the report be filed:

1. That our American Medical Association (AMA) support working with payers and interested parties to ensure that prior authorization denial letters include at a minimum (1) a detailed explanation of the denial reasoning, (2) a copy of or publicly accessible link to any plan policy or coverage rules cited or used as part of the denial, and (3) what rationale or additional documentation would need to be provided to approve the original prescription and alternative options to the denied medication.

2. That our AMA amend Policy H-120.919 to read as follows:

   That our AMA will: (1) continue to support efforts to ~~publish~~ implement a ~~Real-Time Prescription Benefit (RTPB)~~ Real-Time Benefit Tool (RTBT) standard that meets the needs of all physicians and other prescribers, utilizing any electronic health record (EHR), and prescribing on behalf of any insured patient; (2) support efforts to ensure that provider-facing and patient facing RTBT systems align; and (3) advocate that all payers (i.e., public and private prescription drug plans) be required to implement and keep up to date an ~~RTPB~~ RTBT standard tool that integrates with all EHR vendors, and that any changes that must be made to accomplish ~~RTPB~~ RTBT tool integration be accomplished with minimal disruption to EHR usability and cost to physicians and hospitals; (4) advocate that RTBT systems provide a justification for why prior authorization is required and include approved/covered alternative prescription medications; ~~and~~ (~~3~~5) develop and disseminate educational materials that will empower physicians to be prepared to optimally utilize ~~RTPB tools~~ RTBT and other health information technology tools that can be used to enhance communications between physicians and pharmacists to reduce the incidence of prescription abandonment; (6) advocate that payers honor coverage

information that is based on a RTBT at the time of prescription and that prior authorization approvals should be valid for the duration of the prescribed/ordered treatment; and (7) continue to advocate for the accuracy and reliability of data provided by RTBTs and for vendor neutrality to ensure that it is supportive to physician efforts.

3. That our AMA reaffirm Policy H-110.963, which addresses the regulation and monitoring of third-party Pharmacy Benefit Managers (PBMs) in an effort to control prescription drug pricing.

4. That our AMA reaffirm Policy H-125.979, which outlines advocacy efforts to ensure that physicians have access to real-time formulary data when prescribing.

5. That our AMA reaffirm Policy H-320.945, which details opposition to the abuse of prior authorization and the requirement for payers to accurately report denials and approvals.

6. That our AMA reaffirm Policy H-125.986, which outlines the AMA's position that certain actions from PBMs interfere with physician practice and may impact the patient-physician relationship.

7. That our AMA reaffirm Policy D-120.933, which encourages the gathering of data to better understand the impact that PBM actions may lead to an erosion of the patient-physician relationship.

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CMS Report Economics of Prior Authorization
Relevant AMA Policy

Drug Formularies and Therapeutic Interchange (H-125.991)
It is the policy of the AMA:
(1) That the following terms be defined as indicated:

a) Formulary: a compilation of drugs or drug products in a drug inventory list; open (unrestricted) formularies place no limits on which drugs are included whereas closed (restrictive) formularies allow only certain drugs on the list;
b) Formulary system: a method whereby the medical staff of an institution, working through the pharmacy and therapeutics committee, evaluates, appraises, and selects from among the numerous available drug entities and drug products those that are considered most useful in patient care;
c) Pharmacy & Therapeutics (P&T) Committee: an advisory committee of the medical staff that represents the official, organizational line of communication and liaison between the medical staff and the pharmacy department; its recommendations are subject to medical staff approval;
d) Therapeutic alternates: drug products with different chemical structures but which are of the same pharmacological and/or therapeutic class, and usually can be expected to have similar therapeutic effects and adverse reaction profiles when administered to patients in therapeutically equivalent doses;
e) Therapeutic interchange: authorized exchange of therapeutic alternates in accordance with previously established and approved written guidelines or protocols within a formulary system; and
f) Therapeutic substitution: the act of dispensing a therapeutic alternate for the drug product prescribed without prior authorization of the prescriber.

(2) That our AMA reaffirms its opposition to therapeutic substitution (dispensing a therapeutic alternate without prior authorization) in any patient care setting.

(3) That drug formulary systems, including the practice of therapeutic interchange, are acceptable in inpatient hospital and other institutional settings that have an organized medical staff and a functioning Pharmacy and Therapeutics (P&T) Committee, provided they satisfy the following standards:

(a) The formulary system must:
(i) have the concurrence of the organized medical staff;
(ii) openly provide detailed methods and criteria for the selection and objective evaluation of all available pharmaceuticals;
(iii) have policies for the development, maintenance, approval, and dissemination of the drug formulary and for continuous and comprehensive review of formulary drugs;
(iv) provide protocols for the procurement, storage, distribution, and safe use of formulary and non-formulary drug products;
(v) provide active surveillance mechanisms to regularly monitor both compliance with these standards and clinical outcomes where substitution has occurred, and to intercede where indicated;
(vi) have enough qualified medical staff, pharmacists, and other professionals to carry out these activities;
(vii) provide a mechanism to inform the prescriber in a timely manner of any substitutions, and that allows the prescriber to override the system when necessary for an individual patient without inappropriate administrative burden;
(viii) provide a mechanism to assure that patients/guardians are informed of any change from an existing outpatient prescription to a formulary substitute while hospitalized, and whether the prior medication or the substitute should be continued upon discharge from the hospital;
(ix) include policies that state that practitioners will not be penalized for prescribing non-formulary drug products that are medically necessary; and
(x) be in compliance with applicable state and federal statutes and/or state medical board requirements.

(b) The P&T Committee must:
(i) objectively evaluate the medical usefulness and cost of all available pharmaceuticals (reliance on practice guidelines developed by physician organizations is encouraged);

(ii) recommend for the formulary those drug products which are the most useful and cost-effective in patient care;
(iii) conduct drug utilization review (DUR) activities;
(iv) provide pharmaceutical information and education to the organization's (e.g., hospital) staff;
(v) analyze adverse results of drug therapy;
(vi) make recommendations to ensure safe drug use and storage; and
(vii) provide protocols for the timely procurement of non-formulary drug products when prescribed by a physician for the individualized care of a specific patient, when that decision is based on sound scientific evidence or expert medical judgment.

(c) The P&T Committee's recommendations must be approved by the medical staff;

(d) Within the drug formulary system, the P & T Committee shall recommend, and the medical staff must approve, all drugs that are subject to therapeutic interchange, as well as all processes or protocols for informing individual prescribing physicians; and

(e) The act of providing a therapeutic alternate that has not been recommended by the P&T Committee and approved by the medical staff is considered unauthorized therapeutic substitution and requires immediate prior consent by the prescriber, (i.e., authorization for a new prescription).

(4) That drug formulary systems in any outpatient setting shall operate under a P&T Committee whose recommendations must have the approval of the medical staff or equivalent body and must meet standards comparable to those listed above. In addition:

(a) That our AMA continues to insist that managed care and other health plans identify participating physicians as their "medical staff" and that they use such staff to oversee and approve plan formularies, as well as to oversee and participate on properly elected P&T Committees that develop and maintain plan formularies;
(b) That our AMA continues to insist that managed care and other health plans have well-defined processes for physicians to prescribe non-formulary drugs when medically indicated, that this process impose minimal administrative burdens, and that it include access to a formal appeals process for physicians and their patients; and
(c) That our AMA strongly recommends that the switching of therapeutic alternates in patients with chronic diseases who are stabilized on a drug therapy regimen be discouraged.

(5) That our AMA encourages mechanisms, such as incentive-based formularies with tiered co-pays, to allow greater choice and economic responsibility in drug selection but urges managed care plans and other third-party payers to not excessively shift costs to patients so they cannot afford necessary drug therapies. (BOT Rep. 45, I-93; Reaffirmed by Sub. Res. 501, A-95; Appended: BOT Rep. 7, I-99; Modified: Sub. Res. 524 and Reaffirmed: Res. 123, A-00; Reaffirmed: Res. 515, I-00; Reaffirmed: CMS Rep. 8, A-02; Reaffirmed: Res. 533, A-03; Modified: CMS Rep. 6, A-03; Modified: CSA Rep. 2, A-04; Reaffirmation I-04; Reaffirmed in lieu of Res. 535, A-05; Reaffirmed: BOT Action in response to referred for decision Res. 503, A-05; Reaffirmed: CMS Rep. 2, I-05; Reaffirmation A-06; Reaffirmation A-08; Reaffirmed: CMS Rep. 2, A-10; Reaffirmed: CMS Rep. 01, A-20)

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

1. Our AMA supports the active regulation of pharmacy benefit managers (PBMs) under state departments of insurance.
2. Our AMA will develop model state legislation addressing the state regulation of PBMs, which shall include provisions to maximize the number of PBMs under state regulatory oversight.
3. Our AMA supports requiring the application of manufacturer rebates and pharmacy price concessions, including direct and indirect remuneration (DIR) fees, to drug prices at the point-of-sale.
4. Our AMA supports efforts to ensure that PBMs are subject to state and federal laws that prevent discrimination against patients, including those related to discriminatory benefit design and mental health and substance use disorder parity.
5. Our AMA supports improved transparency of PBM operations, including disclosing:
   - Utilization information;
   - Rebate and discount information;

- Financial incentive information;
- Pharmacy and therapeutics (P&T) committee information, including records describing why a medication is chosen for or removed in the P&T committee's formulary, whether P&T committee members have a financial or other conflict of interest, and decisions related to tiering, prior authorization, and step therapy;
- Formulary information, specifically information as to whether certain drugs are preferred over others and patient cost-sharing responsibilities, made available to patients and to prescribers at the point-of-care in electronic health records;
- Methodology and sources utilized to determine drug classification and multiple source generic pricing; and
- Percentage of sole source contracts awarded annually.

6. Our AMA encourages increased transparency in how DIR fees are determined and calculated. (CMS Rep. 05, A-19; Reaffirmed: CMS Rep. 6, I-20)

Pharmaceutical Benefits Management Companies (H-125.986)
Our AMA:
(1) encourages physicians to report to the Food and Drug Administration's (FDA) MedWatch reporting program any instances of adverse consequences (including therapeutic failures and adverse drug reactions) that have resulted from the switching of therapeutic alternates;
(2) encourages the Federal Trade Commission (FTC) and the FDA to continue monitoring the relationships between pharmaceutical manufacturers and PBMs, especially with regard to manufacturers' influences on PBM drug formularies and drug product switching programs, and to take enforcement actions as appropriate;
(3) pursues congressional action to end the inappropriate and unethical use of confidential patient information by pharmacy benefits management companies;
(4) states that certain actions/activities by pharmacy benefit managers and others constitute the practice of medicine without a license and interfere with appropriate medical care to our patients;
(5) encourages physicians to routinely review their patient's treatment regimens for appropriateness to ensure that they are based on sound science and represent safe and cost-effective medical care;
(6) supports efforts to ensure that reimbursement policies established by PBMs are based on medical need; these policies include, but are not limited to, prior authorization, formularies, and tiers for compounded medications; and
(7) encourages the FTC and FDA to monitor PBMs' policies for potential conflicts of interests and anti-trust violations, and to take appropriate enforcement actions should those policies advantage pharmacies in which the PBM holds an economic interest. (BOT Rep. 9, I-97; Appended: Res. 224, I-98; Appended: Res. 529, A-02; Reaffirmed: Res. 533A-03; Reaffirmation I-08; Reaffirmation A-10; Reaffirmed: Alt. Res. 806, I-17; Modified: Res. 242, A-18; Reaffirmed: CMS Rep. 08, A-19)

Third-Party Pharmacy Benefit Administrators (H-110.963)
1. Our AMA recommends that third-party pharmacy benefit administrators that contract to manage the specialty pharmacy portion of drug formularies be included in existing pharmacy benefit manager (PBM) regulatory frameworks and statutes, and be subject to the same licensing, registration, and transparency reporting requirements.
2. Our AMA will advocate that third-party pharmacy benefit administrators be included in future PBM oversight efforts at the state and federal levels. (Res. 820, I-22)

Private Health Insurance Formulary Transparency (H-125.979)
1. Our AMA will work with pharmacy benefit managers, health insurers, and pharmacists to enable physicians to receive accurate, real-time formulary data at the point of prescribing.
2. Our AMA supports legislation or regulation that ensures that private health insurance carriers declare which medications are available on their formularies by October 1 of the preceding year, that formulary information be specific as to generic versus trade name and include copay responsibilities, and that drugs may not be removed from the formulary nor moved to a higher cost tier within the policy term.
3. Our AMA will develop model legislation (a) requiring insurance companies to declare which drugs on their formulary will be covered under trade names versus generic, (b) requiring insurance carriers to make this information available to consumers by October 1 of each year and, (c) forbidding insurance carriers from making formulary deletions within the policy term.

4. Our AMA will promote the following insurer-pharmacy benefits manager - pharmacy (IPBMP) to physician procedural policy: In the event that a specific drug is not or is no longer on the formulary when the prescription is presented, the IPBMP shall provide notice of covered formulary alternatives to the prescriber promptly so that appropriate medication can be provided to the patient within 72 hours.
5. Drugs requiring prior authorization, shall be adjudicated by the IPBMP within 72 hours of receipt of the prescription.
6. Our AMA (a) promotes the value of online access to up-to-date and accurate prescription drug formulary plans from all insurance providers nationwide, and (b) supports state medical societies in advocating for state legislation to ensure online access to up-to-date and accurate prescription drug formularies for all insurance plans.
7. Our AMA will continue its efforts with the National Association of Insurance Commissioners addressing the development and management of pharmacy benefits.
8. Our AMA will develop model state legislation on the development and management of pharmacy benefits. (Sub. Res. 724, A-14; Appended: Res. 701, A-16; Appended: Alt. Res. 806, I-17; Reaffirmed: CMS Rep. 07, A-18; Reaffirmed: BOT Rep. 20, A-19; Reaffirmed: CMS Rep. 05, A-19; Reaffirmed: CMS Rep. 2, A-21)

Access to Health Plan Information Regarding Lower-Cost Prescription Options (H-120.919)
Our AMA will: (1) continue to support efforts to publish a Real-Time Prescription Benefit (RTPB) standard that meets the needs of all physicians and other prescribers, utilizing any electronic health record (EHR), and prescribing on behalf of any insured patient; (2) advocate that all payers (i.e., public and private prescription drug plans) be required to implement and keep up to date an RTPB standard tool that integrates with all EHR vendors, and that any changes that must be made to accomplish RTPB tool integration be accomplished with minimal disruption to EHR usability and cost to physicians and hospitals; and (3) develop and disseminate educational materials that will empower physicians to be prepared to optimally utilize RTPB tools and other health information technology tools that can be used to enhance communications between physicians and pharmacists to reduce the incidence of prescription abandonment. (CMS Rep. 2, I-21)

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 ten percent 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 percent 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.
14. Our AMA supports legislation that limits Medicare annual drug price increases to the rate of inflation. (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; Appended: Res. 113, I-21; Reaffirmed in lieu of: Res. 810, I-22

Price of Medicine (H-110.991)
Our AMA: (1) advocates that pharmacies be required to list the full retail price of the prescription on the receipt along with the co-pay that is required in order to better inform our patients of the price of their medications; (2) will pursue legislation requiring pharmacies, pharmacy benefit managers and health plans to inform patients of the actual cash price as well as the formulary price of any medication prior to the purchase of the medication; (3) opposes provisions in pharmacies' contracts with pharmacy benefit managers that prohibit pharmacists from disclosing that a patient's co-pay is higher than the drug's cash price; (4) will disseminate model state legislation to promote drug price and cost transparency and to prohibit "clawbacks"; (5) supports physician education regarding drug price and cost transparency, manufacturers' pricing practices, and challenges patients may encounter at the pharmacy point-of-sale; and (6) work with relevant organizations to advocate for increased transparency through access to meaningful and relevant information about medication price and out-of-pocket costs for prescription medications sold at both retail and mail order/online pharmacies, including but not limited to Medicare's drug-pricing dashboard. (CMS Rep. 6, A-03; Appended: Res. 107, A-07; Reaffirmed in lieu of: Res. 207, A-17; Appended: Alt. Res. 806, I-17; Reaffirmed: BOT Rep. 14, A-18; Appended: CMS Rep. 07, A-18; Reaffirmation: A-19; Appended: Res. 126, A-19)

Prescription Drug Price and Cost Transparency (D-110.988)
1. Our AMA will continue implementation of its TruthinRx grassroots campaign to expand drug pricing transparency among pharmaceutical manufacturers, pharmacy benefit managers and health plans, and to communicate the impact of each of these segments on drug prices and access to affordable treatment.
2. Our AMA will report back to the House of Delegates at the 2018 Interim Meeting on the progress and impact of the TruthinRx grassroots campaign. (Alt. Res. 806, I-17)

Abuse of Preauthorization Procedures (H-320.945)
Our AMA opposes the abuse of preauthorization by advocating the following positions:
(1) Preauthorization should not be required where the medication or procedure prescribed is customary and properly indicated, or is a treatment for the clinical indication, as supported by peer-reviewed medical publications or for a patient currently managed with an established treatment regimen.

(2) Third parties should be required to make preauthorization statistics available, including the percentages of approval or denial. These statistics should be provided by various categories, e.g., specialty, medication or diagnostic test/procedure, indication offered, and reason for denial. (Sub. Res. 728, A-10; Reaffirmation I-10; Reaffirmation A-11; Reaffirmed: Res. 709, A-12; Reaffirmed: CMS Rep. 08, A-17; Reaffirmed: Res. 125, A-17; Reaffirmation: A-17 Reaffirmation: I-17; Reaffirmed: CMS Rep. 4, A-21; Reaffirmation: A-22)

Pharmacy Benefit Managers Impact on Patients (D-120.933)
Our AMA will: (1) gather more data on the erosion of physician-led medication therapy management in order to assess the impact pharmacy benefit manager (PBM) tactics may have on patient's timely access to medications, patient outcomes, and the physician-patient relationship; (2) examine issues with PBM-related clawbacks and direct and indirect remuneration (DIR) fees to better inform existing advocacy efforts; and (3) request from PBMs, and compile, data on the top twenty-five medication precertification requests and the percent of such requests approved after physician challenge. (Res. 225, A-18)

7. ENSURING PRIVACY IN RETAIL HEALTH CARE SETTINGS

Reference committee hearing: see report of Reference Committee A.

HOUSE ACTION: RECOMMENDATIONS ADOPTED
REMAINDER OF REPORT FILED
See Policies D-315.968, H-315.958, H-315.962 and H-480.940

At the 2023 Annual Meeting, the House of Delegates adopted Policy H-315.960, which asks our American Medical Association (AMA) to "study privacy protections, privacy consent practices, the potential for data breaches, and the use of health data for non-clinical purposes in retail health care settings." Testimony at the 2023 Annual Meeting regarding the resolution was unanimously supportive, highlighting a strong commitment to patient privacy as well as expansion to include health data for nonclinical purposes and all retail health care settings. This report focuses on current privacy practices in retail health care settings, highlights AMA advocacy efforts and essential policy, and presents new policy recommendations.

BACKGROUND

As of March 2023, there were 1,801 active retail health care clinics in 44 states, predominantly in major metropolitan areas. While only two percent of retail health care clinics are in rural areas, CVS Health owns half of those as well as 63 percent of all retail health care clinics. Kroger Health is the second largest, at 12 percent market share, with more than 220 retail clinics in 35 states, and Walgreens is the third largest at eight percent.[1] Other participants include Walmart, Amazon, Best Buy, and Dollar General. Most retail clinics are in the Southeast and the Midwest, which account for 62 percent of locations. Nearly half (49.1 percent) of all retail clinics are concentrated in seven states: Texas, Florida, Ohio, California, Georgia, Illinois, and Tennessee, which can be attributed to population density. Retail health care clinics have seen a 202 percent increase in utilization from 2021 to 2022,[2] which is a greater growth percentage than seen by urgent care centers, primary care practices, and hospital emergency departments. While retail health care has been around since the early 2000s, it is now a significant player in the $4 trillion U.S. health care system.[3] Retailers' substantial financial resources and far reach allow them to push a customized consumer experience focused on convenience and driven by digital health products, permitting them to get closer to consumers as e-commerce erodes their traditional business. Companies such as CVS Health, Walgreens, Costco, and Amazon continue to expand their services, pulling together different technology-enabled services such as urgent, primary, home, and specialty care along with pharmacy and, in some cases, full integration with an insurer, prompting anti-trust and privacy concerns.

A 2022 AMA survey found that while 92 percent of people believe that privacy of their health data is a right, most are unclear about the rules relevant to their privacy. The AMA is concerned that health data are increasingly vulnerable and has called for regulations for an individual's right to control, access, and delete personal data collected about them. The issue is further exacerbated by the Supreme Court's decision to overturn *Roe v. Wade*, which challenges the right to privacy by potentially enabling law enforcement to gain access to health data related to abortion care and pregnancy.[4] As such, the AMA has outlined five privacy principles for a national privacy framework, including:

- Individual rights
- Equity
- Entity responsibility
- Applicability
- Enforcement

SNAPSHOT OF CURRENT RETAIL HEALTH CARE MARKET

Walmart is reportedly in negotiations with ChenMed, which touts itself as "family-owned, family-oriented organization committed to bringing superior health care to moderate-to-low-income seniors." Walgreens recently announced that it is teaming up with technology company Pearl Health, which has a platform to enable value-based care. The collaboration will merge Pearl's operating system capabilities with Walgreens' care delivery assets, allowing Walgreens to function as a management services organization for physicians and hospitals. Costco is partnering with the online platform Sesame, which operates outside of insurance networks in order to cater to

patients with high-deductible health plans and to the uninsured. Costco will be able to offer same-day telehealth primary care visits for $29, as well as video prescription refills, mental health consults, and in-person visits for urgent care, among other services. In 2018, Amazon acquired start-up PillPack, which later became Amazon Pharmacy. In November 2022, the company launched Amazon Clinic, a virtual health service that provides users with 24/7 access to physicians and nurse practitioners on Amazon's website and mobile application (app). In February 2023, Amazon purchased One Medical, which is a membership-based, tech-integrated primary care platform. Amazon is now piloting delivery of medications via drone, airlifting certain common medicines to homes within 60 minutes.[5] Most recently, Amazon introduced its Health Conditions Programs, an initiative that enables customers to discover digital health benefits to help manage chronic conditions such as diabetes and hypertension. Customers answer questions to determine if their insurance covers a program and if they are clinically eligible for that program, for which they gain access to specific services (e.g., virtual health coaching) and devices (e.g., continuous glucose monitors) covered by their plan. CVS Health owns Aetna, Oak Street Health, and Caremark. In December 2017, CVS announced its merger with Aetna, representing the biggest health care merger in US history, involving both a horizontal and a vertical merger. While the AMA led advocacy efforts to block the union, it was eventually approved.

FEDERAL DATA PRIVACY LAWS

The Health Insurance Portability and Accountability Act (HIPAA) was enacted in 1996, establishing a comprehensive set of standards for protecting sensitive patient health information. The HIPAA Privacy Rule establishes national standards to protect individuals' medical records and other individually identifiable patient health information (collectively defined as "protected health information" or PHI). It requires appropriate safeguards to protect the privacy of PHI and sets limits and conditions on the uses and disclosures that may be made of such information without an individual's authorization.

PHI is any individually identifiable health information created, received, maintained, or transmitted by a covered entity or business associate that:

- Relates to the past, present, or future physical or mental health or condition of an individual,
- The provision of health care to an individual, or
- The past, present, or future payment for the provision of health care to an individual.

The United States does not have a federal law that affirms who owns medical records. Under HIPAA, patients have the right to access data medical information in their medical records. The HIPAA Privacy Rule requires appropriate safeguards to protect the privacy of PHI and sets limits and conditions on the uses and disclosures that may be made of such information without an individual's authorization. The HIPAA Privacy Rule also gives individuals rights over their PHI, including rights to examine and obtain a copy of their health records, to direct a covered entity to transmit to a third-party an electronic copy of their protected health information in an electronic health record, and to request corrections. It applies to all entities that fall within the definition of a "covered entity," which includes health plans, health care clearinghouses, and those health care providers that conduct certain health care transactions electronically. Third-party organizations that provide a service for or on behalf of a covered entity are referred to as "business associates" when the service they provide requires that the covered entity disclose PHI to them; common examples of a business associate are a claims processing entity or appointment scheduling service. All business associates are required to comply with HIPAA privacy protections to the same extent as the covered entity for which the services are performed.

Retail health care is a term used to describe two discrete models of care: 1) walk-in clinics that provide treatment from employed non-physician practitioners (e.g., CVS Minute Clinic); or 2) services that connect patients with participating online clinics (e.g., Amazon Clinic). This distinction is important as it has implications in deciphering responsibilities of covered entities (e.g., CVS Affiliated Covered Entity, which designates itself as a single covered entity made up of covered entities and health care providers owned or controlled by CVS) and business associates, respectively. In order to help health care providers and organizations determine their HIPAA status, the Centers for Medicare & Medicaid Services has developed a *Covered Entity Decision Tool*.

While HIPAA has been in place since 1996, misconceptions persist regarding what is and is not a covered entity or business associate, and what is or is not PHI. Fortunately, in this regard, the HIPAA regulations have not changed in

10 years, since the 2013 HIPAA and Health Information Technology for Economic Clinical Health Act (HITECH) Omnibus Rule. Therefore, the following still hold true:

- A legally compliant business associate (BA) status can only be achieved by signing a BA agreement (BAA) with a covered entity (CE).
- The minimum terms of each business association agreement (BAA) are mandated by regulations, which have also not changed since 2013.
- The Privacy Rule provides that a BAA must require a BA to return all PHI to the CE or destroy the PHI at the termination of the BAA where feasible.

Legally, the HIPAA Privacy Rule applies to covered entities and business associates. Covered entities are also responsible for guaranteeing their business associates are safeguarding PHI under contract. The contract between the covered entity and its business associate must be HIPAA compliant. If a business associate breaches its contract, then it is up to the covered entity to correct that breach or terminate the contract. In the event of a loss of PHI by a BA, a CE can be responsible for their loss of data.

Health care data that are not created, received, maintained, or transmitted by a CE or BA are referred to as "health care adjacent data" and are not protected by the HIPAA Privacy Rule, nor subject to the safeguards of the HIPAA Security Rule. The HIPAA Security Rule requires CEs and BAs to maintain reasonable and appropriate administrative, technical, and physical safeguards for protecting electronically stored PHI (ePHI). However, health care entities that collect, use, store, and share personal health data from digital health platforms, apps, and other similar software programs (e.g., Fitbit) are not CEs or BAs and are, therefore, beyond the reach of HIPAA. These apps may be held legally accountable by federal regulators for inappropriate disclosures or data breaches by the Federal Trade Commission (FTC).

RETAIL HEALTH CARE ORGANIZATIONS' HIPAA STATUS

In some cases, there is confusion regarding a retail health care company's HIPAA status, requiring patients to read and comprehend several documents together in order to understand their rights. Determining which organizations HIPAA protections apply is a complex question, as HIPAA regulates not only the three types of covered entities (health plans, health care clearinghouses, and health care providers who transmit health information electronically in connection with a covered transaction), but also their business associates, which can be difficult for the layperson to identify. Additionally, while retail health companies often contend that they have stringent customer privacy policies, they may still require customers to sign away some data protection rights. For example, Amazon's privacy page explains that the Clinic is not a health care provider – in other words, it is not a HIPAA covered entity. It goes on to explain that Amazon Clinic is a service provider to health care providers – thereby classifying it as a HIPAA business associate, retaining patient PHI in order to "coordinate health care services and update customer information to facilitate services from other providers." However, the Amazon Clinic HIPAA Authorization webpage states that it is "in compliance with federal privacy laws, including HIPAA" and includes FAQs that reference its use of "HIPAA compliant technology." The challenge is that the Amazon Clinic HIPAA Authorization needs to be read together with the intricate terms of several other Amazon legal policies, including its Amazon Clinic Terms of Use, Amazon.com Conditions of Use, and Amazon.com Privacy Notice in order for patients to understand all their privacy rights. While retail health companies contend that they have stringent customer privacy policies, there have been accounts of companies requiring customers to sign away some data protection rights. In May 2023, the *Washington Post* reported that when enrolling for Amazon Clinic, users are required to provide consent to allow the use and disclosure of their PHI. The form that patients are asked to complete states that after providing consent, Amazon will be authorized to have access to the complete patient file, may re-disclose information contained in that file, and that the information disclosed will no longer be subject to HIPAA Rules.[6] While the terms are voluntary, individuals have no option of using Amazon Clinic if they do not agree to the terms and conditions.[7] The fundamental problem is that once patients agree to the Amazon Clinic authorization, they agree their health information may no longer be protected by HIPAA.[8] How retail health care companies decide to manipulate data and use it may not become apparent for many years.

CONSUMER PROTECTION & PRIVACY LAWS

Retail health care organizations that electronically transmit standard transactions (e.g., payment, enrollment, eligibility) are covered entities subject to HIPAA. They are also subject to other consumer protection and privacy

laws for non-HIPAA covered entities. Privacy rights are included in the FTC's authority to protect consumers from deceptive or unfair business practices. The FTC Health Breach Notification Rule specifically applies to non-HIPAA covered entities who are required to notify their customers, the FTC, and, in some instances, the media if there is a breach of unsecured, individually identifiable health information.[9]
The State of Washington recently passed a privacy-focused law to protect PHI that falls outside HIPAA. The My Health My Data Act makes it illegal to sell or offer to sell PHI without first obtaining authorization from the consumer.[10] Several other states (i.e., California, Colorado, Connecticut, Utah, and Virginia) have enacted general privacy laws with varying applicability to retail health care companies. The latter laws include various exemptions for PHI, HIPAA de-identified information, health care providers, HIPAA covered entities, HIPAA business associates, and non-profits. While all of the latter laws exempt PHI, retail health care companies may have obligations under these laws with respect to other personal information, such as website data.[11]

RETAIL HEALTH PRIVACY PROTECTIONS & CONSENT PRACTICES

In a privacy notice, retail health care companies outline how HIPAA allows them to use and share PHI for treatment, payment, and health care operations. Their privacy notices also describe the circumstances where uses and disclosures of PHI do not require patient approval, including certain uses and disclosures by business associates (i.e., service providers to health care providers), designated patient caregivers, workers' compensation claims, law enforcement, judicial or administrative proceedings, public health purposes, health oversight activities (e.g., audits), institutional review board-approved research, coroners, medical examiners and funeral directors, organ procurement organizations, correctional institutions, and military/national security activities. Retail health care companies are prohibited from disclosing PHI for purposes other than those described in their notices or for marketing purposes of any kind without written patient consent. Additionally, patients are notified that they may revoke their approval at any time, although most companies require submission of formal written notice, explaining that revocation cannot undo any use or sharing of PHI that has already happened based on previously granted permission.

It is important to note that Amazon Clinic is not required to secure any additional waiver or "authorization" from prospective patients in order for Amazon Clinic to provide the services it promises to perform in regard to matching the patient with an available medical provider. This type of scheduling and care coordination is one aspect of "health care operations" under HIPAA, and falls within the Treatment, Payment, and Health Care Operations permissible disclosures under HIPAA, for which no patient authorization is required.[1] Per Department of Health & Human Services-Office of Civil Rights (OCR) guidance, "A business associate agreement may authorize a business associate to make uses and disclosures of PHI the covered entity itself is permitted by the HIPAA Privacy Rule to make. See 45 C.F.R. § 164.504(e)." Patients are asked to sign a voluntary Amazon Clinic HIPAA authorization. The superfluous nature of Amazon's HIPAA authorization form seems to be a tactic aimed at obtaining valuable PHI. This strategy not only allows Amazon access to use and disclose the PHI relevant to its patient matching services, it secures Amazon's ability to collect, use, and disclose each patient's "complete patient file" – far exceeding the amount of information needed to match a patient with a medical provider.

The breadth of retail health care companies' coast-to-coast networks can amplify privacy concerns. In December 2023, the Senate Committee on Finance found that eight of the nation's largest pharmacy chains had routinely turned over customers' PHI to law enforcement agencies, even without a warrant, concluding that, "these companies' privacy practices vary widely, in ways that seriously impact patient privacy." None of the companies required a warrant before turning over requested data, as HIPAA does not require law enforcement to obtain a warrant or judge-issued subpoena before they make a lawful request for records containing PHI.

[1] See 45 C.F.R. §164.506(a) Standard: Permitted uses and disclosures. A covered entity may use or disclose protected health information for treatment, payment, or health care operations provided that such use or disclosure is consistent with other applicable requirements of this subpart. (emphasis in original). See also, "Health care operations are any of the following activities: (a) quality assessment and improvement activities, including case management and care coordination . . ." (emphasis in original) https://www.hhs.gov/hipaa/for-professionals/privacy/laws-regulations/index.html#:~:text=Health %20care %20operations%20are%20any,c)%20conducting%20or%20arranging%20for. See finally, 45 C.F.R. §164.506 (c)(2): "A covered entity may disclose protected health information for treatment activities of a health care provider." In the case of Amazon Clinic, Amazon discloses patient PHI to its participating providers to facilitate the patient's treatment, in addition to care coordination.

ETHICAL & COMPETITIVE CONSIDERATIONS

The investment banking industry utilizes a virtual information barrier between those who have material, non-public information and those who do not, to prevent conflicts of interest, sometimes referred to as an "ethical wall" or privacy wall. The legal services industry utilizes a similar firewall to protect clients by restraining access to information in order to prevent conflicts of interest among law firm attorneys who may have represented a now adverse party in their prior legal work. Establishing a privacy wall between the health business and non-health business of retail health care companies could eliminate sharing of identifiable PHI or re-identifiable PHI for uses not directly related to patients' medical care.

Amazon's acquisition of One Medical is a cautionary example. The union allows Amazon to collect a large cache of PHI to further cement its dominance as an online intermediary for goods and services. Amazon's cross-industry reach allows it to use data to develop detailed insights about individuals, without much risk of violating privacy laws. In order to protect the privacy of patients, it will be important for Amazon to commit to having a privacy wall between its patient data and its other areas. Amazon notes that it "will never share One Medical PHI outside of One Medical for advertising or marketing purposes of other Amazon products and services without clear permission from the customer."[12] However, Amazon makes patients accept its conditions of use prior to treatment, which signs away their PHI protections.[13] The combination of a vast product distributor and marketer with sensitive PHI sets the stage for unfettered targeted advertising.

The implications of horizonal-vertical health care mergers, such as the one between CVS and Aetna, cannot be overlooked. An AMA evidence-based analysis showed how the merger would reduce competition in five key health care markets: Medicare Part D; health insurance; pharmacy benefit management; retail pharmacy; and specialty pharmacy, leading to higher premiums and lower-quality insurance products. Such mergers may lead to increased access to PHI, leveraging data on individual biology, medical history, level of well-being, shopping habits, sleep hygiene, nicotine consumption, and exercise routines to shape patients' digital health IDs. This can allow health insurers to reduce their risks and, therefore, their costs by restricting access to health care services for high-risk patients and vulnerable populations.

POTENTIAL FOR DATA BREACHES

On February 21, 2024, a cyberattack against UnitedHealth Group's Change Healthcare disrupted operations for physicians, hospitals, insurers, and pharmacies. Change Healthcare uses Amazon Web Services (AWS) to submit and process insurance claims, handling close to 14 billion transactions a year. As of March 1, 2024, Change Healthcare reported that it was working with Microsoft and AWS to perform an additional scan of its cloud environment. This breach highlights the potential for cyberattacks to affect patient privacy in the retail health care setting.

The four most common reasons for data breaches include cyberattacks, unauthorized disclosure, theft, and improper disposal of PHI.[14] As retail health care companies expand their reach, the risk of a data breach increases exponentially, especially if they fail to establish the technical controls, training, and employee sanctions necessary to isolate retail health care business from other lines of business. Legal and technical firewalls are essential in preventing retail health care data breaches because they serve as the first line of defense in protecting ePHI from external threats such as hacking, as well as unauthorized or unintended disclosures across business lines.

Once a covered entity knows or by reasonable diligence should have known (referred to as the "date of discovery") that a breach of PHI has occurred, the entity has an obligation to notify the relevant parties "without unreasonable delay" or up to 60 calendar days following the date of discovery, even if upon discovery the entity was unsure as to whether PHI had been compromised. If the breach involves the unsecured PHI of more than 500 individuals, a covered entity must notify a prominent media outlet serving the state or jurisdiction in which the breach occurred, in addition to notifying the Department of Health & Human Services (HHS). For breaches involving fewer than 500 individuals, covered entities are permitted to maintain a log of the relevant information and notify HHS within 60 days after the end of the calendar year via the HHS website. Additionally, covered entities may offer affected individuals free identity restoration services or credit reports for a defined period of time. While such offerings are well intended, they do not necessarily allow reparations commensurate with the degree of harm experienced by the affected individuals.

USE OF HEALTH DATA FOR NON-CLINICAL PURPOSES

Secondary use of PHI includes activities such as analysis, research, quality and safety measurement, public health, payment, physician accreditation, marketing, risk stratifying to limit care to high-risk patients and vulnerable populations, and other business applications. As retail health care companies continue to expand their reach, the potential for them to use PHI for non-clinical purposes grows. The FTC sent a letter to Amazon in anticipation of its acquisition of One Medical, reminding it of the obligation to protect sensitive health information and inquiring as to how the integrated entity will use One Medical PHI for purposes beyond the provision of health care. Amazon's acquisition of One Medical was finalized in February 2023 without a regulatory challenge. While the FTC could file a lawsuit to unwind the transaction in the future, experts agree that if regulators had found a reason to block the deal, they already would have. Granting retail health care companies enormous tranches of PHI is viewed by some as a mistake, given that loopholes exist in every legal framework.

THE ROLE OF AUGMENTED INTELLIGENCE IN DATA PRIVACY

De-identifying PHI enables HIPAA covered entities to share health data for large-scale medical research studies, policy assessments, comparative effectiveness studies, and other studies and assessments without violating the privacy of patients or requiring authorizations to be obtained from each patient prior to data being disclosed. Once PHI is de-identified and theoretically can no longer be traced back to an individual, it is no longer protected by the HIPAA Privacy Rule.[15] HIPAA-compliant de-identification of PHI is possible using one of two methods – Safe Harbor or Expert Determination. While neither method will remove all risk of re-identification of patients, both can reduce risk. In essence, almost all de-identified PHI is re-identifiable.

A covered entity may assign a code or other means of record identification to allow information de-identified to be re-identified by the covered entity. However, as long as the covered entity does not use or disclose the code or other means of record identification for any other purpose or does not disclose the mechanism for re-identification, they remain compliant with HIPAA.

The complexity and rise of data in health care means that augmented intelligence (AI) will increasingly be applied within the field. Several types of AI are already employed by payers, health plans, and life sciences companies. At the present time, the key categories of applications involve diagnosis and treatment recommendations, patient engagement and adherence, and administrative activities.[16] Health care adjacent data, such as data collected by wearables and health care applications, are commonly transmitted to an AI-driven health care solution – for example, for the early diagnosis of a heart condition. Accordingly, there is rising concern about the ability of AI to facilitate the re-identification of PHI with relative ease. AI algorithms are sophisticated enough to "learn" new strategies from data, such as how to discern patterns in the data. Through this detection, an algorithm may be able to effect PHI re-identification. The HIPAA Privacy Rule outlines specific requirements to adhere to when de-identifying health data, but there is currently no standardized approach for using de-identified data or validating best practices. While current laws do not address the role AI might play in data privacy, regulators are continually enacting and revising their policies, such as the European Union's General Data Protection Regulation (GDPR) and California's Consumer Privacy Act (CCPA). Under the GDPR, there must be a legal basis for collecting personal data, while the CCPA requires that users have the ability to opt out of any personal information collection practices. At the federal level, National Institute of Standards and Technology AI Standards are currently under development, while the Government Accountability Office report, Artificial Intelligence in Health Care provides guidance for future legislation. In the interim, AI vendors and software developers are advised to follow the Xcertia mHealth Guidelines, which align with many of HIPAA's standards and are backed by the AMA, one of the founding members. The Joint Commission recently launched the Responsible Use of Health Data Certification (RUHD), a voluntary program aimed at providing health care entities with an objective evaluation of how well they maintain health data privacy best practices in their secondary use of data for endeavors such as operations improvement or AI development. The RUHD will evaluate whether an organization de-identifies data in accordance with HIPAA, whether it has established a governance structure for the use of de-identified data, and how the organization communicates with key stakeholders about the secondary use of de-identified data. The AMA has also recently created a set of AI Principles which identify and advocate for enhanced protections for de-identified data when used in conjunction with generative AI and large language models.

ROADBLOCKS TO PRIVACY PROTECTION

As HIPAA only covers CEs and BAs, concerns arise in the regulation of entities currently beyond the scope of HIPAA, such as digital health platforms, apps, and other similar software programs that collect, use, store, and share personal health data. Under federal law there is no floor – no minimum threshold at all – for an organization's privacy policy. Thus, any health app or digital health platform can word their stated privacy policy in a weak, evasive, easy-to-comply-with manner that will sound reassuring to the consumers who choose to read it. Unfair and deceptive acts and practices affective commerce are a required basis of an FTC action. This is in stark contrast to the HIPAA Notice of Privacy Practices, which must include specific representations as to a CE's privacy practices.

Entities such as Amazon Clinic have taken a savvy approach by positioning themselves as BAs and thus subject to HIPAA, which reassures consumers. Amazon Clinic's BA status appears to have been achieved by entering into a BAA with each of the medical providers (i.e., CEs) who participate with Amazon Clinic. Amazon Clinic collects data from consumers and matches them with the Clinic's participating providers. Amazon is able to avoid most of the compliance burden and privacy protections that HIPAA requires of BAs, by requiring consumers to click through a screen whereby they effectively waive their HIPAA protections. Under HIPAA, a BA may not use or disclose PHI in a manner that would violate the Privacy Rule if done by the CE, but HIPAA does allow patients to effectively waive their rights against disclosure by the CE by giving an authorization, which is how Amazon characterizes its waiver/click-through screen. While amending HIPAA to provide that BAs may not get a waiver from consumers might be helpful, sophisticated companies such as Amazon would likely devise a strategy so the patient "authorization for disclosure" appears to come from the medical provider, and patient authorizations to disclose their PHI are a necessary feature of HIPAA. When patients sign up for treatment through Amazon Clinic, they also authorize all those involved (physicians, pharmacies, laboratories) to share their PHI with Amazon. Amazon then has the right to "retain, use, and disclose" PHI to facilitate services from "other providers." It is unclear who these other providers are, leading some to believe it could include businesses looking to target patients with ads related to their condition. A substantial hurdle to privacy protection seems to be the willingness of consumers to click through screens.

CHALLENGING PRIVACY ROADBLOCKS

To ensure robust privacy protections, the Council believes that retail health care companies should be prohibited from utilizing "clickwrap" agreements, which are online agreements where the user indicates their acceptance by clicking a button or checking a box that states, "I agree." While the purpose of a clickwrap agreement is to digitally capture acceptance of a contract, they permit patients to access a service without specific affirmative consent to data sharing. Common uses include asking website visitors to acknowledge that the website they are visiting uses cookies, installing a mobile app, or connecting to a wireless network.

The Council also believes it is important that retail health care companies' Terms of Use do not require data sharing for uses not directly related to patients' medical care in order to receive care – unless required by law (e.g., reporting of infectious diseases). Operationally, this means that the Terms of Use should be distinct from the Notice of Privacy Practices, with clear indication that patients are not required to sign the latter in order to receive care. Retail health care companies should provide education on this concept to reduce patient vulnerability and achieve meaningful consent.

There are four types of consent: express consent, implied consent, opt-in consent and opt-out consent. Several retail health care companies utilize opt-out consent, which assumes user consent unless they act to withdraw it. Opt-out consent requires users to take action to indicate non-consent, placing the responsibility on users to actively protect their data. When opt-out consent is coupled with deceptive wording, it may lead patients to agree to something without meaningful consent. Meaningful consent requires a patient to be given sufficient and understandable knowledge to make a valid decision. Requiring retail health care companies to use a default opt-in consent plus plain language is essential toward protecting patients' privacy and fostering health literacy. Once consent is given, it then becomes important to provide clear direction on how patients can withdraw consent. Section 1798.105(a) of the California Consumer Privacy Act grants consumers the right to request that a business delete any personal information about the consumer which the business has collected from the consumer. While the CCPA "right to be forgotten" has many exceptions that allow businesses to keep personal information, it could serve as a prototype for regulations in the retail health care arena.

RELEVANT AMA POLICY, ADVOCACY, & RESOURCES

The AMA Privacy Principles, derived primarily from AMA House of Delegates policy, serve as the foundation for AMA advocacy on privacy extrinsic to HIPAA covered entities. In addition to shifting the responsibility for privacy from individuals to data holders, the principles implore that individuals have the right to know whether their data will be used to develop and/or train AI algorithms and hold entities accountable toward making their de-identification processes and techniques publicly available. These Principles were developed based on an identified need to extend AMA advocacy efforts beyond protections for HIPAA covered entities to (1) provide individuals with rights and protections from discrimination; (2) shift the responsibility for privacy from individuals to data holders other than HIPAA covered entities; and (3) create principles for robust enforcement, individual rights, equity, applicability, and entity responsibility. The AMA Privacy Principles advocate for the expansion of FTC oversight to consumer data that is accessed, used, or exchanged by technology companies and vendors not classified as covered entities under HIPAA. The Principles contend that "health care data" is a subjective term and one that should be evaluated by a federal agency with broad expertise in data privacy. Accordingly, the AMA Privacy Principles' use of the term "data" includes information that can be used to identify an individual, even if it is not descriptive on its face, such as IP addresses and advertising identifiers from mobile phones.

While the AMA Privacy Principles recognize a role for the FTC, it is important to note why the OCR is absent from the discussion. The OCR administers and enforces HIPAA regulations with a focus on PHI, and, therefore, expanding OCR's HIPAA legislative umbrella to include technology companies and vendors not classified as covered entities was a consideration. However, it was recognized that (1) OCR lacks the structure, resources, and expertise to regulate technology companies and vendors, who are themselves new entrants into the health care arena, and (2) an existing federal agency is better equipped to regulate health data that flows outside the traditional HIPAA covered entity arena. Furthermore, extending HIPAA protections for PHI to non-HIPAA covered technology companies and vendors could create a gap in needed privacy policies.

Although the Office of the National Coordinator for Health Information Technology (ONC) is not mentioned in the AMA Privacy Principles, it has a role in ensuring that sensitive medical information regarding reproductive health, sexual orientation, gender identity, and substance use disorder is placed behind a firewall in the electronic health record as well as when it is requested and shared with others using national health information exchanges, such as under ONC's Trusted Exchange Framework and Common Agreement. The 21st Century Cures Act lifted limitations on the scope of ePHI, allowing information blocking regulations to go into full effect. Physicians who interfere with the access, exchange, or use of ePHI could be considered "information blockers" and subject to financial penalties, making it difficult for them to protect sensitive information.

The AMA's longstanding goal to support strong protections for patient privacy is reinforced by several policies, including those that:

- Advocate for legislation that aligns mobile health apps and other digital health tools with the AMA Privacy Principles (Policy D-315.968);
- Oppose the sale or transfer of medical history data and contact information for use in marketing or advertising (Policy D-315.973);
- Engage with stakeholders to identify relevant guiding principles to promote a vibrant, useful, and trustworthy mHealth market (Policy D-480.972);
- Advocate for narrowing the definition of "health care operations" to include only those activities that are routine and critical for general business operations and that cannot be reasonably undertaken with de-identified health information (Policy H-315.975);
- Support strong protections for patient privacy and, in general, require that patient medical records be kept strictly confidential unless waived by the patient in a meaningful way, de-identified, or in rare instances when strong countervailing interests in public health or safety justify invasions of patient privacy or breaches of confidentiality (Policy H-315.983);
- Work to ensure that computer-based patient record systems and networks, and the legislation and regulations governing their use, include adequate technical and legal safeguards for protecting the confidentiality, integrity, and security of patient data (Policy H-315.989); and
- Support that mHealth apps and associated devices, trackers and sensors must abide by applicable laws addressing the privacy and security of patients' medical information (Policy H-480.943).

AMA policy has been developed related to the potential complications introduced by the intersection of AI and patient privacy, including those that:

- Re-examine existing guidance relevant to the confidentiality of patient information, striving to preserve the benefits of widespread use of de-identified patient data for purposes of promoting quality improvement, research, and public health while mitigating the risks of re-identification of such data (Policy D-315.969);
- Support efforts to promote transparency in the use of de-identified patient data and to protect patient privacy by developing methods of, and technologies for, de-identification of patient information that reduce the risk of re-identification of such data (Policy H-315.962); and
- Promote development of thoughtfully designed, high-quality, clinically validated health care AI that safeguards patients' privacy interests and preserves the security and integrity of personal information (Policy H-480.940).

The AMA has written several comment letters addressing the issue of patient privacy, including a December 2018 letter to NIST which references the tenets of Policy H-315.983, noting that when breaches of confidentiality are compelled by concerns for public health and safety, those breaches must be as narrow in scope and content as possible, must contain the least identifiable and sensitive information possible, and must be disclosed to the fewest possible to achieve the necessary end. In a February 2019 letter to the Office for Civil Rights, the AMA offers suggestions on a Request for Information about modifying HIPAA Rules to improve coordinated care, including how the regulations can be revised to promote the goals of value-based care and care coordination while preserving and protecting the privacy and security of a patient's health information. In May 2019, the AMA submitted patient privacy comments to several recipients, including the Office of the National Coordinator for Health Information Technology and the Centers for Medicare & Medicaid Services, and the FTC. While slightly different audiences, the message for each was similar, with a focus on the AMA approach to privacy. The AMA outlined how data segmentation is critical for health information exchange, regardless of where the data resides, how it is used, or with whom it is exchanged. Consistent with that approach, patient consent and privacy, data provenance, governance, and state and federal law compliance must be inherent in the development of technology. A June 2023 letter to the National Governors Association urged that comprehensive state legislative privacy proposals provide adequate protections for consumer health data, especially health data obtained by apps and other devices or organizations that do not fall within HIPAA or state privacy laws. In August 2023, the AMA submitted written comments to the FTC regarding the Health Breach Notification Rule, noting the deficiencies in regulation of health apps. A September 2023 AMA letter to Senator Bill Cassidy in response to his request for information outlines the distinction between PHI and health information outside of HIPAA, and the potential for harm to individuals caused by confusion between the two.

In addition to advocacy, the AMA provides members with robust resources on the issue of patient privacy. The AMA health data privacy framework surveyed patient perspectives to shed light on fundamental data privacy issues that can impact individuals nationwide, while the AMA patient privacy webpage provides resources to ensure that patients have meaningful controls over their PHI. As part of the AMA Patient Access Playbook, the AMA has developed a case for privacy by design in app development. The 2023 AMA Principles for Augmented Intelligence Development, Deployment, and Use address privacy and cybersecurity as well as establish guardrails around payer use of AI in automated denials.

DISCUSSION

While HIPAA was enacted in 1996, misconceptions have muddied the waters around what is and is not a covered entity or business associate, and what is or is not PHI. Given that HIPAA only governs covered entities and business associates, concerns arise in the regulation of entities currently beyond the scope of HIPAA, such as digital health platforms, apps, and other similar software programs that collect, use, store, and share personal health data. Under federal law there is no floor – no minimum threshold – for an organization's privacy policy other than it cannot be unfair or deceptive. Thus, any health app or digital health platform can word their stated privacy policy in a weak, evasive, easy-to-comply-with manner that will sound reassuring to the consumers who choose to read it. Furthermore, there is confusion surrounding retail health care companies' HIPAA status, as they require patients to read and comprehend several documents together in order to understand their rights. Determining which organizations HIPAA applies to can be difficult for the layperson.

The Council therefore recommends a series of principles to address retail health care companies' handling of PHI. Any health care providing entity, or one that is facilitating the referral of patients for care, regardless of whether it

provides the care directly, must be held to the standard of a HIPAA covered entity, complete with a privacy wall between the health and non-health lines of business to eliminate sharing of PHI for uses not directly related to patients' medical care. Retail health care companies should be prohibited from utilizing "clickwrap" agreements, which permit patients to use a service without affirmatively consenting to the data sharing. It is also important that retail health care companies' Terms of Use do not require data sharing for uses not directly related to patients' medical care in order to receive care unless required by law. Operationally, this means that the Terms of Use should be distinct from the Notice of Privacy Practices, with clear indication that patients are not required to sign the latter in order to receive care. Requiring retail health care companies to use a default opt-in consent plus plain language is essential toward protecting patients' privacy and fostering health literacy. Opt-in user consent requires patients to acknowledge the proposed data activity, understand the purposes for collection, and agree to have their data collected, processed, and stored. Once consent is given, it then becomes important to provide clear direction on how patients can withdraw consent.

The Council also recommends reaffirmation of policies that advocate for legislation that aligns mobile health apps and other digital health tools with the AMA Privacy Principles, supports efforts to promote transparency in the use of de-identified patient data, and promotes development of thoughtfully designed, high-quality, clinically validated health care AI that safeguards patients' privacy interests and preserves the security and integrity of personal information.

RECOMMENDATIONS

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

1. That our American Medical Association (AMA) will:
   (a) support regulatory guidance to establish a privacy wall between the health business and non-health business of retail health care companies to eliminate sharing of protected health information, re-identifiable patient data, or data that could be reasonably be used to re-identify a patient when combined with other data for uses not directly related to patients' medical care;
   (b) support the prohibition of Terms of Use that require data sharing for uses not directly related to patients' medical care in order to receive care, while still allowing data sharing where required by law (e.g., infectious disease reporting);
   (c) support the separation of consents required to receive care from any consents to share data for non-medical care reasons, with clear indication that patients do not need to sign the data-sharing agreements in order to receive care;
   (d) support the prohibition of "clickwrap" contracts for use of a health care service without affirmative patient consent to data sharing;
   (e) support the requirement that retail health care companies must use an active opt-in selection for obtaining meaningful consent for data use and disclosure, otherwise the default should be that the patient does not consent to disclosure;
   (f) support the requirement that retail health care companies clearly indicate how patients can withdraw consent and request deletion of data retained by the non-health care providing units, which should be by a means no more onerous than providing the initial consent.

2. That our AMA reaffirm Policy D-315.968, which advocates for legislation that aligns mobile health apps and other digital health tools with the AMA Privacy Principles.

3. That our AMA reaffirm Policy H-315.962, which supports efforts to promote transparency in the use of de-identified patient data and to protect patient privacy by developing methods of, and technologies for, de-identification of patient information that reduce the risk of re-identification of such data.

4. That our AMA reaffirm Policy H-480.940, which promotes development of thoughtfully designed, high-quality, clinically validated health care AI that safeguards patients' privacy interests and preserves the security and integrity of personal information.

5. Rescind Policy H-315.960, as having been completed with this report.

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Ensuring Privacy in Retail Health Care Settings
Policy Appendix

Supporting Improvements to Patient Data Privacy D-315.968
Our AMA will (1) strengthen patient and physician data privacy protections by advocating for legislation that reflects the AMA's Privacy Principles with particular focus on mobile health apps and other digital health tools, in addition to non-health apps and software capable of generating patient data and (2) will work with appropriate

stakeholders to oppose using any personally identifiable data to identify patients, potential patients who have yet to seek care, physicians, and any other health care providers who are providing or receiving health care that may be criminalized in a given jurisdiction.
Res. 227, A-22 Modified: Res. 230, I-22 Reaffirmation: A-23

Research Handling of De-Identified Patient Information D-315.969
The Council on Ethical and Judicial Affairs will consider re-examining existing guidance relevant to the confidentiality of patient information, striving to preserve the benefits of widespread use of de-identified patient data for purposes of promoting quality improvement, research, and public health while mitigating the risks of re-identification of such data.
BOT Rep. 16, I-21

Preventing Inappropriate Use of Patient Protected Medical Information in the Vaccination Process D-315.973
Our AMA will: (1) advocate to prohibit the use of patient/customer information collected by retail pharmacies for COVID-19 vaccination scheduling and/or the vaccine administration process for commercial marketing or future patient recruiting purposes, especially any targeting based on medical history or conditions; and (2) oppose the sale or transfer of medical history data and contact information accumulated through the scheduling or provision of government-funded vaccinations to third parties for use in marketing or advertising.
Res. 232, A-21

Guidelines for Mobile Medical Applications and Devices D-480.972
1. Our AMA will monitor market developments in mobile health (mHealth), including the development and uptake of mHealth apps, in order to identify developing consensus that provides opportunities for AMA involvement.
2. Our AMA will continue to engage with stakeholders to identify relevant guiding principles to promote a vibrant, useful and trustworthy mHealth market.
3. Our AMA will make an effort to educate physicians on mHealth apps that can be used to facilitate patient communication, advice, and clinical decision support, as well as resources that can assist physicians in becoming familiar with mHealth apps that are clinically useful and evidence based.
4. Our AMA will develop and publicly disseminate a list of best practices guiding the development and use of mobile medical applications.
5. Our AMA encourages further research integrating mobile devices into clinical care, particularly to address challenges of reducing work burden while maintaining clinical autonomy for residents and fellows.
6. Our AMA will collaborate with the Liaison Committee on Medical Education and Accreditation Council for Graduate Medical Education to develop germane policies, especially with consideration of potential financial burden and personal privacy of trainees, to ensure more uniform regulation for use of mobile devices in medical education and clinical training.
7. Our AMA encourages medical schools and residency programs to educate all trainees on proper hygiene and professional guidelines for using personal mobile devices in clinical environments.
8. Our AMA encourages the development of mobile health applications that employ linguistically appropriate and culturally informed health content tailored to linguistically and/or culturally diverse backgrounds, with emphasis on underserved and low-income populations.
CSAPH Rep. 5, A-14 Appended: Res. 201, A-15 Appended: Res. 305, I-16 Modified: Res. 903, I-19

Research Handling of De-Identified Patient Information H-315.962
Our AMA supports efforts to promote transparency in the use of de-identified patient data and to protect patient privacy by developing methods of, and technologies for, de-identification of patient information that reduce the risk of re-identification of such information.
BOT Rep. 16, I-21 Reaffirmation: A-22

Police, Payer, and Government Access to Patient Health Information H-315.975
(1) Our AMA advocates vigorously, with respect to the final privacy rule or other privacy legislation, to define "health care operations" narrowly to include only those activities and functions that are routine and critical for general business operations and that cannot reasonably be undertaken with de-identified information.
(2) Our AMA advocates vigorously, with respect to the final privacy rule or other privacy legislation, that the Centers for Medicare & Medicaid Services (CMS) and other payers shall have access to medical records and

individually identifiable health information solely for billing and payment purposes, and routine and critical health care operations that cannot reasonably be undertaken with de-identified health information.
(3) Our AMA advocates vigorously, with respect to the final privacy rule or other privacy legislation, that CMS and other payers may access and use medical records and individually identifiable health information for non-billing, non-payment purposes and non-routine, non-critical health care operations that cannot reasonably be undertaken with de-identified health information, only with the express written consent of the patient or the patient's authorized representative, each and every time, separate and apart from blanket consent at time of enrollment.
(4) Our AMA advocates vigorously, with respect to the final privacy rule or other privacy legislation that no government agency, including law enforcement agencies, be permitted access to medical records or individually identifiable health information (except for any discretionary or mandatory disclosures made by physicians and other health care providers pursuant to ethical guidelines or to comply with applicable state or federal reporting laws) without the express written consent of the patient, or a court order or warrant permitting such access.
(5) Our AMA continues to strongly support and advocate a minimum necessary standard of disclosure of individually identifiable health information requested by payers, so that the information necessary to accomplish the intended purpose of the request be determined by physicians and other health care providers, as permitted under the final privacy rule.
Res. 246, A-01 Reaffirmation I-01 Reaffirmation A-02 Reaffirmed: BOT Rep. 19, I-06 Reaffirmation A-07 Reaffirmed: BOT Rep. 19, A-07 Reaffirmed: BOT Rep. 22, A-17 Reaffirmed: BOT Rep. 16, I-21

Patient Privacy and Confidentiality H-315.983
1. Our AMA affirms the following key principles that should be consistently implemented to evaluate any proposal regarding patient privacy and the confidentiality of medical information: (a) That there exists a basic right of patients to privacy of their medical information and records, and that this right should be explicitly acknowledged; (b) That patients' privacy should be honored unless waived by the patient in a meaningful way or in rare instances when strong countervailing interests in public health or safety justify invasions of patient privacy or breaches of confidentiality, and then only when such invasions or breaches are subject to stringent safeguards enforced by appropriate standards of accountability; (c) That patients' privacy should be honored in the context of gathering and disclosing information for clinical research and quality improvement activities, and that any necessary departures from the preferred practices of obtaining patients' informed consent and of de-identifying all data be strictly controlled; (d) That any information disclosed should be limited to that information, portion of the medical record, or abstract necessary to fulfill the immediate and specific purpose of disclosure; and (e) That the Health Insurance Portability and Accountability Act of 1996 (HIPAA) be the minimal standard for protecting clinician-patient privilege, regardless of where care is received.
2. Our AMA affirms: (a) that physicians and medical students who are patients are entitled to the same right to privacy and confidentiality of personal medical information and medical records as other patients, (b) that when patients exercise their right to keep their personal medical histories confidential, such action should not be regarded as fraudulent or inappropriate concealment, and
(c) that physicians and medical students should not be required to report any aspects of their patients' medical history to governmental agencies or other entities, beyond that which would be required by law.
3. Employers and insurers should be barred from unconsented access to identifiable medical information lest knowledge of sensitive facts form the basis of adverse decisions against individuals. (a) Release forms that authorize access should be explicit about to whom access is being granted and for what purpose and should be as narrowly tailored as possible. (b) Patients, physicians, and medical students should be educated about the consequences of signing overly-broad consent forms. (c) Employers and insurers should adopt explicit and public policies to assure the security and confidentiality of patients' medical information. (d) A patient's ability to join or a physician's participation in an insurance plan should not be contingent on signing a broad and indefinite consent for release and disclosure.
4. Whenever possible, medical records should be de-identified for purposes of use in connection with utilization review, panel credentialing, quality assurance, and peer review.
5. The fundamental values and duties that guide the safekeeping of medical information should remain constant in this era of computerization. Whether they are in computerized or paper form, it is critical that medical information be accurate, secure, and free from unauthorized access and improper use.
6. Our AMA recommends that the confidentiality of data collected by race and ethnicity as part of the medical record, be maintained.
7. Genetic information should be kept confidential and should not be disclosed to third parties without the explicit informed consent of the tested individual.
8. When breaches of confidentiality are compelled by concerns for public health and safety, those breaches must be

as narrow in scope and content as possible, must contain the least identifiable and sensitive information possible, and must be disclosed to the fewest possible to achieve the necessary end.
9. Law enforcement agencies requesting private medical information should be given access to such information only through a court order. This court order for disclosure should be granted only if the law enforcement entity has shown, by clear and convincing evidence, that the information sought is necessary to a legitimate law enforcement inquiry; that the needs of the law enforcement authority cannot be satisfied by non-identifiable health information or by any other information; and that the law enforcement need for the information outweighs the privacy interest of the
individual to whom the information pertains. These records should be subject to stringent security measures.
10. Our AMA must guard against the imposition of unduly restrictive barriers to patient records that would impede or prevent access to data needed for medical or public health research or quality improvement and accreditation activities. Whenever possible, de-identified data should be used for these purposes. In those contexts where personal identification is essential for the collation of data, review of identifiable data should not take place without an institutional review board (IRB) approved justification for the retention of identifiers and the consent of the patient. In those cases where obtaining patient consent for disclosure is impracticable, our AMA endorses the oversight and accountability provided by an IRB.
11. Marketing and commercial uses of identifiable patients' medical information may violate principles of informed consent and patient confidentiality. Patients divulge information to their physicians only for purposes of diagnosis and treatment. If other uses are to be made of the information, patients must first give their uncoerced permission after being fully informed about the purpose of such disclosures
12. Our AMA, in collaboration with other professional organizations, patient advocacy groups and the public health community, should continue its advocacy for privacy and confidentiality regulations, including: (a) The establishment of rules allocating liability for disclosure of identifiable patient medical information between physicians and the health plans of which they are a part, and securing appropriate physicians' control over the disposition of information from their patients' medical records. (b) The establishment of rules to prevent disclosure of identifiable patient medical information for commercial and marketing purposes; and (c) The establishment of penalties for negligent or deliberate breach of confidentiality or violation of patient privacy rights.
13. Our AMA will pursue an aggressive agenda to educate patients, the public, physicians and policymakers at all levels of government about concerns and complexities of patient privacy and confidentiality in the variety of contexts mentioned.
14. Disclosure of personally identifiable patient information to public health physicians and departments is appropriate for the purpose of addressing public health emergencies or to comply with laws regarding public health reporting for the purpose of disease surveillance.
15. In the event of the sale or discontinuation of a medical practice, patients should be notified whenever possible and asked for authorization to transfer the medical record to a new physician or care provider. Only de-identified and/or aggregate data should be used for "business decisions," including sales, mergers, and similar business transactions when ownership or control of medical records changes hands.
16. The most appropriate jurisdiction for considering physician breaches of patient confidentiality is the relevant state medical practice act. Knowing and intentional breaches of patient confidentiality, particularly under false pretenses, for malicious harm, or for monetary gain, represents a violation of the professional practice of medicine.
17. Our AMA Board of Trustees will actively monitor and support legislation at the federal level that will afford patients protection against discrimination on the basis of genetic testing.
18. Our AMA supports privacy standards that would require pharmacies to obtain a prior written and signed consent from patients to use their personal data for marketing purposes.
19. Our AMA supports privacy standards that require pharmacies and drug store chains to disclose the source of financial support for drug mailings or phone calls.
20. Our AMA supports privacy standards that would prohibit pharmacies from using prescription refill reminders or disease management programs as an opportunity for marketing purposes.
21. Our AMA will draft model state legislation requiring consent of all parties to the recording of a physician-patient conversation.
BOT Rep. 9, A-98 Reaffirmation I-98 Appended: Res. 4, and Reaffirmed: BOT Rep. 36, A-99 Appended: BOT Rep. 16 and Reaffirmed: CSA Rep. 13, I-99 Reaffirmation A-00 Reaffirmed: Res. 246 and 504 and Appended Res. 504 and 509, A-01 Reaffirmed: BOT Rep. 19, I-01 Appended: Res. 524, A-02 Reaffirmed: Sub. Res. 206, A-04 Reaffirmed: BOT Rep. 24, I-04 Reaffirmed: BOT Rep. 19, I-06 Reaffirmation A-07 Reaffirmed: BOT Rep. 19, A-07 Reaffirmed: CEJA Rep. 6, A-11 Reaffirmed in lieu of Res. 705, A-12 Reaffirmed: BOT Rep. 17, A-13 Modified: Res. 2, I-14 Reaffirmation: A-17 Modified: BOT Rep. 16, A-18 Appended: Res. 232, A-18 Reaffirmation: I-18

Reaffirmed: Res. 219, A-21 Reaffirmed: Res. 229, A-21 Reaffirmed: BOT Rep. 12, I-21 Reaffirmed: BOT Rep. 22, A-22 Reaffirmation: A-23

Confidentiality of Computerized Patient Records H-315.989
The AMA will continue its leadership in protecting the confidentiality, integrity, and security of patient-specific data; and will continue working to ensure that computer-based patient record systems and networks, and the legislation and regulations governing their use, include adequate technical and legal safeguards for protecting the confidentiality, integrity, and security of patient data.
BOT Rep. F, A-93 Reaffirmation I-99 Reaffirmed: BOT Rep. 19, I-06 Reaffirmed: BOT Rep. 19, A-07 Reaffirmed in lieu of Res. 818, I-07 Reaffirmation I-08 Reaffirmation A-10 Reaffirmed: BOT Rep. 17, A-13

Augmented Intelligence in Health Care H-480.940
As a leader in American medicine, our AMA has a unique opportunity to ensure that the evolution of augmented intelligence (AI) in medicine benefits patients, physicians, and the health care community.
To that end our AMA will seek to:
1. Leverage its ongoing engagement in digital health and other priority areas for improving patient outcomes and physicians' professional satisfaction to help set priorities for health care AI.
2. Identify opportunities to integrate the perspective of practicing physicians into the development, design, validation, and implementation of health care AI.
3. Promote development of thoughtfully designed, high-quality, clinically validated health care AI that:
a. is designed and evaluated in keeping with best practices in user-centered design, particularly for physicians and other members of the health care team;
b. is transparent;
c. conforms to leading standards for reproducibility;
d. identifies and takes steps to address bias and avoids introducing or exacerbating health care disparities including when testing or deploying new AI tools on vulnerable populations; and
e. safeguards patients and other individuals privacy interests and preserves the security and integrity of personal information.
4. Encourage education for patients, physicians, medical students, other health care professionals, and health administrators to promote greater understanding of the promise and limitations of health care AI.
5. Explore the legal implications of health care AI, such as issues of liability or intellectual property, and advocate for appropriate professional and governmental oversight for safe, effective, and equitable use of and access to health care AI.
BOT Rep. 41, A-18

Integration of Mobile Health Applications and Devices into Practice H-480.943
1. Our AMA supports the establishment of coverage, payment and financial incentive mechanisms to support the use of mobile health applications (mHealth apps) and associated devices, trackers and sensors by patients, physicians and other providers that: (a) support the establishment or continuation of a valid patient-physician relationship; (b) have a high-quality clinical evidence base to support their use in order to ensure mHealth app safety and effectiveness; (c) follow evidence-based practice guidelines, especially those developed and produced by national medical specialty societies and based on systematic reviews, to ensure patient safety, quality of care and positive health outcomes; (d) support care delivery that is patient-centered, promotes care coordination and facilitates team-based communication; (e) support data portability and interoperability in order to promote care coordination through medical home and accountable care models; (f) abide by state licensure laws and state medical practice laws and requirements in the state in which the patient receives services facilitated by the app; (g) require that physicians and other health practitioners delivering services through the app be licensed in the state where the patient receives services, or be providing these services as otherwise authorized by that state's medical board; and (h) ensure that the delivery of any services via the app be consistent with state scope of practice laws.
2. Our AMA supports that mHealth apps and associated devices, trackers and sensors must abide by applicable laws addressing the privacy and security of patients' medical information.
3. Our AMA encourages the mobile app industry and other relevant stakeholders to conduct industry-wide outreach and provide necessary educational materials to patients to promote increased awareness of the varying levels of privacy and security of their information and data afforded by mHealth apps, and how their information and data can potentially be collected and used.

4. Our AMA encourages the mHealth app community to work with the AMA, national medical specialty societies, and other interested physician groups to develop app transparency principles, including the provision of a standard privacy notice to patients if apps collect, store and/or transmit protected health information.
5. Our AMA encourages physicians to consult with qualified legal counsel if unsure of whether an mHealth app meets Health Insurance Portability and Accountability Act standards and also inquire about any applicable state privacy and security laws.
6. Our AMA encourages physicians to alert patients to the potential privacy and security risks of any mHealth apps that he or she prescribes or recommends, and document the patient's understanding of such risks
7. Our AMA supports further development of research and evidence regarding the impact that mHealth apps have on quality, costs, patient safety and patient privacy.
8. Our AMA encourages national medical specialty societies to develop guidelines for the integration of mHealth apps and associated devices into care delivery.
CMS Rep. 06, I-16 Reaffirmation: A-17 Reaffirmation: A-23

8. SUSTAINABLE PAYMENT FOR COMMUNITY PRACTICES

Reference committee hearing: see report of Reference Committee A.

HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS IN LIEU OF RESOLUTION 108-A-23 REMAINDER OF REPORT FILED
See Policies D-400.990, D-405.988, H-200.949, H-285.904, H-290.976, H-385.921, H-385.986 and H-450.921

At the 2023 Annual Meeting, the House of Delegates (HOD) referred Resolution 108, which was sponsored by the District of Columbia Delegation. Resolution 108-A-23 asked for the American Medical Association (AMA) to:

> "(1) study small medical practices to assess the prevalence of insurance payments to these practices that are below Medicare rates and to assess the effects of these payment levels on practices' ability to provide care, and report back by the 2024 Annual Meeting; (2) study and report back on remedies for such reimbursement rates for physician practices; (3) study the impact on small and medium-sized physician practices of being excluded from population health management, outcome evidence-based care, and value-based purchasing arrangements; and study and report back to the House of Delegates options for model legislation for states and municipalities seeking to correct reimbursement rates for medical practices that are below those required to meet fixed costs."

The Council on Medical Service developed Report 7-I-23, Sustainable Payment for Community Practices, which was referred to allow reconsideration of a) non-Medicare benchmarks for private payers; b) a minimum government rate, including Medicaid; and c) the impact that rates below these benchmarks have on small community practices. In this report, the Council expands on the discussion included in Council Report 7-I-23 to include Medicaid payment schedules and how they compare to Medicare and private insurance payment rates, while acknowledging the costs of providing care to the Medicaid population as well as the challenges of tying payment schedules to a Medicare benchmark. Our focus is on non-hospital owned small practices, which are typically not eligible for facility fees nor possess the market power inherent in larger, hospital-owned practices. We compare Medicare, Medicaid, and private insurance payment rates, outline collaborative and negotiating resources available to small practices, highlight essential AMA policy and resources, and present new policy recommendations.

BACKGROUND

Despite the current trend toward larger practices, more than half of physicians (51.8 percent) still work in small practices of 10 or fewer physicians, a percentage that has fallen continuously from 61.4 percent in 2012.[1] Contributing factors to the shift include mergers and acquisitions, practice closures, physician job changes, and the different practice settings chosen by younger physicians compared to those of retiring physicians. The "cohort effect"[2] demonstrates that younger physicians appear to prefer larger practices for the more predictable income and work-life balance they can offer.[3] They also may be hesitant to assume the business and entrepreneurial responsibilities demanded by smaller practices.[4]

However, small practices have some advantages that cannot be matched by larger practices, most notably patients of small practices have lower rates of preventable readmissions than those in larger practices.[5] The autonomy of small practices and preservation of the traditional patient-physician relationship provide reassurance to patients that the physician is acting in their best interests. It is thought that the patient-physician bond generates trust, which leads to better adherence to a treatment plan.[6] As small practices become patient-centered medical homes, their decisions can control downstream costs, highlighting the importance of trusted, engaged, and financially aligned physicians in value-based payment systems. Although the medical home model suggests that physicians in small practices are uniquely positioned to succeed in value-based purchasing arrangements, they are not necessarily well equipped to do so given the financial investment and regulatory, technological, and analytic expertise necessary to enter these arrangements. In addition to these inherent limitations of small practices, extrinsic factors can play a role in creating an uneven playing field, including the fact that independent primary care physicians more often fill gaps in care in low-income, rural, and other underserved communities.[7]

Assessing the current level of sustainability for small community practices requires appreciating the current limitations of governmental authority, understanding the impact of Medicare, Medicaid, and private insurance payment rates, acknowledging relevant AMA policy and advocacy, and exploring the resources available for small practices that want to engage more fully in an evolving value-based health care system.

FAIR LABOR STANDARDS ACT OF 1938

The Fair Labor Standards Act of 1938 (FLSA) protects workers against unfair employment practices. FLSA rules specify when workers are considered "on the clock" and when they should be paid overtime, along with a minimum wage. Employees are deemed either exempt or nonexempt under the FLSA.

Resolution 108-A-23 postulates that the FLSA confers governmental authority to establish minimum levels of payment for medical practices. However, Section 13(a)(1) of the FLSA provides an exemption from both minimum wage and overtime pay for employees employed as "bona fide executive, administrative, professional, and outside sales employees." Physicians are exempted from FLSA protection since they are considered "Learned Professionals," as their primary duty requires advanced knowledge, defined as work that is predominantly intellectual in character and that includes work requiring the consistent exercise of discretion and judgment, in a field of science or learning; and customarily acquired by a prolonged course of specialized intellectual instruction.[8] As such, the FLSA cannot provide protection for small medical practices regarding minimum levels of payment.

MEDICARE PHYSICIAN PAYMENT SCHEDULE

Medicare is a federal insurance program where coverage is generally offered to individuals who are 65 years or older, have certain disabilities, or suffer from end-stage renal disease or amyotrophic lateral sclerosis. In 1992, the federal government established a standardized Medicare Physician Payment Schedule (MPPS) based on a resource-based relative value scale (RBRVS). Prior to that, the federal government paid physicians using a system of "customary, prevailing, and reasonable" (CPR) charges, which was based on the "usual, customary, and reasonable" system used by many private insurers. The Medicare CPR system allowed for wide variation in the amount paid for the same service, resulting in unfounded discrepancies in Medicare payment levels among geographic service areas and physician specialties.

In an RBRVS system, payments for services are determined by the standardized resource costs needed to provide them, which are then adjusted to account for differences in work, practice expense, and professional liability insurance costs across national geographic service areas. The RBRVS publishes relative value units (RVUs) for each service, which are then converted to a payment amount using geographical practice cost indices and an annually updated Medicare Conversion Factor to establish the MPPS. The AMA/Specialty Society Relative Value Scale Update Committee (RUC) identifies the resources required to provide physician services, which the Centers for Medicare & Medicaid Services (CMS) then considers in developing RBRVS RVUs. While, historically, 90 percent or more of RUC recommendations have been accepted,[9] CMS makes all final Medicare payment decisions.

MEDICAID PAYMENT SCHEDULES

The Department of Health and Human Services describes Medicare as an insurance program, whereas Medicaid is an assistance program. Medicaid is a federal and state-sponsored program that assists low-income individuals with paying for their health care costs. Each state defines who is eligible for Medicaid coverage, but the program generally covers individuals who have limited income, including:

- Individuals 65 years or older
- Children under 19 years old
- Pregnant women
- Individuals living with a disability
- Parents or adults caring for a child
- Adults without dependent children
- Eligible immigrants

States have the option to charge premiums and determine cost sharing requirements for Medicaid beneficiaries. While maximum out-of-pocket costs are limited, states can impose higher charges for targeted groups of somewhat higher income individuals. Certain vulnerable groups, such as children and pregnant women, are exempt from most out-of-pocket costs and copayments and coinsurance cannot be charged for some services. The federal government funds a percentage of the operating costs for each state through the federal medical assistance percentage (FMAP). The FMAP varies from state to state and is inversely related to state per capita income. The matching rate for a state can range from 50 percent to 83 percent. On average, the federal government nominally pays 57 percent of the cost of the program.[10] Medicaid payment rates are determined by the state for each service in accordance with its approved Medicaid state plan.

PRIVATE INSURANCE PAYMENT SCHEDULES

For small community practices, payment schedules are typically negotiated between the payer and the practice as part of a network of preferred physicians. Practices agree to these payment schedules to permit inclusion in the network, since being in-network is generally more appealing to patients, allows access to in-network referrals, and reduces the chance of unexpectedly low payment to the practice.

When negotiating payment schedules, it is important that the practice is aware of its fixed and variable costs for a given service so that the long-term break-even point can be determined. The smaller the practice, the more important it is to negotiate with as much data and defined value proposition as possible, because a smaller practice has less leverage. Given that private insurance payment schedules are negotiated between two parties, they can vary by state, region, payer, specialty, and/or practice. Thus, it is likely that most small practices accept multiple different payment schedules from different payers.

Private insurance payments are variable across physician specialties. The Urban Institute conducted an analysis of FAIR Health professional claims from March 2019 to February 2020, comparing them to the MPPS for the same time period. The analysis included 17 physician specialties and approximately 20 services per specialty, which represented about 40 percent of total professional spending. The Urban Institute found significant variation in relative prices across specialties, with commercial-to-Medicare payment ratio across all selected services for the 17 specialties averaging 1.6 using an expenditure-weighted approach.[11]

Areas where there is greater market concentration among physicians tend to have higher payment amounts from private insurance.[12] The Health Care Cost Institute's Health Care Cost and Utilization Report found that there was substantial variation in private insurance payments across states, with average commercial prices ranging from 98 percent to 188 percent of Medicare rates. Seven states had payments that were, on average, higher than 150 percent of Medicare rates while 11 states had average payments within 10 percent of Medicare. The states with the highest private insurance payments relative to Medicare tended to be in the northwest of the country and along the Great Plains.[13]

MEDICARE VERSUS PRIVATE INSURANCE PAYMENT RATES

A 2020 KFF literature review discovered that private insurance paid 143 percent of Medicare rates for physician services, on average, ranging from 118 percent to 179 percent of Medicare rates across studies.[14] Estimates from a more recent Milliman white paper closely align, finding that 2022 commercial payment for professional medical services to be approximately 141 percent of Medicare fee-for-service rates.[15] A 2022 Congressional Budget Office report identified "rapid increases in the prices that commercial insurers pay for hospitals' and physicians' services,"[16] leading to further divergence between private and public insurance payment rates, a trend that has proven consistent over time. A 2003 Office of the Inspector General review determined that of 217 procedures, 119 were valued lower by Medicare than by private insurers[17] and a 2017 Health Care Cost Institute report found that commercial payments for the average professional service were 122 percent of what would have been paid under Medicare.[18] The 2022 AMA Physician Practice Benchmark Survey found that small practices of 1 to 15 physicians have a higher percentage of private health insurance patients than larger practices (45.9 percent vs 40.9 percent).[19] Since research shows that private insurance payment rates are, on average, higher than Medicare payment rates for the same health services, this may benefit small practices.

While the Council was unable to identify a survey focused on small practice Medicare to private insurance rate ratios, anecdotal reports indicate that some small practices are seeing private insurers offer payment below 100 percent of Medicare, which may be further depressed when insurers utilize a prior year Medicare rate. A Washington, DC two-physician clinic reported receiving private insurance payment rates ranging from 16-43 percent lower than Medicare, despite becoming a Patient-Centered Medical Home and entering into a local accountable care organization (ACO). Similarly, a solo endocrinologist who left a university-affiliated practice reported being disadvantaged by no longer being able to collect facility fees to generate higher billing, forcing him to opt out of all insurance plans due to inadequate payment.

MEDICAID PAYMENT COMPARISON AND HEALTH EQUITY IMPLICATIONS

In 2019, Medicaid fee-for-service payments for physician services were nearly 30 percent below Medicare payment levels, with an even larger differential for primary care physician services.[20] A 2017 study found that total payments for physician office visits under Medicaid averaged 62.2 percent of payment amounts under private insurance and 73.7 percent of those under Medicare.[21] As the largest public health insurance provider in the United States, Medicaid policy has significant health equity implications. Low payment rates may limit access to quality care and contribute to poor health outcomes for Medicaid beneficiaries. Research has found that increasing Medicaid primary care rates by $45 per service would reduce access-to-care inequities by at least 70 percent.[22]

While Medicaid state flexibility is intended to preserve state operational autonomy and programming, it has fostered wide variability and geographic inequities, particularly between Medicaid expansion states and non-expansion states,[23] further enabling health disparities. Substantial dependence on state revenues has led to low payment rates that effectively limit access, as it disincentivizes providing care to the often minoritized populations the program serves. As small practices must absorb costs required to provide care to the Medicaid population, such as compliance with regulations and addressing Social Determinants of Health toward equitable care, lower payment makes it almost impossible to recover those costs. Small practices experience higher burdens for translation services in regions where Medicaid patients may have limited English proficiency. Small practices also have challenges in assuring adequate patient follow-up due to a lack of reliable communications (e.g., lack of working phone numbers or inability to reach patients during the daytime while they are working, lack of access to a computer/internet) and transportation challenges.

PAYMENT BENCHMARKS

An ideal payment benchmark will reflect the cost of providing care both in the short term and long term while acknowledging risk, variable expenses, an appropriate allocation of fixed costs, and physician work. It is essential that the benchmark reflect the full cost of practice and the value of the care provided, as well as include inflation-based updates. The benchmark should disclose payment amounts and the methodology used to calculate them, as these are fundamental to establishing trust between physicians and insurers and promoting sound decision making by all participants in the health care system. As the Medicare RBRVS values and methodology are fully transparent, a payment benchmark uncoupled from the RBRVS must be accompanied by commensurate transparency in payment methodology.

A general measurement of a payment schedule is its relative payment rate compared to the MPPS or "benchmarking" to Medicare. Payment schedules that are less than the MPPS are considered beneficial for the payer, whereas payment schedules that match or are greater than the MPPS are considered beneficial for the practice. The percentage of MPPS rates is one of the most widely accepted payment benchmarks when evaluating physician payment level and comparing contracts in the health care industry. It can reflect the mix of services across physicians and plans while removing impacts from billed charges that can vary widely across providers and regions. Additionally, Medicare RBRVS values remain the foundation for many Alternative Payment Models (APMs) as they can produce more or less value by influencing how physicians spend their time and the mix of services provided to patients.
However, there are challenges presented by tying payment to a Medicare benchmark. Some payers may adopt only a portion of the Medicare RBRVS (e.g., use RVU) but utilize a lower conversion factor) or use an outdated RBRVS where the RVUs are no longer reflective of current resource costs. Other payers may implement time-limited or temporary arrangements or apply the RBRVS to only certain specialties, leading to disruption in care or difficulties with patient referrals. Most importantly, continuing to tether payment to a Medicare payment rate that has been reduced by almost 10 percent in four years presents an untenable situation for small practices. After adjusting for inflation, Medicare physician payment has effectively declined 29 percent from 2001 to 2024.

Some have suggested the development of a "minimum government rate" as a payment benchmark. However, it is challenging to identify a rate and methodology defensible across the six major government health care programs:

1) Medicare
2) Medicaid
3) The Children's Insurance Program (CHIP)
4) The Department of Defense TRICARE and TRICARE for Life Programs
5) The Veterans Health Administration program
6) The Indian Health Service

While these programs collectively provide health care services to one-third of Americans, they differ extensively in terms of size, scope, financing, and program design, making it unfeasible to establish an equitable minimum payment rate appropriate for all. Furthermore, it would be impracticable to establish a minimum payment rate in the private physician market, which is currently riding a consolidation wave, transforming health insurers into much larger and more powerful conglomerates. Helping small practices escape the vice grip of unfair market rates from consolidated insurers begs the need for strong antitrust reform. While reference prices and price floors have been used in various sectors of the economy, they appear to have a low likelihood of being adopted in health care, as demonstrated by the Economic Stabilization Program of the early 1970s.[24] Programs that provide for low income and rural patient populations already struggle to obtain adequate funding. As demonstrated in the oil and agricultural sectors, policymakers are not likely to set a payment floor unless they are granted influence over the distribution of health care prices in return.

SUSTAINABLE PAYMENT FOR SMALL COMMUNITY PRACTICES

Small practices are disproportionately affected by payment rates that fall below an ideal benchmark. One of the most notable changes has been the redistribution of physicians from small to large practices. The share of physicians who worked in practices that had 10 or fewer physicians decreased from 61.4 percent in 2012 to 51.8 percent in 2022, with the need to better negotiate favorable (higher) payment rates with payers as one of the most important motivations for private practices selling to hospitals or health systems.[25]

The term "sustainable" denotes that something is bearable and capable of being continued at a certain level over a period of time. For small community practices, sustainable payment reflects the full cost of practice and the value of the care provided. Additionally, it includes annual inflation-based payment updates, which are essential to measure practice cost inflation and account for changes in physicians' operating costs. Annual updates enable small practices to better absorb other payment redistributions triggered by budget neutrality rules and performance adjustments, as well as periods of high inflation and rising staffing costs; they also help physicians invest in their practices and implement new strategies to provide high-value care.

The single most influential factor in ensuring a sustainable level of payment for small practices is leverage. Strong network adequacy requirements that expect all health plans to contract with sufficient numbers and types of

physicians bestow bargaining power by making it difficult for insurers to dismiss negotiation on an in-network payment schedule. Alternatively, when small practices are able to drop onerous insurance contracts and achieve out-of-network status, their leverage is amplified, most markedly when underwritten by fair out-of-network rules that require out-of-network physicians be eligible to be paid at rates higher than in-network physicians would otherwise receive for those services.

Physicians have been moving to larger group practices in order to gain leverage as well as access to more resources to effectively implement value-based care and risk-based payment models.[26] In this era of consolidation, there is an expectation of progression from solo or small physician practices to groups and multispecialty practices and, finally, to fully integrated delivery systems that employ the physicians, own the hospitals, and use a single information system. In this limited view, the earlier forms of practice organization are assumed to be incapable of implementing the supporting systems needed for population health (e.g., registries, electronic medical records, care management, team-based care) and are therefore unable to compete in value-based payment systems. A 2011 report of the Massachusetts Attorney General concluded that while bearing financial risk through value-based payments encourages coordinated care, it also requires significant investment to develop the capacity to effectively manage risk, which is more difficult for most physicians who practice in small groups and have historically been paid less than larger practices.[27] The report also found that physicians who transitioned to larger groups received professional payment that was approximately 30 percent higher, which accelerated the number of physicians leaving small practices and joining larger groups.

However, small practices are able to compete if they join forces to create profitable economies of scale without forfeiting the advantages of being small.[28] When small practices collaborate, they form a network of peers to learn from and to glean deeper insights from population health models. Alliances can provide the scale needed to negotiate value-based contracts and to spread the risk across multiple practices, so that a handful of unavoidable hospitalizations does not destroy a single practice. Collaboration allows each practice access to the necessary technologies to draw actionable insights from data and regulatory and coding expertise to maximize revenue, while laying the groundwork for future savings.

Independent practice associations (IPAs), if structured in compliance with antitrust laws, allow contracting between independent physicians and payers and can succeed in value-based purchasing arrangements if they are able to achieve results equal to more highly capitalized and tightly structured large medical groups and hospital-owned practices. Traditionally, most IPAs have been networks of small practices organized for the purpose of negotiating fee-for-service contracts with health insurers. While small practices considering participating in an IPA should be aware of the potential risks, such as underfunded capitation revenue, IPAs can act as a platform for sharing resources and negotiating risk-bearing medical services agreements on behalf of participating practices. Many IPAs, especially those that are clinically integrated, have already converted to an ACO, or provide the infrastructure for their members to organize as one. Because many of these organizations have already operated as risk-bearing provider networks, IPAs are well positioned to take leading roles in developing ACOs or acting as sustaining member organizations. Even if the physician organization has operated in a fee-for-service environment, an IPA can bring expertise regarding contracting, analytics, and management. For example, the Greater Rochester IPA (GRIPA) has over 1,500 physician members who benefit from data analytics services to stratify and manage patients, as well as care management support, pharmacists, visiting home nurses, and diabetes educators. GRIPA has its own ACO, which distributed 83 percent of its 2020 shared savings to participants. ACOs can also benefit from participation by small practices. A 2022 study found that small practices in ACOs reduced their beneficiaries' spending more than large practices in ACOs, thereby generating higher savings for the ACOs consisting of small practices.[29]

CMS structures several of its initiatives in an effort to support small practices in value-based participation, such as the Small, Underserved, and Rural Support initiative, which provides free, customized technical assistance to practices with 15 or fewer physicians. Small practices can contact selected organizations in their state to receive help with choosing quality measures, strategic planning, education and outreach, and health information technology optimization. CMS also includes several reporting flexibilities and rewards, specifically targeting solo and small practices under the Quality Payment Program's Merit-Based Incentive Payment System, most notably by varying submission methods and allowing special scoring consideration. The CMS ACO Investment Model built on the experience with the Alternative Payment Model (APM) to test the use of pre-paid shared savings to encourage new ACOs to form in rural and underserved areas and to encourage current Medicare Shared Savings Program ACOs to transition to arrangements with greater financial risk. It resulted in more physicians in rural and underserved communities signing on to participate in ACOs. These new ACOs invested in better care coordination, and savings

have been attributed to fewer unnecessary acute hospitalizations, fewer emergency department visits, and fewer days in skilled nursing facilities among beneficiaries. The ACO Investment Model generated $381.5 million in net Medicare savings between 2016 and 2018.[30] In June 2024, CMS will launch the Making Care Primary program to allow practices to build a value-based infrastructure by "improving care management and care coordination, equipping primary care clinicians with tools to form partnerships with health care specialists, and leveraging community-based connections to address patients' health needs as well as their health-related social needs such as housing and nutrition." The program will offer three progressive tracks to recognize participants' varying experience in value-based care, including one reserved for practices with no prior value-based care experience.

RESOURCES FOR SMALL PRACTICES

There has been a recent emergence of payer-sponsored arrangements, such as the one sponsored by Acuitas Health. It is a partnership between a nonprofit health plan and a large multispecialty group that offers a range of services to small practices, including billing and coding assistance, practice transformation consulting, and patient aggregation, thereby allowing practices to achieve the scale needed for value-based contracts. Through its work with Acuitas, the NYC Population Health Improvement Program was able to "answer important questions about what skills small practices need in order to succeed in the new environment and how small practices might work together to share the services necessary to develop those skills…(as well as) break new ground by presenting a financial model for the cost of shared services and probing the legal and regulatory issues raised by such arrangements."[31] Other private companies have created shared service infrastructures to allow small, independent practices to participate in APMs, offering low-cost shared resources in return for a portion of downstream savings.

Regardless of the payment rates, small practices can increase profit margins if they are able to keep their costs down. Group purchasing organizations (GPOs) and physician buying groups (PBGs) can offer independent practices a chance to access lower costs by using the power of many practices to benefit all. Some GPOs do not require purchases from a given supplier yet still offer leverage with other suppliers to grant small practices reduced rates. As most community-based practices offer vaccines, PBGs can play an important role in keeping costs down. Vaccines are one of the most costly and important investments a practice makes, and PBGs can offer practices lower contract pricing and rebates from the vaccine manufacturer. Practices can save five to 25 percent on the cost of supplies by joining a GPO or PBG, most of which have no fee and often allow practices to join several organizations.[32]

Small practices typically sign "evergreen" contracts with payers, which continuously renew automatically until one party terminates the agreement. A payment schedule is part of the contract and will not be updated unless one party opens the contract for negotiation. In most cases, this must be the practice since it is not usually in the payer's best financial interest to negotiate a new contract. As such, practices need to be prepared to contact the payer multiple times in order to actually get a contract negotiated – and then come to the table with as much data and population health metrics (e.g., A1C numbers for patients with diabetes) as possible. A practice able to successfully manage complex patients will have costs within a relatively narrow range without many outliers, thereby increasing negotiating leverage. Small practices can also gain a negotiating advantage if they have extended office hours, are considered the "only show in town," provide specialized care for an underserved patient population, have obtained quality accreditation recognition (e.g., National Committee for Quality Assurance), or can share positive patient testimonials.

The AMA has several resources dedicated to support physicians in private practice, such as the AMA Private Practice Simple Solutions series, which are "free, open access rapid learning cycles designed to provide opportunities to implement actionable changes that can immediately increase efficiency in private practices." Session topics range from marketing to recruitment to reducing administrative burden. The AMA Practice Management Center developed the Evaluating and Negotiating Emerging Payment Options manual to assist members who are considering transitioning to risk-based payment, while the AMA Value Based Care Toolkit is being updated for 2023 to provide a step-by-step guide to designing, adopting, and optimizing the value-based care model. The 2016 adoption of AMA Policy D-160.926, which calls for the development of a guide to provide information to physicians in or considering solo and small practice on how they can align through Independent Practice Associations, Accountable Care Organizations, Physician Hospital Organizations, and other models to help them with the imminent movement to risk-based contracting and value-based care, resulted in the development of the Joining or Aligning with a Physician-Led Integrated Health System guide, which was updated in June 2020. The AMA also offers a Private Practice Group Membership Program to drive sustainability and accelerate innovation for

members in private practice, as well as a Voluntary Best Practices to Advance Data Sharing Playbook to address the future of sustainable value-based payment.

AMA POLICY

The AMA's longstanding goal to promote the sustainability of solo, small, and primary care practices is reflected in numerous AMA policies, including those that:

- Call for the development of a guide to provide information to physicians in or considering solo and small practice on how they can align through IPAs, ACOs, Physician Hospital Organizations, and other models to help them with the imminent movement to risk-based contracting and value-based care (Policy D-160.926);
- Advocate in Congress to ensure adequate payment for services rendered by private practicing physicians, create and maintain a reference document establishing principles for entering into and sustaining a private practice, and issue a report in collaboration with the Private Practice Physicians Section at least every two years communicating efforts to support independent medical practices (Policy D-405.988);
- Support development of administrative mechanisms to assist primary care physicians in the logistics of their practices to help ensure professional satisfaction and practice sustainability, support increased financial incentives for physicians practicing primary care, especially those in rural and urban underserved areas, and advocate for public and private payers to develop physician payment systems to promote primary care and specialty practices in progressive, community-based models of integrated care focused on quality and outcomes (Policy H-200.949);
- Reinforce the freedom of physicians to choose their method of earning a living and the right of physicians to charge their patients their usual fee that is fair, irrespective of insurance/coverage arrangements between the patient and the insurers (Policy H-385.926);
- Support insurance payment rates that are established through meaningful negotiations and contracts (Policy H-165.838);
- Call for a formal, legal review of ongoing grievous behaviors of the health insurance industry (Policy D-385.949);
- Advocate for payment rates that are sufficient to cover the full cost of sustainable medical practice, continue to monitor health care delivery and physician payment reform activities, and provide resources to help physicians understand and participate in payment reform initiatives (Policy H-390.849);
- Seek positive inflation-adjusted annual physician payment updates that keep pace with rising practice costs to ensure payment rates cover the full cost of sustainable medical practice (D-390.946); and
- Support fair out-of-network payment rules coupled with strong network adequacy requirements for all physicians (H-285.904).

The AMA has policy that addresses the challenges presented by the evolving value-based health care system, such as those that:

- Provide guidance and support infrastructure that allows independent physicians to join with other physicians in clinically integrated networks independent of any hospital system, identify financially viable prospective payment models, and develop educational opportunities for physicians to learn and collaborate on best practices for such payment models for physician practice, including but not limited to independent private practice (Policy H-385.904);
- Support a pluralistic approach to third-party payment methodology, promoting flexibility in payment arrangements (Policy H-385.989);
- Reaffirm the AMA's support for a neutral public policy and fair market competition among alternative health care delivery and financing systems (Policy H-385.990); and
- Emphasize the AMA's dedication to seeking payment reform, supporting independent physicians in joining clinically integrated networks, and refining relative values for services based on valid and reliable data (Policy H-400.972).

AMA policy does not endorse a specific payment mechanism such as Medicare RBRVS, but instead, states that use of RBRVS relative values is one option that could provide the basis for both public and private physician payment systems. Among the most relevant policies are those that:

- Oppose any type of national mandatory fee schedule (Policy H-385.986);

- Support uncoupling of commercial fee schedules from Medicare conversion factors and seek legislation and/or regulation to prevent insurance companies from utilizing a physician payment schedule below the updated Medicare professional fee schedule (Policy D-400.990); and
- Support a pluralistic approach to third-party payment methodology under fee-for-service, and do not support a preference for usual and customary or reasonable or any other specific payment methodology (Policy H-385.989).

Finally, AMA policies establish a minimum physician payment of 100 percent of the RBRVS Medicare allowable for CHIP and Medicaid (Policy H-290.976) as well as for TRICARE and any other publicly funded insurance plan (Policy H-385.921).

DISCUSSION

Research has found that small community practices are able to deliver more personalized patient care and have lower rates of preventable hospital admissions. They are able to detect potential conditions before they result in hospital admissions and accordingly play a vital role in keeping patients healthier. However, small community practices may be challenged in implementing the support systems needed for participation in population health management and value-based purchasing arrangements. As such, the Council believes that bonuses for population-based programs must be accessible to small community practices, taking into consideration the size of the populations they manage and with a specific focus on improving care and payment for children, pregnant people, and people with mental health conditions, as these groups are often disproportionately covered by Medicaid.

Small practices are typically not eligible to collect facility fees or utilize various addresses or facility types to generate higher billing for similar procedures depending on contracts and incentives, thereby creating a revenue differential with larger practices. Most importantly, small practices lack the leverage retained by larger practices, putting them at a significant disadvantage when negotiating payment schedules. The single most influential factor in ensuring a sustainable level of payment for small practices is leverage. Strong network adequacy requirements that expect all health plans to contract with sufficient numbers and types of physicians bestow bargaining power by making it difficult for insurers to dismiss negotiation on an in-network payment schedule. Alternatively, when small practices are able to drop onerous insurance contracts and achieve out-of-network status, their leverage is amplified, most markedly when underwritten by fair out-of-network rules that require out-of-network physicians be eligible to be paid at rates higher than in-network physicians would otherwise receive for those services. There are resources available to help small practices succeed, most notably in underserved markets where average private professional service payments tend to be higher than those in more competitive physician markets.[33]

Resolution 108-A-23 presumes that small practices experience private insurance payment rates well below Medicare payment rates. However, research shows that private insurance payment rates are, on average, higher than Medicare payment rates for the same health care services.[34] While there are limitations in the available data due to inclusion of larger practices and hospital-employed physicians, variability in private insurance payment schedules means that most small practices accept multiple different payment schedules from different payers, making it difficult for them to respond to questions about payment rates with accuracy. Accordingly, the Council believes a physician survey is not likely to illuminate payment variations in small practices between private insurance and Medicare payment rates. Small practices have a higher percentage of private health insurance patients than larger practices, which should benefit them. However, not all private insurance payments are reflective of the full cost of practice, the value of the care provided, or include inflation-based updates.

Research also indicates that Medicaid payment rates are substantially below Medicare payment rates. As the largest public health insurance provider in the United States, Medicaid policy has significant health equity implications. Low payment rates may limit access to quality care and contribute to poor health outcomes for Medicaid beneficiaries. While Medicaid state flexibility is intended to preserve state operational autonomy and programming, it has fostered wide variability and geographic inequities, particularly between Medicaid expansion states and non-expansion states, further enabling health disparities. Substantial dependence on state revenues has led to low payment rates that effectively limit access, as it disincentivizes providing care to the often minoritized populations the program serves. As small practices must absorb costs required to provide care to the Medicaid population, such as compliance with regulations and addressing Social Determinants of Health toward equitable care, lower payment makes it almost impossible to recover those costs.

Although AMA policy does not endorse a specific payment mechanism such as the Medicare RBRVS and opposes any type of mandatory payment schedule, it does support payment at no less than 100 percent of RBRVS Medicare allowable as one option that could provide the basis for both public and private physician payment systems. However, consideration must be given to the challenges presented by tying payment to a Medicare benchmark, which can be manipulated by payers to provide them with a financial advantage. Some payers may adopt only a portion of the Medicare RBRVS or use an outdated RBRVS where the RVUs are no longer reflective of current resource costs. Other payers may implement time-limited or temporary arrangements or apply the RBRVS to only certain specialties, leading to disruption in care or difficulties with patient referrals. Most importantly, continuing to tether payment to a Medicare payment rate that has been reduced by almost 10 percent in four years presents an untenable situation for small practices. As such, uncoupling payment schedules from a Medicare benchmark may allow for a level of payment that reflects the full cost of practice, the value of the care provided, and includes inflation-based updates, thereby sustaining small practices.

It is unfeasible to establish an equitable minimum government payment rate defensible across the six major government health care programs. Furthermore, it would be impracticable to establish a minimum payment rate in the private physician market, which is currently riding a consolidation wave, transforming health insurers into much larger and more powerful conglomerates. The Council believes that an ideal payment benchmark will reflect the cost of providing care both in the short term and long term while acknowledging risk, variable expenses, an appropriate allocation of fixed costs, and physician work. It is essential that the benchmark reflect the full cost of practice and the value of the care provided, as well as include inflation-based updates. The benchmark should disclose payment amounts and the methodology used to calculate them, as these are fundamental to establishing trust between physicians and insurers and promoting sound decision making by all participants in the health care system.

For small community practices, sustainable payment reflects the full cost of practice and the value of the care provided. Additionally, it includes annual inflation-based payment updates, which are essential to measure practice cost inflation and account for changes in physicians' operating costs. Annual updates enable small practices to better absorb other payment redistributions triggered by budget neutrality rules and performance adjustments, as well as periods of high inflation and rising staffing costs; they also help physicians invest in their practices and implement new strategies to provide high-value care.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 108-A-23, and the remainder of the report be filed:

1. That our American Medical Association (AMA) support making bonuses for population-based programs accessible to small community practices, without untenable exposure to administrative burden or downside risk, taking into consideration the size of the populations they manage and with a specific focus on improving care and payment for children, pregnant people, and people with mental health conditions, as these groups are often disproportionately covered by Medicaid.

2. That our AMA amend Policy D-400.990 by addition and deletion, and modify the title by addition and deletion, as follows:

   Uncoupling Commercial Fee Schedules from the Medicare Physician Payment Schedule ~~Conversion Factors~~ D-400.990
   Our AMA: (1) shall use every means available to convince health insurance companies and managed care organizations to immediately uncouple fee schedules from the Medicare Physician Payment Schedule ~~conversion factors~~ and to maintain a ~~fair and appropriate~~ level of payment ~~reimbursement~~ that is sustainable, reflects the full cost of practice, and the value of the care provided, and includes inflation-based updates; and (2) will seek legislation and/or regulation to prevent managed care companies from utilizing a physician payment schedule below the updated Medicare Physician Payment ~~professional fee~~ ~~s~~Schedule.

3. That our AMA amend Policy H-290.976 by addition and deletion, and modify the title by addition and deletion, as follows:

Enhanced ~~S~~CHIP Enrollment, Outreach, and Payment ~~Reimbursement~~ H-290.976
1. It is the policy of our AMA that prior to or concomitant with states' expansion of ~~State~~ Children's Health Insurance Programs (~~S~~CHIP) to adult coverage, our AMA urge all states to maximize their efforts at outreach and enrollment of ~~S~~CHIP eligible children, using all available state and federal funds.
2. Our AMA affirms its commitment to advocating for ~~reasonable~~ ~~S~~CHIP and Medicaid payment that is sustainable, reflects the full cost of practice, and the value of the care provided, includes inflation-based updates, ~~reimbursement for its medical providers, defined as at minimum~~ and pays no less than 100 percent of RBRVS Medicare allowable.

4. That our AMA amend Policy H-385.921 by addition and deletion as follows:

Health Care Access for Medicaid Patients H-385.921
It is AMA policy that to increase and maintain access to health care for all, payment for physician providers for Medicaid, TRICARE, and any other publicly funded insurance plan must be sustainable, reflect the full cost of practice and the value of the care provided, include inflation-based updates, and is pays less than ~~at minimum~~ 100 percent of ~~the~~ RBRVS Medicare allowable.

5. That our AMA reaffirm Policy D-405.988, which calls for advocacy in Congress to ensure adequate payment for services rendered by private practicing physicians, creating and maintaining a reference document establishing principles for entering into and sustaining a private practice, and issuing a report in collaboration with the Private Practice Physicians Section at least every two years to communicate efforts to support independent medical practices.

6. That our AMA reaffirm Policy H-200.949, which supports development of administrative mechanisms to assist primary care physicians in the logistics of their practices to help ensure professional satisfaction and practice sustainability, support increased financial incentives for physicians practicing primary care, especially those in rural and urban underserved areas, and advocate for public and private payers to develop physician payment systems to promote primary care and specialty practices in progressive, community-based models of integrated care focused on quality and outcomes.

7. That our AMA reaffirm Policy H-285.904, which supports fair out-of-network payment rules coupled with strong network adequacy requirements for all physicians.

8. That our AMA reaffirm Policy H-385.986, which opposes any type of national mandatory fee schedule.

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Council on Medical Service Report 8-A-24
Sustainable Payment for Community Practices
Policy Appendix

Uncoupling Commercial Fee Schedules from Medicare Conversion Factors D-400.990
Our AMA: (1) shall use every means available to convince health insurance companies and managed care organizations to immediately uncouple fee schedules from Medicare conversion factors and to maintain a fair and appropriate level of reimbursement; and (2) will seek legislation and/or regulation to prevent managed care companies from utilizing a physician payment schedule below the updated Medicare professional fee schedule.
Res. 137, A-02 Reaffirmed: CCB/CLRPD Rep. 4, A-12 Appended: Res. 103, A-13 Reaffirmation: A-19

The Preservation of the Private Practice of Medicine D-405.988
Our AMA: (1) supports preserving the value of the private practice of medicine and its benefit to patients; (2) will utilize its resources to protect and support the continued existence of solo and small group medical practice, and to protect and support the ability of these practices to provide quality care; (3) will advocate in Congress to ensure adequate payment for services rendered by private practicing physicians; (4) will work through the appropriate channels to preserve choices and opportunities, including the private practice of medicine, for new physicians whose choices and opportunities may be limited due to their significant medical education debt; (5) will work through the appropriate channels to ensure that medical students and residents during their training are educated in all of medicine's career choices, including the private practice of medicine; (6) will create, maintain, and make accessible to medical students, residents and fellows, and physicians, resources to enhance satisfaction and practice sustainability for physicians in private practice; (7) will create and maintain a reference document establishing principles for entering into and sustaining a private practice, and encourage medical schools and residency programs to present physicians in training with information regarding private practice as a viable option; and (8) will issue a report in collaboration with the Private Practice Physicians Section at least every two years communicating their efforts to support independent medical practices.
Res. 224, I-10 Appended: Res. 604, A-12 Reaffirmation I-13 Appended: Res. 735, A-14 Reaffirmed in lieu of Res. 223, I-14 Modified: Speakers Rep. 01, A-17 Reaffirmed: Res. 724, A-22 Reaffirmation: A-22 Appended: Res. 602, A-22

Principles of and Actions to Address Primary Care Workforce H-200.949
1. Our patients require a sufficient, well-trained supply of primary care physicians--family physicians, general internists, general pediatricians, and obstetricians/gynecologists--to meet the nation's current and projected demand for health care services.
2. To help accomplish this critical goal, our American Medical Association (AMA) will work with a variety of key stakeholders, to include federal and state legislators and regulatory bodies; national and state specialty societies and medical associations, including those representing primary care fields; and accreditation, certification, licensing, and regulatory bodies from across the continuum of medical education (undergraduate, graduate, and continuing medical education).
3. Through its work with these stakeholders, our AMA will encourage development and dissemination of innovative models to recruit medical students interested in primary care, train primary care physicians, and enhance both the perception and the reality of primary care practice, to encompass the following components: a) Changes to medical school admissions and recruitment of medical students to primary care specialties, including counseling of medical students as they develop their career plans; b) Curriculum changes throughout the medical education continuum; c) Expanded financial aid and debt relief options; d) Financial and logistical support for primary care practice, including adequate reimbursement, and enhancements to the practice environment to ensure professional satisfaction and practice sustainability; and e) Support for research and advocacy related to primary care.
4. Admissions and recruitment: The medical school admissions process should reflect the specific institution's mission. Those schools with missions that include primary care should consider those predictor variables among applicants that are associated with choice of these specialties.
5. Medical schools, through continued and expanded recruitment and outreach activities into secondary schools, colleges, and universities, should develop and increase the pool of applicants likely to practice primary care by seeking out those students whose profiles indicate a likelihood of practicing in primary care and underserved areas, while establishing strict guidelines to preclude discrimination.
6. Career counseling and exposure to primary care: Medical schools should provide to students career counseling related to the choice of a primary care specialty, and ensure that primary care physicians are well-represented as teachers, mentors, and role models to future physicians.
7. Financial assistance programs should be created to provide students with primary care experiences in ambulatory settings, especially in underserved areas. These could include funded preceptorships or summer work/study opportunities.
8. Curriculum: Voluntary efforts to develop and expand both undergraduate and graduate medical education programs to educate primary care physicians in increasing numbers should be continued. The establishment of appropriate administrative units for all primary care specialties should be encouraged.
9. Medical schools with an explicit commitment to primary care should structure the curriculum to support this objective. At the same time, all medical schools should be encouraged to continue to change their curriculum to put more emphasis on primary care.
10. All four years of the curriculum in every medical school should provide primary care experiences for all students, to feature increasing levels of student responsibility and use of ambulatory and community-based settings.
11. Federal funding, without coercive terms, should be available to institutions needing financial support to expand resources for both undergraduate and graduate medical education programs designed to increase the number of primary care physicians. Our AMA will advocate for public (federal and state) and private payers to a) develop enhanced funding and related incentives from all sources to provide education for medical students and resident/fellow physicians, respectively, in progressive, community-based models of integrated care focused on quality and outcomes (such as the patient-centered medical home and the chronic care model) to enhance primary care as a career choice; b) fund and foster innovative pilot programs that change the current approaches to primary care in undergraduate and graduate medical education, especially in urban and rural underserved areas; and c) evaluate these efforts for their effectiveness in increasing the number of students choosing primary care careers and helping facilitate the elimination of geographic, racial, and other health care disparities.
12. Medical schools and teaching hospitals in underserved areas should promote medical student and resident/fellow physician rotations through local family health clinics for the underserved, with financial assistance to the clinics to compensate their teaching efforts.
13. The curriculum in primary care residency programs and training sites should be consistent with the objective of training generalist physicians. Our AMA will encourage the Accreditation Council for Graduate Medical Education to (a) support primary care residency programs, including community hospital-based programs, and (b) develop an accreditation environment and novel pathways that promote innovations in graduate medical education, using progressive, community-based models of integrated care focused on quality and outcomes (such as the patient-centered medical home and the chronic care model).

14. The visibility of primary care faculty members should be enhanced within the medical school, and positive attitudes toward primary care among all faculty members should be encouraged.
15. Support for practicing primary care physicians: Administrative support mechanisms should be developed to assist primary care physicians in the logistics of their practices, along with enhanced efforts to reduce administrative activities unrelated to patient care, to help ensure professional satisfaction and practice sustainability.
16. There should be increased financial incentives for physicians practicing primary care, especially those in rural and urban underserved areas, to include scholarship or loan repayment programs, relief of professional liability burdens, and Medicaid case management programs, among others. Our AMA will advocate to state and federal legislative and regulatory bodies, among others, for development of public and/or private incentive programs, and expansion and increased funding for existing programs, to further encourage practice in underserved areas and decrease the debt load of primary care physicians. The imposition of specific outcome targets should be resisted, especially in the absence of additional support to the schools.
17. Our AMA will continue to advocate, in collaboration with relevant specialty societies, for the recommendations from the AMA/Specialty Society RVS Update Committee (RUC) related to reimbursement for E&M services and coverage of services related to care coordination, including patient education, counseling, team meetings and other functions; and work to ensure that private payers fully recognize the value of E&M services, incorporating the RUC-recommended increases adopted for the most current Medicare RBRVS.
18. Our AMA will advocate for public (federal and state) and private payers to develop physician reimbursement systems to promote primary care and specialty practices in progressive, community-based models of integrated care focused on quality and outcomes such as the patient-centered medical home and the chronic care model consistent with current AMA Policies
H-160.918 and H-160.919.
19. There should be educational support systems for primary care physicians, especially those practicing in underserved areas.
20. Our AMA will urge urban hospitals, medical centers, state medical associations, and specialty societies to consider the expanded use of mobile health care capabilities.
21. Our AMA will encourage the Centers for Medicare & Medicaid Services to explore the use of telemedicine to improve access to and support for urban primary care practices in underserved settings.
22. Accredited continuing medical education providers should promote and establish continuing medical education courses in performing, prescribing, interpreting and reinforcing primary care services.
23. Practicing physicians in other specialties--particularly those practicing in underserved urban or rural areas--should be provided the opportunity to gain specific primary care competencies through short-term preceptorships or postgraduate fellowships offered by departments of family medicine, internal medicine, pediatrics, etc., at medical schools or teaching hospitals. In addition, part-time training should be encouraged, to allow physicians in these programs to practice concurrently, and further research into these concepts should be encouraged.
24. Our AMA supports continued funding of Public Health Service Act, Title VII, Section 747, and encourages advocacy in this regard by AMA members and the public.
25. Research: Analysis of state and federal financial assistance programs should be undertaken, to determine if these programs are having the desired workforce effects, particularly for students from disadvantaged groups and those that are underrepresented in medicine, and to gauge the impact of these programs on elimination of geographic, racial, and other health care disparities. Additional research should identify the factors that deter students and physicians from choosing and remaining in primary care disciplines. Further, our AMA should continue to monitor trends in the choice of a primary care specialty and the availability of primary care graduate medical education positions. The results of these and related research endeavors should support and further refine AMA policy to enhance primary care as a career choice.
CME Rep. 04, I-18

Out-of-Network Care H-285.904
1. Our AMA adopts the following principles related to unanticipated out-of-network care:
A. Patients must not be financially penalized for receiving unanticipated care from an out-of-network provider.
B. Insurers must meet appropriate network adequacy standards that include adequate patient access to care, including access to hospital-based physician specialties. State regulators should enforce such standards through active regulation of health insurance company plans.
C. Insurers must be transparent and proactive in informing enrollees about all deductibles, copayments and other out-of-pocket costs that enrollees may incur.
D. Prior to scheduled procedures, insurers must provide enrollees with reasonable and timely access to in-network physicians.

E. Patients who are seeking emergency care should be protected under the "prudent layperson" legal standard as established in state and federal law, without regard to prior authorization or retrospective denial for services after emergency care is rendered.
F. Out-of-network payments must not be based on a contrived percentage of the Medicare rate or rates determined by the insurance company.
G. Minimum coverage standards for unanticipated out-of-network services should be identified. Minimum coverage standards should pay out-of-network providers at the usual and customary out-of-network charges for services, with the definition of usual and customary based upon a percentile of all out-of-network charges for the particular health care service performed by a provider in the same or similar specialty and provided in the same geographical area as reported by a benchmarking database. Such a benchmarking database must be independently recognized and verifiable, completely transparent, independent of the control of either payers or providers and maintained by a non-profit organization. The non-profit organization shall not be affiliated with an insurer, a municipal cooperative health benefit plan or health management organization.
H. Independent Dispute Resolution (IDR) should be allowed in all circumstances as an option or alternative to come to payment resolution between insurers and physicians.
2. Our AMA will advocate for the principles delineated in Policy H-285.904 for all health plans, including ERISA plans.
3. Our AMA will advocate that any legislation addressing surprise out-of-network medical bills use an independent, non-conflicted database of commercial charges.
Res. 108, A-17 Reaffirmation: A-18 Appended: Res. 104, A-18 Reaffirmed in lieu of: Res. 225, I-18 Reaffirmation: A-19 Reaffirmed: Res. 210, A-19 Appended: Res. 211, A-19 Reaffirmed: CMS Rep. 5, A-21 Modified: Res. 236, A-22

Enhanced SCHIP Enrollment, Outreach, and Reimbursement H-290.976
1. It is the policy of our AMA that prior to or concomitant with states' expansion of State Children's Health Insurance Programs (SCHIP) to adult coverage, our AMA urge all states to maximize their efforts at outreach and enrollment of SCHIP eligible children, using all available state and federal funds.
2. Our AMA affirms its commitment to advocating for reasonable SCHIP and Medicaid reimbursement for its medical providers, defined as at minimum 100 percent of RBRVS Medicare allowable.
Res. 103, I-01 Reaffirmation A-07 Reaffirmation A-11 Reaffirmed: CMS Rep. 7, I-14 Reaffirmation A-15 Reaffirmed: CMS Rep. 3, A-15 Reaffirmation: A-17 Reaffirmed: CMS Rep. 02, A-19 Reaffirmed: CMS Rep. 5, I-20 Reaffirmed: CMS Rep. 9, A-21 Reaffirmed: CMS Rep. 3, I-21 Reaffirmed: CMS Rep. 1, I-22

Health Care Access for Medicaid Patients H-385.921
It is AMA policy that to increase and maintain access to health care for all, payment for physician providers for Medicaid, TRICARE, and any other publicly funded insurance plan must be at minimum 100 percent of the RBRVS Medicare allowable.
Res. 103, A-07 Reaffirmed: CMS Rep. 2, I-08 Reaffirmation A-12 Reaffirmed: Res 132, A-14 Reaffirmed in lieu of Res. 808, I-14 Reaffirmation A-15 Reaffirmed in lieu of: Res. 807, I-18

National Mandatory Fee Schedule H-385.986
The AMA opposes any type of national mandatory fee schedule.
Res. 27, A-85 Reaffirmed: BOT Rep. UU, A-93 Reaffirmed CLRPD Rep. 2, I-95 Reaffirmed: CMS Rep. 7, A-05 Reaffirmed in lieu of Res. 127, A-10 Reaffirmation A-15