

REPORT 3 OF THE BOARD OF TRUSTEES (I-18)  
2018 AMA Advocacy Efforts

EXECUTIVE SUMMARY

Policy G-640.005, "AMA Advocacy Analysis," calls on the Board of Trustees (BOT) to provide a report to the House of Delegates (HOD) at each Interim Meeting highlighting the year's advocacy activities and should include efforts, successes, challenges, and recommendations/actions to further optimize advocacy efforts. The BOT has prepared this report to fulfill this HOD directive and to provide an update on 2018 American Medical Association (AMA) advocacy activities.

The AMA was a strong and effective advocate once again for our nation's patients and physicians this year. The AMA advanced HOD-developed policy on numerous issues. Key victories for the AMA and the Federation of Medicine include:

- Convincing Anthem to reverse course on its Modifier 25 proposal which averted cuts of \$100 million in annual payments to physician practices;
- Legislative improvements to the Quality Payment Program (QPP) which will ease physicians' QPP transition;
- Repeal of the Independent Payment Advisory Board (IPAB);
- Reauthorization of the Children's Health Insurance Program (CHIP) for 10 years;
- Progress on key recommendations from the AMA Opioid Task Force regarding physician prescribing, physician education, use of prescription drug monitoring programs (PDMPs), and naloxone prescription availability;
- More than 60 state-level victories in collaboration with the Federation on key issues including opioids, insurer practices, and scope of practice;
- Release of the Economic Impact Statement report, which gives policymakers concrete evidence demonstrating how their local communities tangibly benefit when they support legislation that helps physician practices thrive; and
- Over 2 million grassroots engagements through social media to advance the AMA advocacy agenda.

Staff note: This report was prepared in September 2018, and may be updated prior to the Interim Meeting based on more recent advocacy developments.

## REPORT OF THE BOARD OF TRUSTEES

B of T Report 3-I-18

Subject: 2018 AMA Advocacy Efforts

Presented by: Jack Resneck, Jr., MD, Chair

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### 1 BACKGROUND

2  
3 Policy G-640.005, "AMA Advocacy Analysis," calls on the Board of Trustees (BOT) to provide a  
4 report to the House of Delegates (HOD) at each Interim Meeting highlighting the year's advocacy  
5 activities and should include efforts, successes, challenges, and recommendations/actions to further  
6 optimize advocacy efforts. The BOT has prepared the following report to provide an update on  
7 2018 American Medical Association (AMA) advocacy activities.

8  
9 Once again in 2018, the AMA was a strong and effective advocate for our nation's patients and  
10 physicians. Key wins included Anthem's reversal of its Modifier 25 policy, Quality Payment  
11 Program (QPP) improvements, repeal of the Independent Payment Advisory Board (IPAB), and  
12 extension of the Children's Health Insurance Program for 10 years. The AMA also conducted  
13 impactful research such as the Economic Impact Study report. AMPAC continued its strong  
14 performance and positioned the AMA to be influential in the 2018 elections (see separate report in  
15 Not for Official Business Bag). Finally, AMA grassroots networks and microsites were extremely  
16 effective with over 2 million grassroots engagements to advance our advocacy agenda through  
17 social media.

### 18 19 DISCUSSION OF 2018 ADVOCACY EFFORTS

#### 20 21 *Health system reform*

22  
23 In the Bipartisan Budget Act of 2018, Congress repealed the Independent Payment Advisory Board  
24 (IPAB) which was an AMA priority and came after several years of strong Federation advocacy. In  
25 the same bill, Congress extended the Children's Health Insurance Program (CHIP) for 10 years.  
26 Further, the AMA convinced Congress to strike the House-passed language that would have  
27 extended the expiring "misvalued codes" provision for an additional year in 2019. Such a provision  
28 would have had both short term and longer term negative effects for physicians.

29  
30 On June 7, 2018, the Department of Justice filed a brief declining to defend the Affordable Care  
31 Act (ACA) in a case (*Texas v. United States*) brought by 20 state attorneys general. A week later,  
32 the AMA and four physician specialty associations filed an amicus brief urging the court to reject  
33 the effort to undermine the patient care gains under the ACA. In announcing the filing, the AMA  
34 noted that "if the lawsuit were successful, federal policy could roll back to 2009, which would be  
35 remarkably disruptive to our nation's health system and every single American." It would void  
36 protections for those with pre-existing conditions, and provisions that allow children to remain on  
37 their parents' plan until age 26. Insurers would no longer be held to the 85 percent medical loss  
38 ratio, meaning they could generate higher profits at the expense of coverage and payments for  
39 services, and 100 percent coverage for certain preventive services would cease. Furthermore,

1 annual and life-time dollar limits could be reinstated, leading to more bankruptcies due to health  
2 care costs.

3  
4 Also in 2018, the Administration and the Congress attempted to continue chipping away at the  
5 infrastructure of the ACA. The major “repeal and replace” efforts from 2017 were not repeated, but  
6 there were several efforts to modify the ACA’s impact. The AMA commented extensively in the  
7 regulatory process on the Administration’s actions—cutting back funds for navigators, shortening  
8 the enrollment period, eliminating the cost sharing reduction subsidies, expanding association  
9 health plans and short-duration limited coverage plans, and reducing risk adjustment payments.  
10 The AMA is concerned that these actions will lead to higher cost/lower quality health plan choices  
11 for many patients. The AMA is also opposing Medicaid work requirements that are being  
12 considered by both federal and state policymakers.

13  
14 *QPP implementation*

15  
16 The AMA continues to support physicians as they transition to the Quality Payment Program  
17 (QPP). The AMA is also working to improve the QPP at both the regulatory and legislative levels.  
18 The Bipartisan Budget Act of 2018 included a number of QPP refinements requested by the AMA:

- 19  
20 • Medicare Part B drug costs will be excluded from the Merit-based Incentive Payment System  
21 (MIPS) payment adjustments and from the low-volume threshold determination;  
22 • The Centers for Medicare & Medicaid Services (CMS) may reweight the MIPS cost  
23 performance category to not less than 10 percent for the third, fourth and fifth program years  
24 (rather than requiring a weight of 30 percent in the third year);  
25 • CMS has more flexibility in setting the MIPS performance threshold for years three through  
26 five to ensure a gradual and incremental transition to the threshold being set at the mean or  
27 median performance level in the sixth year; and  
28 • The Physician Focused Payment Model Technical Advisory Committee may provide initial  
29 feedback regarding the extent to which alternative payment model proposals meet criteria and  
30 an explanation of the basis for the feedback.

31  
32 On July 12, CMS released a proposed rule covering Medicare physician fee schedule and QPP  
33 changes for 2019. Positive elements of the proposal included:

- 34  
35 • Reduced documentation burden for evaluation and management (E/M) office visit services;  
36 • New payments for services that are not part of a face-to-face visit (e.g., virtual check-ins with  
37 patients, remote patient consults using videos/photographs, online consults with other  
38 physicians);  
39 • Continuation of the low volume threshold policy to exempt practices from MIPS; and  
40 • A reduction in problematic measures in the Promoting Interoperability component of MIPS  
41 (formerly Meaningful Use and Advancing Care Information).

42  
43 However, there were also several areas of concern for which the AMA will be recommending  
44 changes in its comments to CMS, which are due on September 10. These include:

- 45  
46 • A proposed collapse of E/M payments for physician office visit codes;  
47 • Reduced payments for office visits and procedures performed on the same day; and  
48 • The need for a simplified MIPS scoring framework and reduced quality measure requirements.

49  
50 The AMA has been working with Federation groups to further identify positive and problematic  
51 aspects of the proposed regulations, as well as potential constructive solutions.

1 *Regulatory relief*

2  
3 The AMA is focused on regulatory relief and administrative simplification issues beyond what is  
4 included in the QPP. For example, in 2017 the AMA convinced CMS to retroactively align legacy  
5 pay-for-reporting programs with the current MIPS program for the 2016 reporting period, reducing  
6 penalties for physicians by \$22 million in 2018. This year, major regulatory wins include:

- 7  
8 • The Veterans Administration agreed to exempt only employed physicians from multistate  
9 licensure requirements when delivering telehealth services;
- 10 • CMS created a new beneficiary look-up tool and launched an education campaign to assist  
11 physicians as beneficiaries' social security numbers are removed from their Medicare cards;
- 12 • CMS delayed implementation of appropriate-use criteria;
- 13 • Office of the National Coordinator promoted AMA STEPS Forward™ modules with the  
14 Federal Health IT Playbook;
- 15 • Medicare administrative contractors now must use targeted modeling for audits that  
16 emphasizes education to prevent billing errors before they are referred to recovery audit  
17 contractors (RACs);
- 18 • CMS auditors must use predictive analytics to focus audits on claims that are at high risk for  
19 improper payments; and
- 20 • RAC auditors now must reimburse physicians for medical records as part of the audit process.

21  
22 The AMA also sponsored an online discussion board with practice managers and two focus groups  
23 with physicians in Chattanooga, TN, and Iselin, NJ, to further explore physicians' regulatory  
24 burdens in order to refine and prioritize its advocacy agenda. Topics covered during the discussions  
25 included electronic health record requirements, prior authorization, carrier audits, documentation  
26 burdens, prescription drug monitoring programs, and patient translators, among others.

27  
28 The AMA also commented both to Congress and the Administration on the impact that current  
29 Stark self-referral and the anti-kickback statutes are having on physician development and adoption  
30 of alternative payment models.

31  
32 Further, the AMA, through the Professional Satisfaction and Practice Sustainability focus area, has  
33 created a Debunking Regulatory Myths website to clarify common regulatory compliance  
34 questions for physicians as part of the broader effort to reduce administrative burdens.

35  
36 *Prior authorization (PA)*

37  
38 Prior Authorization (PA) has grown into a major concern among physicians due to patient care  
39 delays and practice burdens. The AMA conducted a survey of 1,000 practicing physicians at the  
40 end of 2017 which was released this year. Among surveyed physicians, 64 percent reported waiting  
41 at least one day for PA decisions from health plans, while 30 percent reported waiting at least three  
42 business days. Not surprisingly, 92 percent of physicians said that PA can delay access to necessary  
43 care. These delays may have serious implications for patients, as 78 percent of physicians reported  
44 that PA can lead to treatment abandonment, and 92 percent indicated that PA can have a negative  
45 impact on patient clinical outcomes. Moreover, PA hassles have been growing over time, with 86  
46 percent of physicians reporting that PA burdens have increased over the past five years. Physicians  
47 and practice managers also placed PA at the top of their list of administrative frustrations in focus  
48 groups and online research conducted by the AMA.

49  
50 To address these issues, the AMA has undertaken a major campaign to urge health plans to "right-  
51 size" PA programs. In January 2017, the AMA established a coalition of 16 other organizations and

1 released a set of 21 Prior Authorization and Utilization Management Reform Principles. Over 100  
2 additional provider and patient groups have signed on to the principles as formal supporters. The  
3 principles spurred conversations with health plans about the need for significant reform in PA  
4 programs. One result of these discussions was the January 2018 release of the Consensus Statement  
5 on Improving the Prior Authorization Process by the AMA, American Hospital Association,  
6 America's Health Insurance Plans, American Pharmacists Association, Blue Cross Blue Shield  
7 Association, and Medical Group Management Association. This document reflects an agreement  
8 between provider and health plan organizations to pursue PA reform in several key areas.  
9

10 State legislative efforts are also critical in the AMA's campaign to improve PA processes, and the  
11 AMA is working with state and specialty societies to enact PA and utilization management  
12 legislation. The AMA offers model legislation that continues to serve as the basis for many of the  
13 state bills and provides resources and support for these efforts. This year alone, more than 20 states  
14 are addressing utilization management reform in their legislatures with significant enactments in  
15 Indiana, New Mexico, and West Virginia. Physicians struggle with PA in the Medicare Advantage  
16 (MA) and Medicare Part D drug plans, so the AMA is addressing PA issues at the federal level too.  
17 These efforts include a recent AMA letter to CMS disputing the findings of a Government  
18 Accountability Office report that recommended increased use of PA for Medicare-covered services.  
19

20 The AMA has also launched a grassroots advocacy website dedicated to PA  
21 ([www.FixPriorAuth.org](http://www.FixPriorAuth.org)). The website includes both patient- and physician-oriented online  
22 experiences that end with a "share your story" call to action. Compelling stories gathered thus far  
23 are featured in the site's story gallery, and additional physician and patient PA accounts will be  
24 added over time and used to guide and support the AMA's advocacy efforts. FixPriorAuth.org also  
25 contains a resource library of PA-related news stories and AMA PA advocacy and educational  
26 tools, including the three-part video series on electronic prior authorization that has been approved  
27 for 0.25 credits of *AMA PRA Category 1 Credit*<sup>TM</sup>.  
28

### 29 *Telemedicine*

30

31 After concerted AMA advocacy coupled with the efforts of the Digital Medicine Payment  
32 Advisory Group (DMPAG), beginning January 1, 2018, Medicare expanded coverage of remote  
33 patient chronic care management. This represents a historic expansion of coverage that extends  
34 throughout the country without geographic limitations and includes services delivered virtually in a  
35 patient's home. In addition, CMS has proposed to cover additional remote patient management  
36 services including a range of technical and professional components that accurately reflect the costs  
37 of delivering such services beginning January 1, 2019. Furthermore, the AMA's coalition building  
38 and strong support for the Medicare telehealth provisions of the Bipartisan Budget Act of 2018  
39 which passed earlier this year paves the way for expanded Medicare coverage for telestroke and  
40 telehealth services for patients with end stage renal disease, chronically ill patients in Medicare  
41 Advantage, as well as coverage of telehealth for beneficiaries in certain accountable care  
42 organizations (two-sided risk models only).  
43

44 The AMA has also worked at the state level to ensure coverage of telemedicine and modernization  
45 of medical practice acts. In the 2018 legislative session, 44 states introduced over 160 telehealth-  
46 related pieces of legislation. Many bills addressed different aspects of payment regarding both  
47 private payers and Medicaid, with some bills making changes to existing payment laws. Many  
48 states also proposed legislation directing licensure boards to establish standards for the practice of  
49 telehealth within their given profession. The AMA was pleased to see that many of these bills were  
50 either based on the AMA Telemedicine Act, or were amended to incorporate language from this  
51 model bill. In addition, the AMA supported several state efforts to join the Interstate Medical

1 Licensure Compact, with now 24 states, DC, and Guam participating in the Compact's expedited  
2 licensure process.

3  
4 *Diabetes Prevention Program (DPP)*  
5

6 CMS approved coverage of the Medicare Diabetes Prevention Program (MDPP) effective April  
7 2018. This was a very positive development in the effort to prevent diabetes on a national scale. To  
8 further advance these efforts, the AMA has been urging CMS to approve coverage of virtual or  
9 digital MDPP programs participation to improve access in rural and underserved areas. The AMA  
10 also has ongoing discussions with staff at the Center for Medicare & Medicaid Innovation (CMMI)  
11 about the MDPP and has been working to disseminate information about it to potential suppliers.  
12 For example, the AMA convened a webinar for health systems interested in the DPP with a CMMI  
13 presenter and developed a question-and-answer document for them following the webinar.  
14

15 *Mergers*  
16

17 The AMA was instrumental in last year's action to block the Anthem/Cigna and Aetna/Humana  
18 mergers. The Anthem/Cigna merger alone would have cost physicians \$500 million in payments  
19 annually. In 2018, the AMA had to evaluate several new potential mergers that were not just a  
20 health insurer merging with a health insurer but more complicated mergers such as CVS/Aetna  
21 which involves a health insurer merging with a pharmacy chain/pharmacy benefits manager  
22 (PBM).  
23

24 In February, the AMA submitted a statement to the House Judiciary Subcommittee on Regulatory  
25 Reform, Commercial and Antitrust Law for a hearing on this merger. The statement expressed the  
26 AMA's concerns that the proposed merger has the potential to worsen competition (or reduce  
27 hopes for amelioration) in three poorly performing markets: PBM services; local health insurance  
28 markets; and many local retail pharmacy markets.  
29

30 On June 19, the AMA moved to oppose the CVS/Aetna merger. This was announced in California  
31 at a Department of Insurance (DOI) hearing. AMA President Barbara L. McAneny, MD, presented  
32 testimony urging regulators to block the proposed CVS/Aetna merger because it is likely to  
33 substantially lessen competition in many health care markets, to the detriment of patients. A  
34 CVS/Aetna deal would allow the combined corporate entity to fortify dominant positions in health  
35 insurance, pharmaceutical benefit management, retail and specialty markets that already lack  
36 competition. The AMA's filing for the hearing also outlined further the merger's potential negative  
37 consequences for health care access, quality and affordability, including:  
38

- 39
- 40 • An expected increase in premiums due to a substantial increase in market concentration in 30  
41 of 34 Medicare Part D regional markets;
  - 42 • An anticipated increase in drug spending and out-of-pocket costs for patients as Aetna and  
43 CVS fortify their dominant positions in the health insurance, pharmaceutical benefit  
44 management, retail and specialty pharmacy markets that already lack competition;
  - 45 • Reduced competition in health insurance markets that will adversely affect patients with higher  
46 premiums and contribute to a decline in the quality of insurance; and
  - 47 • A foreseeable failure to realize proposed efficiencies and benefits because the merger faces  
48 enormous implementation challenges, and those efficiencies have a questionable evidence  
49 base.

50 On August 1, 2018, the California DOI agreed with our arguments and those of the experts that  
51 testified, urging the U.S. Department of Justice (DOJ) to block the proposed merger. The AMA

1 also submitted extensive comments to the DOJ on the proposed merger on August 8. At the time of  
2 this report, the outcome of the proposed merger had yet to be decided, so AMA advocacy  
3 continues.

4  
5 *Insurer coverage issues*

6  
7 In 2018, the AMA continued to collaborate with state and specialty medical societies to ensure that  
8 patients have appropriate coverage for unanticipated out-of-network care. The AMA continues to  
9 promote coverage policies that are based on reasonable physician charges, to financially protect  
10 patients and promote fair contracting between physicians and insurers. AMA model legislation  
11 serves as the basis for many of these proactive efforts. Similarly, problematic state bills have been  
12 regularly defeated as the AMA and medical societies communicate to legislators about their impact  
13 on patient access to care and physician practice stability. The AMA has worked closely with state  
14 medical associations and the American College of Emergency Physicians (ACEP) to combat  
15 Anthem/BCBS policies that deny coverage for emergency care when the final diagnosis is  
16 determined to be non-emergent. Legislative restrictions were adopted in Missouri.

17  
18 *Modifier 25*

19  
20 At the 2017 Interim Meeting, the House of Delegates established new policy to advocate against  
21 payment reductions for evaluation and management (E/M) codes appropriately reported with a  
22 Current Procedural Terminology (CPT) modifier 25. Considerable concerns regarding this issue  
23 have been raised by many state medical associations and national medical specialty societies, most  
24 recently in regard to health insurer Anthem's proposed policy to reduce payments by 50 percent for  
25 E/M services billed with CPT modifier 25 when reported with a minor surgical procedure code  
26 beginning in the first quarter of 2018. Several other insurers have followed suit with similar  
27 proposals.

28  
29 Starting in November 2017, the AMA advocated directly to Anthem to halt this proposed move.  
30 The AMA sent a letter to Anthem expressing our concerns and hosted two meetings with AMA and  
31 Anthem senior leadership. During these discussions, the AMA voiced strong objections to this  
32 unwarranted reduction in physician payment and presented evidence showing that the  
33 recommendations of the AMA/Specialty Society Relative Value Scale Update Committee (RUC)  
34 do not include duplicative physician work or practice expense for procedures typically billed with  
35 an E/M service on the same date. Many state medical associations and national medical specialty  
36 societies also strongly advocated for Anthem to rescind this policy, which would impede the  
37 provision of unscheduled, medically necessary care. Following these combined efforts, Anthem  
38 withdrew its modifier 25 payment reduction. The AMA welcomed this news, as this policy would  
39 have had resulted in a \$100 million cut in physician payments nationwide.

40  
41 The AMA has continued advocacy on this issue, to include provision of supporting documentation  
42 to assist medical societies in successfully fighting implementation of modifier 25 payment  
43 reductions by Blue Cross Blue Shield of Michigan and Health Net in California. This will be an  
44 ongoing campaign, and the AMA will engage national commercial insurers and governmental  
45 entities considering similar policies involving modifier 25 or other CPT modifiers. The Centers for  
46 Medicaid & Medicare Services proposed a new application of the Modifier 25 policy as part of the  
47 Evaluation and Management coding proposals. In comments on the proposed rule, the AMA  
48 stressed that these reductions were inappropriate and if advanced would necessitate an extensive  
49 review of related codes to assure that services were accurately valued.

1 *Opioid epidemic*

2  
3 The opioid epidemic continues to have a devastating effect on our nation; however, there are signs  
4 of progress in physicians' actions to help end this public health epidemic. The AMA Opioid Task  
5 Force issued a report in June 2018 highlighting some of this progress:

- 6  
7 • Between 2013 and 2017, the number of opioid prescriptions decreased by more than 55 million  
8 —or 22.2 percent;
- 9 • Use of prescription drug monitoring programs (PDMPs) is growing—more than 300 million  
10 queries were made in 2017;
- 11 • Naloxone prescriptions more than doubled in 2017, from approximately 3,500 to 8,000  
12 dispensed per week;
- 13 • More than 549,000 physicians and other health care professionals completed continuing  
14 medical education (CME) trainings and other Federation education resources in 2017; and
- 15 • Finally, the number of physicians trained/certified to provide buprenorphine in-office continues  
16 to rise—more than 50,000 physicians are now certified—a 42 percent increase in the past 12  
17 months.

18  
19 Attention to the need for increased access to Medication Assisted Therapy (MAT) resources is a  
20 top priority in 2018—as is calling on health insurers to eliminate PA requirements and other  
21 barriers to MAT as well as enhancing access to comprehensive, multidisciplinary treatments for  
22 pain, including non-opioid alternatives. AMA model state legislation can help address these and  
23 other related areas.

24  
25 At the federal level, Congress enacted the Consolidated Appropriations Act of 2018 which includes  
26 nearly \$4 billion for prevention, treatment, and law enforcement efforts targeted at addressing the  
27 opioid epidemic. The AMA has been calling for increased federal funding for several years.

28  
29 In 2018, the AMA offered background, analysis, and technical support to at least 25 states as they  
30 addressed the opioid epidemic. This includes support for bills aligned with AMA policy, and  
31 efforts to amend or defeat bills with negative provisions. The AMA also continues to maintain and  
32 update the AMA opioid microsite, [www.end-opioid-epidemic.org](http://www.end-opioid-epidemic.org), with more than 400 education  
33 and training resources specific to state and specialty societies.

34  
35 *Pharmaceutical cost transparency*

36  
37 In 2018, the AMA is encouraging patients and physicians to share their stories about the impact of  
38 drug pricing and is urging state medical associations to advance AMA model legislation to increase  
39 transparency requirements on payers, pharmacy benefit managers and pharmaceutical  
40 manufacturers. The AMA also updated the Truthinrx.org website and continues to issue regular  
41 updates through the Patients Action Network (PAN) and the Physicians Grassroots Network (PGN)  
42 social media channels. The campaign is well-positioned to engage grassroots pressure in favor of  
43 positive reform-minded legislation once it materializes.

44  
45 In May of 2018, the Trump Administration issued a Blueprint for addressing the problem, which is  
46 a high priority for the Secretary of HHS, Alex Azar. While the Blueprint lacks detail on key issues,  
47 it appears the focus will be on limited regulatory actions that the Administration can take without  
48 action by Congress.

49  
50 The AMA commented on the Blueprint, and expressed strong support for a select number of  
51 provisions: (1) requiring pharmaceutical supply chain transparency; (2) accelerating and expanding

1 regulatory action to increase pharmaceutical market competition and combat anti-competitive  
2 practices; (3) ensuring prescribers have accurate point-of-care coverage and patient cost-sharing  
3 information as part of their workflow, including in the electronic health record (EHR); and  
4 (4) ensuring federal programs and commercial practices billed as lowering prescription medication  
5 prices do so for patients directly. The AMA identified and expressed concern about Blueprint  
6 proposals that would increase patient costs and erect barriers, including onerous insurer paperwork  
7 requirements that impede timely patient access to affordable and medically necessary medications  
8 and treatments. Further, the AMA opposes policies that would financially penalize physicians and  
9 pharmacists for high cost prescription medication.

10  
11 The AMA also sent a letter of support to the Hill for S. 2554, which would prohibit the use of gag  
12 clauses in a manner the AMA strongly supports and would provide the Federal Trade Commission  
13 with clear authority to combat pay for delay agreements entered into between biological/biosimilar  
14 companies.

15  
16 The AMA has also been working to influence legislative efforts at the state level to address drug  
17 costs, often by questioning the business practices and value equation that pharmacy benefit  
18 managers (PBMs) add to the system. The AMA has been engaged in the development of model  
19 bills by both the National Association of Insurance Commissioners (NAIC) and the National  
20 Conference of Insurance Legislators (NCOIL) to better regulate PBM practices. Additionally,  
21 nearly 20 states have now enacted legislation to allow pharmacists to discuss drug costs and  
22 payment options with patients (gag clause legislation)—policies supported by the AMA and  
23 outlined in AMA model legislation.

#### 24 25 *Gun violence*

26  
27 After another series of tragic mass shootings, the AMA renewed the call for the U.S. Centers for  
28 Disease Control and Prevention (CDC) to investigate the root causes of gun violence. There is  
29 concern that the CDC is prohibited from conducting this research, but the Dickey Amendment only  
30 prohibits the CDC from using appropriated funds “to advocate or promote gun control.” The AMA  
31 urged Congress to earmark appropriations specifically for gun violence research efforts. It also  
32 commented on proposed regulations issued by the Department of Justice on so-called “bump  
33 stocks.”

34  
35 As the push for federal funding continues, the AMA recently partnered with the American  
36 Foundation for Firearm Injury Reduction in Medicine (AFFIRM), a physician-led, non-profit  
37 organization that aims to counter the lack of federal funding for gun violence research by  
38 sponsoring gun violence research with privately-raised funds. AMA Trustee, Albert Osbahr, III,  
39 MD, is on AFFIRM’s steering committee; other physician group partners include the American  
40 College of Surgeons, American College of Emergency Physicians, and the Massachusetts Medical  
41 Society. More information about the group can be found at [www.affirmresearch.org](http://www.affirmresearch.org).

42  
43 In 2018, nine states (Kansas, Louisiana, Maryland, New York, Ohio, Oregon, Utah, Vermont and  
44 Washington) enacted laws restricting access to firearms for individuals convicted of domestic  
45 violence or subject to a restraining order due to domestic violence. Delaware, Florida, Illinois,  
46 Maryland, Massachusetts, New Jersey, Rhode Island and Vermont passed laws establishing gun  
47 violence restraining orders. Nine states (Connecticut, Delaware, Florida, Hawaii, Maryland, New  
48 Jersey, Rhode Island, Vermont, and Washington) banned bump stocks. Finally, Florida, Louisiana,  
49 New Jersey, Oregon, Tennessee and Vermont strengthened background check requirements.

1 The AMA adopted several policies on gun violence at its 2018 Annual Meeting and will continue  
2 to seek opportunities at the federal and state levels to advance new and existing AMA policy on  
3 this topic:

- 4
- 5 • Advocating for schools as gun-free zones;
- 6 • Calling for a ban on the sale of assault-type weapons, high-capacity magazines;
- 7 • Expanding domestic violence restraining orders to include dating partners;
- 8 • Removing firearms from high-risk individuals;
- 9 • Supporting an increase in legal age of purchasing ammunition and firearms from 18 to 21;
- 10 • Opposing federal legislation permitting “concealed carry reciprocity” across state lines; and
- 11 • Supporting gun buyback programs in order to reduce the number of circulating, unwanted  
12 firearms.

13  
14 *Scope of Practice*

15  
16 Policy adopted at the 2017 Interim Meeting called on the AMA to convene a meeting of relevant  
17 physician stakeholders to create a consistent national strategy to effectively oppose efforts to grant  
18 independent practice to non-physician practitioners. To implement this directive, the AMA hosted  
19 a summit at AMA headquarters in March 2018. The Scope of Practice Partnership (SOPP)  
20 provided funding to support the summit. Eighty-one physicians, executive staff, and government  
21 affairs staff from 32 state medical associations, 16 national medical specialty societies, and the  
22 American Osteopathic Association joined AMA leadership and staff at the summit. The strategy  
23 resulting from this meeting was discussed in detail at the A-18 SOPP meeting and will guide our  
24 ongoing advocacy efforts.

25  
26 In 2018, there was a great deal of concern about the Advanced Practice Registered Nurse (APRN)  
27 Compact, a multistate licensure compact developed by the National Council of State Boards of  
28 Nursing (NCSBN). It establishes a process by which an APRN with certain credentials can receive  
29 a multistate license that allows the APRN to practice in any APRN Compact member state. APRNs  
30 practicing under this multistate license can practice and prescribe independently, despite any state  
31 law to the contrary. Idaho, North Dakota, and Wyoming have joined the APRN Compact, which  
32 will go into effect if 10 states join. Due to AMA and Federation efforts, bills were defeated in  
33 Iowa, Minnesota, Nebraska, and no further APRN Compact bills were enacted in 2018.

34  
35 *Immigration*

36  
37 Based on policy adopted at A-18, the AMA wrote to the Administration to withdraw its “zero  
38 tolerance” immigration policy and to stop separating children from their families. The fear is that  
39 Administration’s policy will do great harm to children and their parents or caregivers. The AMA  
40 sent the letter to the secretaries of the Homeland Security and Health and Human Services  
41 departments, as well as the U.S. Attorney General. The letter pointed out that childhood trauma and  
42 adverse childhood experiences created by inhumane treatment often create negative health impacts  
43 that can last an individual’s entire lifespan. The president subsequently issued an executive order  
44 reversing the Administration’s position on separating children. The AMA is closely monitoring the  
45 reunification of parents and children.

46  
47 The AMA also voiced concerns in a letter to the Director of the U.S. Citizenship and Immigration  
48 Services about delays in H-1B visa processing due to increased inspection of prevailing wage data  
49 for incoming non-U.S. international medical graduates (IMGs) who have accepted positions in U.S.  
50 Graduate Medical Education (GME) programs.

1 *Cybersecurity*  
2

3 The AMA has been raising awareness of cybersecurity threats to physician practices. Last year, an  
4 AMA/Accenture survey of 1300 physicians found that phishing and viruses are the most common  
5 types of cyberattacks encountered by small practices. Viruses often appear as a result of software  
6 that is not regularly updated or “patched.” To assist physicians, the HHS Office for Civil Rights  
7 (OCR) issued a monthly newsletter devoted to cybersecurity issues. In addition to encouraging the  
8 federal government to issue additional guidance like this to physicians, the AMA continues to urge  
9 stakeholders—including health information technology vendors—to pay special attention to the  
10 needs of small and mid-sized practices, which often lack the resources that larger practices and  
11 health systems enjoy.  
12

13 *Protecting the patient-physician relationship*  
14

15 In response to the Administration’s plan to withhold federal family planning funding from Planned  
16 Parenthood and other entities, the AMA issued a statement and submitted comments strongly  
17 objecting to the policy change, asserting that it interferes with patient-physician relationships and  
18 negatively affects quality of care. The HHS announcement specifically noted that the regulation  
19 update “would prohibit referral for abortion as a method of family planning.” The proposal would  
20 also endanger access to care that the Title X program has helped to facilitate. Title X has helped to  
21 expand access to basic reproductive health care like birth control, cancer screenings, STI testing  
22 and treatment, and exams. The program serves roughly 4 million people every year, many of whom  
23 would otherwise be unable to access care. The AMA’s stance on this issue is in keeping with its  
24 longstanding position on maintaining patient choice and physician freedom to practice in the  
25 setting they choose, and reflects a broader commitment to protecting free communication between  
26 patients and physicians.  
27

28 *Physician conscience rights*  
29

30 In 2018, HHS issued a Notice of Proposed Rulemaking on “Protecting Statutory Conscience Rights  
31 in Health Care; Delegations of Authority.” In response, the AMA sent a letter to Secretary Azar to  
32 express opposition to the measure, citing concern for vulnerable patient populations and asserting  
33 that conscience rights for physicians are not unlimited. The proposed rule would dramatically  
34 expand the discretion that religious or moral objectors have to refuse care without meaningful  
35 safeguards to ensure that the rights of those receiving care are protected. The rule is part of a  
36 broader Administration effort to protect religious rights and follows the announcement in late  
37 January of the creation of a new office within the Office of Civil Rights (OCR), the Conscience  
38 and Religious Freedom Division. The AMA is alarmed because if implemented, the rule would  
39 function as a shield for people asserting objections on religious or moral grounds and could permit  
40 them to withhold care from already vulnerable groups and create confusion in health care  
41 institutions. While the AMA is committed to conscience protections for physicians and other health  
42 professional personnel, the exercise of those rights must be balanced against the fundamental  
43 obligations of the medical profession and physicians’ paramount responsibility and commitment to  
44 serving the needs of their patients.  
45

46 *Equality issues*  
47

48 Five states (Delaware, Hawaii, Maryland, New Hampshire, and Washington) enacted laws  
49 opposing “conversion therapy.” AMA policy strongly opposes conversion therapy, and the AMA  
50 stands ready to work with state medical associations interested in pursuing a ban on this harmful  
51 practice.

1 In addition, the AMA advocated before the U.S. Department of Veterans Affairs and the  
2 Department of Defense on coverage for transgender-related health care services.

3  
4 *Tobacco*

5  
6 The AMA along with more than a dozen other physician groups sent a letter to ranking members of  
7 the Senate and House appropriations committees urging them to oppose any provisions that weaken  
8 or delay the U.S. Food and Drug Administration's (FDA) ability to regulate any and all tobacco  
9 products. Responding to provisions passed by the House in recent years that exempt thousands of  
10 tobacco products—including many candy- and fruit-flavored products now favored by teens—from  
11 the scientific review process mandated by the Family Smoking and Prevention Tobacco Control  
12 Act is cause for concern as 11.3 percent of high school students in 2016 reported using e-cigarettes  
13 during the last 30 days. Under these House provisions, many tobacco products that the FDA had  
14 only just begun to regulate, such as e-cigarettes and cigars, would be exempted from a product  
15 review if they were on the market prior to Aug. 8, 2016. The oft-cited reason for these provisions is  
16 the ability of e-cigarettes to help smokers quit traditional cigarettes; however, the efficacy of this is  
17 not yet proven by the research.

18  
19 At the state level, Maine and Oregon raised the tobacco purchase age to 21. Five states now have  
20 this requirement. California, Hawaii, and New Jersey enacted laws in previous sessions.

21  
22 *Economic Impact Study*

23  
24 At the beginning of 2018, the AMA released its updated Economic Impact Study. The report gives  
25 policymakers concrete evidence demonstrating how their local communities tangibly benefit when  
26 they support legislation that helps physician practices thrive. The 2018 study found that nationally:

- 27  
28 • Physicians support nearly 12.6 million jobs. On average, each physician supports more than 17  
29 jobs;  
30 • Physicians create a total of \$2.3 trillion in economic output, comprising about 13 percent of the  
31 total U.S. economy. On average, each physician supports \$3.2 million in economic output;  
32 • Physicians contribute more than \$1 trillion in wages and benefits for all supported jobs. On  
33 average, physicians support \$1.4 million in total wages and benefits per physician; and  
34 • Physicians support \$92.9 billion in state and local tax revenues—approximately \$126 thousand  
35 per physician on average.

36  
37 *AMPAC Activities*

38  
39 AMPAC has once again worked closely with its state medical association PAC partners this  
40 election cycle on contribution support decisions for candidates running Congress. A report  
41 summarizing AMPAC activities will be distributed at the Interim Meeting in National Harbor.

42  
43 **CONCLUSION**

44  
45 Once again, the AMA has delivered some significant advocacy victories in a challenging political  
46 environment. The outcome of the 2018 elections is unknown at the time this report was prepared,  
47 but the AMA is poised to work with both sides of the aisle in 2019 to advance the interests of  
48 patients and physicians on the most critical health care issues. The AMA thanks its Federation  
49 partners for their collaboration and support and looks forward to tackling medicine's biggest issues  
50 when newly elected state and federal officials take office in January.