AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: MB 1&2
(I-19)

Introduced by:

Subject: AMA Position on Payment Provisions in Health Insurance Policies

Referred to: Reference Committee on

Whereas, certain health insurance policies require payments be sent to patients rather than physicians, and

Whereas, these policies occur primarily in out-of-network care settings, making it more difficult for the physician to collect payment for service rendered to the patient; and

Whereas, health insurance companies are more frequently inserting provisions into their plan documents that prevent a patient from assigning their benefits to their doctor, and

Whereas, such 'anti-assignment' provisions significantly harm both doctor and patient, are fundamentally unfair and have benefit only for the insurance company, therefore, be it

Resolved, that the AMA will seek legislation to ban anti-assignment provisions in health insurance plans; and be it further

Resolved, that the AMA support legislation requiring health insurers to issue payment directly to the physician when the patient or patient representative signs an agreement which permits payment directly to the physican.

Current AMA Policy

Health Plan Payment of Patient Cost-Sharing D-180.979

Our 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 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 (eg, 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.

Requiring Third Party Reimbursement Methodology be Published for Physicians H-185.975
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 to the terms of the contract, the contract may not be used by any other payer.

Authorized Assignment of Benefits D-390.995
Our AMA will seek: (1) legislation or regulation, or develop model state legislation to ensure that third party payers be required to issue payment directly to providers when the patient has signed an authorization for the assignment of benefits; and (2) legislative relief mandating that health plans notify physicians when claim **payments** are issued to the insured rather than the **physician** who has an assignment agreement.

Update on HSAs, HRAs, and Other Consumer-Driven Health Care Plans H-165.849
1. Our AMA opposes health plan requirements that require physicians to bill patients for out-of-pocket **payments** and do not allow physicians to collect these **payments** in a more efficient manner, such as collecting at point-of-service, establishing systems of electronic transfers from a patient's account, or offering cash discounts for expedited payment, particularly for patients enrolled in health savings accounts (HSAs), health reimbursement arrangements (HRAs), and other consumer-directed health care plans.
2. Our AMA will engage in a dialogue with health plan representatives (e.g., America"s Health Insurance Plans, Blue Cross and Blue Shield Association) about the increasing difficulty faced by **physician** practices in collecting co-**payments** and deductibles from patients enrolled in high-deductible health plans.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: MB 4 added
(I-19)

Introduced by:

Subject: AMA Should Provide a Summary of Its Advocacy Efforts on Surprise Medical Bills

Referred to: Reference Committee on

Whereas, there has recently been very significant legislative activity in regards to surprise medical bills and balance billing, critically important issues for physicians, and

Whereas, insurance companies have tried to use the issue of surprise medical bills to essentially outlaw all physician billing, which would be devastating to the medical profession, and

Whereas, physicians rarely get to understand the efforts that the AMA makes in regards to advocacy, and

Whereas, if this effort were more transparent it would help physicians to appreciate what has been done and would also allow consideration of what might be done better in the future, therefore, be it

Resolved, that the AMA will provide a detailed report of its efforts and those of its opponents on the issue of surprise medical bills in 2019; this discussion should include the following points comparing the AMA activity vs that of its opponents (the insurance companies):

1) What testimony was provided at various committee meetings?
2) What letters were written to various legislators?
3) What grass roots efforts were performed?
4) What other groups supported the efforts
5) What other groups were recruited to support the efforts?
6) What media efforts were performed?
7) What television ads were run?
8) What radio ads were run?
9) What print ads were run?
10) What op-ed pieces were run, in national journals, Washington journals, and regional publications?
11) What meetings occurred with various legislators?
12) What meetings occurred with members of the administration?
13) How much money was spent on the various efforts?
14) What studies were published in insurance journals, medical journals, and other journals on this matter?
15) Which senators and representatives and administration members could either side count on as solid supporters?
16) What level of collaboration was there with other national, state, and specialty societies and how was this carried out?

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: MB21
(I-19)

Introduced by:

Subject: AMA Will Specifically Seek to Improve the Current Medicare Fee Schedule for Physicians

Referred to: Reference Committee on

Whereas, the current Medicare fee schedule for physicians is completely inadequate and completely detached from reality, and

Whereas, insurers and hospitals and policymakers often refer to the Medicare fee schedule as if there was some actual meaning or significance to these numbers, and suggest that these figures somehow represent the appropriate payment for services, therefore, be it

Resolved, that while in the process of trying to repair the Medicare fee schedule for physician professional fees, that the AMA specifically discredit the Medicare fee schedule as currently inadequate and defective.

Current AMA Policy

AMA advocacy platform

https://physiciansgrassrootsnetwork.org/be-heard?vvsrc=%2fcampaigns%2f67832%2frespond

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.(A-19)

Uncoupling Commercial Fee Schedules from Medicare Conversion Factors H-400.946

Our AMA urges that uncoupling of commercial fee schedules from Medicare conversion factors should persist until such time as our AMA determines that a new and acceptable formula for computation of the Medicare conversion factors has been implemented. (A-18)

Physician Payment Reform H-400.972

It is the policy of the AMA to (1) take all necessary legal, legislative, and other action to redress the inequities in the implementation of the RBRVS, including, but not limited to, (a) reduction of allowances for new physicians; (b) the non-payment of EKG interpretations; (c) defects in the Geographic Practice Cost Indices and area designations; (d) inappropriate Resource-Based Relative Value Units; (e) the deteriorating economic condition of physicians' practices disproportionately affected by the Medicare payment system; (f) the need for restoration of the RBRVS conversion factor to levels consistent with the statutory requirement for budget neutrality; (g) the inadequacy of payment for services of assistant surgeons; and (h) the loss of surgical-tray benefit for many outpatient procedures (Reaffirmed by Rules & Credentials Cmt. A-96);
(2) seek an evaluation of (a) stress factors (i.e., intensity values) as they affect the calculation of the Medicare Payment Schedule, seeking appropriate, reasonable, and equitable adjustments; and (b) descriptors (i.e., vignettes) and other examples of services used to determine RBRVS values and

payment levels and to seek adjustments so that the resulting values and payment levels appropriately pertain to the elderly and often infirm patients;

(3) evaluate the use of the RBRVS on the calculation of the work component of the Medicare Payment Schedule and to ascertain that the concept for the work component continues to be an appropriate part of a resource-based relative value system;
(4) seek to assure that all modifiers, including global descriptors, are well publicized and include adequate descriptors;
(5) seek the establishment of a reasonable and consistent interpretation of global fees, dealing specifically with preoperative office visits, concomitant office procedures, and/or future procedures;
(6) seek from CMS and/or Congress an additional comment period beginning in the Fall of 1992;
(7) seek the elimination of regulations directing patients to points of service;
(8) support further study of refinements in the practice cost component of the RBRVS to ensure better reflection of both absolute and relative costs associated with individual services, physician practices, and medical specialties, considering such issues as data adequacy, equity, and the degree of disruption likely to be associated with any policy change;
(9) take steps to assure that relative value units in the Medicare payment schedule, such as nursing home visits, are adjusted to account for increased resources needed to deliver care and comply with federal and state regulatory programs that disproportionately affect these services and that the Medicare conversion factor be adjusted and updated to reflect these increased overall costs;
(10) support the concepts of HR 4393 (the Medicare Geographic Data Accuracy Act of 1992), S 2680 (the Medicare Geographic Data Accuracy Act of 1992), and S 2683 (Medicare Geographic Data Accuracy Act) for improving the accuracy of the Medicare geographic practice costs indices (GPCIs) and work with CMS and the Congress to assure that GPCIs are updated in as timely a manner as feasible and reflect actual physician costs, including gross receipt taxes;
(11) request that CMS refine relative values for particular services on the basis of valid and reliable data and that CMS rely upon the work of the AMA/Specialty Society RVS Updating Committee (RUC) for assignment of relative work values to new or revised CPT codes and any other tasks for which the RUC can provide credible recommendations;
(12) pursue aggressively recognition and CMS adoption for Medicare payment schedule conversion factor updates of an index providing the best assurance of increases in the monetary conversion factor reflective of changes in physician practice costs, and to this end, to consider seriously the development of a "shadow" Medicare Economic Index;
(13) continue to implement and refine the Payment Reform Education Project to provide member physicians with accurate and timely information on developments in Medicare physician payment reform; and
(14) take steps to assure all relative value units contained in the Medicare Fee Schedule are adjusted as needed to comply with ever-increasing federal and state regulatory requirements. (A-19)

Transparency, Participation, and Accountability in CMS' Payment Determination Process D-400.984
1. Our AMA will urgently advocate for the Centers for **Medicare** and Medicaid Services (CMS) to improve its rate-setting processes by first publishing modifications to Medicare physician fees that result from CMS' misvalued codes initiative in the Medicare Physician Fee Schedule proposed rule instead of the final rule to afford adequate time for providers, professional medical societies and other stakeholders to review and comment on such changes before they take effect.
2. Our AMA will demand that CMS be transparent in its processes and methodologies for establishing physician work values and allow adequate opportunity for public comment on its methodologies before changes in physician work values take effect. (A-14)

Sustainable Growth Rate Repeal D-390.953
1. Our AMA supports SGR repeal and continues to strongly advocate for the AMA's Pay-for-Performance Principles and Guidelines (AMA Policy H-450.947).
2. Our AMA will advocate with CMS and Congress for alternative payment models, developed in concert with specialty and state medical organizations, including private contracting as an option.
3. Our AMA will continue to advocate for future positive updates in the Medicare physician fee schedule. (A-19)