ILLINOIS STATE MEDICAL SOCIETY

Resolution 12.2022-35
(A-23)

Introduced by: John V. Prunskis, MD, ISMS Member

Subject: Medicare Advantage Policies to Offer Same Access to Procedures as Traditional Medicare

Referred to: Council on Economics

---

1 Whereas, Medicare Advantage policies frequently do not allow its members to
2 receive the same procedures that traditional Medicare allows a patient to benefit from;
3 and
4
5 Whereas, this has a detrimental effect to the health and access to care of Medicare
6 advantage policy holders in certain situations; and
7
8 Whereas, some now refer to the Medicare Advantage policies as "Medicare
9 Disadvantage" policies since they frequently restrict patients from getting necessary
10 procedures and access to the medical care they need; therefore, be it
11
12 RESOLVED, that the Illinois State Medical Society support as policy and
13 introduce legislation to mandate that Medicare Advantage policies must offer its
14 members the same access to procedures that traditional Medicare policies allow; and be
15 it further
16
17 RESOLVED, that the Illinois delegation to the AMA introduced a similar
18 resolution directing the AMA to adopt as policy and introduce national legislation on
19 this issue as well.

Fiscal Note:

None

<u>Existing ISMS policy related to this issue:</u>

It is the policy of ISMS that all CDC/ACIP-recommended vaccines should be included for all Medicare enrollees, including those in traditional Medicare and in Medicare Advantage programs, with no out-of-pocket cost. (HOD 2015)

House of Delegates adopted Resolution B223 (A-16) which calls for ISMS to: Draft legislation that creates network adequacy rules modeled on those proposed by the American Medical Association (AMA) to the Centers for Medicare & Medicaid Services' Acting Administrator Andrew Slavitt in the Jan. 14, 2016, letter titled, "Re: Draft 2017 Letter to Issuers in the Federally Facilitated Marketplaces;" Draft legislation mandating adequate network directories, modeled on the AMA model bill titled, "Meaningful Access to Accurate Provider Directories;" Draft legislation that provides adequate out-of-network notification and payment structures, modeled on the AMA model bill titled, "Truth in Out of Network Healthcare Benefits Act;" Draft legislation to protect patients from out-of-network charges that were incurred due to emergency care or charges that were incurred without prior notification, similar to the "Surprise Medical Bill" law enacted in the State of New York; Draft legislation that provides a transparent and efficient appeals process for coverage and claim disputes with insurers for patients and providers, utilizing a third-party mediator when necessary, modeled on the "Surprise Medical Bill" law enacted in the State of New York; Draft legislation that mandates that insurers provide 90-day advance notice to current enrollees prior to the open enrollment time period, case management services for transition of care to in-network providers, and a 90-day period of additional coverage for those patients affected by an insurer's elimination of an insurance product or narrowing of their network within an insurance product. (HOD 2016)

House of Delegates adopted Resolution 59 (A-03), which directed that the ISMS submit a resolution to the AMA urging Medicare to include a section in its beneficiary manual specifically listing the services that are not covered by Medicare, including but not limited to: screening physician exams, screening blood tests including cholesterol panels, prescription medications, cosmetic procedures and services provided for the convenience of the patient or family; and that the ISMS submit a resolution to the AMA urging Medicare to list in its beneficiary manual the penalties for physicians who defraud or abuse Medicare benefits seeking to have non-covered services paid by Medicare misrepresenting services as medically necessary; and that the ISMS submit a resolution to the AMA urging Medicare to include information in its beneficiary manual explaining the limits on physician charges imposed by Medicare and the fact that supplemental insurance covers only the portion of the Medicare-approved charge not covered by Medicare. (HOD 2003)

Existing AMA policy related to this issue:

Medicare Advantage Policies H-330.878

1. Our AMA supports that Medicare Advantage plans must provide enrollees with coverage for, at a minimum, all Part A and Part B original Medicare services, if the enrollee is entitled to benefits under both parts.

2. Our AMA will advocate: (a) for better enforcement of Medicare Advantage regulations to hold the Centers for Medicare & Medicaid Services (CMS) accountable for presenting transparency of minimum standards and to determine if those standards are being met for physicians and their patients; (b) that Medicare Advantage plans be required to post all components of Medicare covered and not covered in all plans across the US on their website along with the additional benefits provided; and (c) that CMS maintain a publicly available database of physicians in network under Medicare Advantage and the status of each of these physicians in regard to accepting new patients in a manner least burdensome to physicians.

Prevent Medicare Advantage Plans from Limiting Care D-285.959

Our AMA will: (1) ask the Centers for Medicare and Medicaid Services to further regulate Medicare Advantage Plans so that the same treatment and authorization guidelines are followed for both fee-for-service Medicare and Medicare Advantage patients, including admission to inpatient rehabilitation facilities; and (2) advocate that proprietary criteria shall not supersede the professional judgment of the patient's physician when determining Medicare and Medicare Advantage patient eligibility for procedures and admissions.