

AMERICAN MEDICAL ASSOCIATION
BOARD OF TRUSTEES MEETING
SUMMARY AND HIGHLIGHTS

June 7-14, 2017

AMA Headquarters
Chicago, IL

Members of the Board Present

Patrice A. Harris, MD, MA, Chair
Gerald E. Harmon, MD, Chair-Elect
Stephen R. Permut, MD, JD, Immediate Past Chair
Andrew W. Gurman, MD, President
David O. Barbe, MD, MHA, President-Elect
Steven J. Stack, MD, Immediate Past President
Jack Resneck, Jr., MD, Secretary
Susan R. Bailey, MD, Speaker, House of Delegates
Bruce A. Scott, MD, Vice Speaker, House of Delegates
Maya A. Babu, MD, MBA
Willarda V. Edwards, MD, MBA
Jesse M. Ehrenfeld, MD, MPH
William E. Kobler, MD
Russell W.H. Kridel, MD
Omar Z. Maniya, MBA
Barbara L. McAneny, MD
William A. McDade, MD, PhD
Albert J. Osbahr, III, MD
Carl A. Sirio, MD
Georgia A. Tuttle, MD
Kevin W. Williams

Senior Management

James L. Madara, MD, Executive Vice President, CEO
Bernard L. Hengesbaugh, Chief Operating Officer
Brian D. Vandenberg, JD, General Counsel
Howard Bauchner, Editor-in-Chief, JAMA Network, Senior Vice President, Scientific Publications
Robert W. Davis, Senior Vice President, Human Resources and Corporate Services
Richard A. Deem, Senior Vice President, Advocacy
Thomas J. Easley, Senior Vice President and Publisher, Periodical Publications
Denise M. Hagerty, Chief Financial Officer and Senior Vice President, Finance
Laurie A.S. McGraw, Senior Vice President, Business Solutions
Kenneth Sharigian, PhD, Senior Vice President, Chief Strategy Officer
Rodrigo A. Sierra, Senior Vice President, Chief Communications & Marketing Officer
Todd D. Unger, MBA, Chief Experience Officer and Senior Vice President, Physician Engagement
Leslie Weber, Senior Vice President, Senior Vice President and Chief Information Officer
Modena H. Wilson, MD, MPH, Senior Vice President, Chief Health and Science Officer
Jon Burkhardt, Chief of Staff, Vice President, Executive Offices

The Board meeting was called to order at 9:15am (Central) on Wednesday, June 7, 2017 by the Chair, Patrice A. Harris, MD, MA. Dr. Harris commented on the projects that have been completed in the past year, those that are in progress or are ongoing, on the items in the “parking lot” for

future discussion, lessons learned during previous Board development sessions; and reviewed briefly the Board Norms and Principles.

- **Meeting Overview & Metrics** – The Board **heard** a brief recap from James L. Madara, MD, EVP, CEO of the April Board meeting presentations including: the CLRPD Stakeholder Report; Membership, The Joint Commission, and the Strategic Focus areas, noting that an in-depth update on ACE, the Education Center and PS2 will be done at this meeting, and a deeper dive will be done on Health2047 and IHO at the July Planning Retreat and September Board meeting, respectively. In addition, an update on the Dashboard was presented, and all initiatives are on track, with the exception of Membership, which is slightly down in dues-paying members through April 2017; the full range of metrics for each of our domains has been posted to the portal; and while operational metrics are important, measurement alone is not the only indicator of success; developing strategy is equally as important as implementing strategy. The Board also **heard** a presentation on the integrating conceptualization of the Strategic Arcs of: 1) Developing Critical Tools and Policies for the Field; 2) Guiding Professional Development; and 3) Solving the Chronic Care Dilemma; and the relationship to the Focus areas.
- **Strategy Update** – The Board **heard** brief updates on Improving Health Outcomes (IHO), Accelerating Change in Medical Education (ACE) and the Education Center (EC) and a more comprehensive briefing on Physician Satisfaction and Practice Sustainability (PS2) as summarized below:

IHO – The Board **heard** an update on IHO priorities including plans to: increase awareness among primary care physicians and patients; activate a scalable client service model to engage market-leading healthcare delivery systems and groups; prevent diabetes, control blood pressure and manage cholesterol; expand from 3 to 10 state medical societies and state business and coalitions funded and delivering client contacts and DPP coverage; ensure programs qualify as IAs under MIPS; secure coverage for home BP devices; and expand use of IHO content by ACE schools.

ACE – The Board **heard** an update on recent ACE activities including: six additional schools contracted for Regenstrief Clinical Learning Platform; seven schools (University of Washington, Penn State, Brown, California State University, Long Beach, and the University of Utah) using the ACE Health Systems Science (HSS) textbook; two new schools adopted the HSS exam; ACE webinar series launched; upcoming ACE meetings and conferences announced; and the newly published “Handbook on Faculty Coaching for Competency Achievement.”

EC – The Board **heard** an update from Modena Wilson, MD, MPH, SVP, Chief Health and Science Officer, on the EC vision and goals including: building a platform and infrastructure that can scale and deliver more compelling experiences to physicians; testing the viability of one or more model dimensions; advancing the EC user experience to promote frequent engagement; increasing the breadth and depth of EC content offering; transitioning from Introduction to the Practice of Medicine (IPM) to a new and improved platform – AMA GME Competency Education Program (GCEP) which includes 15 modules upgraded to a more engaging learning format; and executing a soft launch to a targeted audience and preparing for a full launch in 2018.

PS2 – The Board **heard** an in-depth update from Michael Tutty, PhD, Group Vice President, including: 20 PS2 staff members working on practice transformation, payment and quality, digital health, and professional development; developing more research on physician burnout in 2017, to be measured again in 2020 and 2023; collaborating with Advocacy to update/create new MACRA resources (Payment Model Evaluator, MACRA Action Plan and FAQs); designing and building AMA’s Payment and Quality Resource Center; convening communities with events such as Joy in Medicine Research Summit and Joy in Medicine CEO Summit; collaborating with MedStar to improve EHR usability; employing Xcertia industry guidelines to improve mHealth apps; and building online communities of physicians/residents/students through the Physician Network.

- **Brand and Marketing Campaign Update** – The Board **heard** an update from Rod Sierra, Senior Vice President, Chief Communications & Marketing Officer, on the brand and marketing campaign. The report noted that a brand initiative is rooted in a long-term commitment that: seeks to shift stakeholder perception, build brand equity that can create a willingness to listen and a willingness to act; is an ongoing analysis and optimization in order to establish and incorporate learnings; seeks engagement and input from students, residents and practicing physicians to co-create campaign evolution; and is measurable to ensure objectives are being met. The goal of brand initiative is to enhance brand perception from “trusted and respected” to also “credible and relevant to me.” Key drivers of success are identified as: Ambassadorship (increase in # of referrals and recommendations, increase in social shares and referrals); Emotion (increase in brand ratings vs. baseline, and increase in positive brand social sentiment); Membership (increase in perception of value of membership); Perception (increase in positive brand sentiment, and increase in awareness of/interest in new programs/offerings); and Behavioral Interaction (increase in digital, social & email engagement).
- **Customer Experience and Membership Update** – The Board **heard** a presentation from Todd Unger, CXO, SVP, Physician Engagement, including: building a best-in-class digital marketing machine driven by testing and data; optimizing membership landing page experience by providing single step sign-up and personal messaging; targeting high-potential AMA Insurance Agency customers; aggressive testing of email channel resulting in a 50% increase in performance; filling in the gap from direct mail responses with digital marketing; re-thinking target segmentation to go beyond the career and product based approach; and expanding advocacy messaging approach, built around interest and attitudes, which led to 469 new members.
- **Advocacy Update** – The Board **heard** a presentation from Rich Deem, SVP, Advocacy including: AMA was a principal voice in the health care debate, cited often in the news and repeatedly during House floor debate on American Health Care Act (AHCA); the partisan divide in Congress continues over support of AHCA, with Republicans having a more favorable view of the plan than Democrats or Independents; political challenges and key issues of the Senate surrounding AHCA; and current AMA advocacy activities regarding MACRA, regulatory relief efforts, Electronic Health Records, and the AMA Opioid Task Force.
- **Board of Trustee Reports to HOD at A-17** – The Board **considered** and **voted to approve** the following reports for transmittal to the House of Delegates at the 2017 Annual Meeting:

1. Protecting Patient Access to Health Insurance Coverage, Physicians, and Quality Health Care (Res. 205-I-16)
 2. Specialty Society Representation in the House of Delegates – Five Year Review
- **Young Physician Membership Dues Pilot** – The Board **considered** a request from management for approval to begin a test pilot program for young physician membership dues. The request included background noting that in the late 1970's and early 1980's, the AMA House of Delegates instituted a three-year phase-in to full physician dues rates for first year and second year in practice physicians. The dues rates \$210 and \$315 for first year and second year in practice, respectively, have been unchanged since 1994.

The Board **voted to approve** a test of a Young Physician Dues Pilot to learn if expanding the phase-in to full dues paying rates from two to four years, as outlined below, will improve membership acquisition and retention. The pilot would begin with the 2018 membership year and be offered to a test audience over a four-month period. If the test results in a significant response lift as compared to the control, we will report back and request approval for a broader roll out of the offer. If the test results in little to no improvement, the Board will be informed and the test will be discontinued.

- **Time Sensitive Dues Offer** – The Board **considered** a report from management noting that the Physician Engagement team is testing many elements of the membership direct marketing tactics including offers, content, creative and packaging. Physician Engagement/Membership would like the ability to test a purchase-now discount of up to 15% on individual membership dues with the hypothesis that creating urgency by offering a time sensitive discount will result in higher conversion rates. This approach would offer the test group the purchase-now membership price discount while the control group does not receive the price discount. It will be measured based on a significant lift in membership conversion of the test population compared to the control group.

By testing purchase-now membership price discounting in a controlled environment, we will quickly learn the efficacy of those discounts and report back to the Board of Trustees on the impact to our 2018 year end results along with a recommendation as to whether the test should be expanded or alternatively, adopted as a full-fledged pilot program.

The Board **voted to approve** the ability to offer a time sensitive AMA Membership Dues discount of up to 15% using a test and learn approach through the Direct Channel for 2018.

- **18-Month Group Membership Pilot** – The Board **considered** a report from management noting that the original Group Pilot was launched in 2010 with a 100% participation requirement. In August of that same year, the requirement was reduced to 75% and an Academic Leadership Pilot was added. In 2012, an additional discount tier was introduced to address the needs of larger groups. The Resident Group Pilot was added in 2013 to address the needs of institutions or societies that wanted to sponsor resident memberships but did not want to participate in the Introduction to the Practice of Medicine, now called the GME Competency Education Program (GCEP). In 2015, an extension of the GCEP program through December 31, 2018 was granted.

Originally, the GCEP program had a 12-month contract cycle and in 2011, an 18-month contract was approved by the Board. We confirmed the hypothesis that an 18-month initial contract period would extend the viable sales time and support growth, with an increase in residency programs from 8 in 2010 to 37 programs in 2011.

Currently, the opportunity for new group sales ends in May due to the timing of our calendar based membership year and the reluctance of groups to pay for a full year of dues when only 6 months or less remain in the current year. These leads are then pursued for the next membership cycle. We would like to extend the sales cycle for the Group Pilot program by offering an 18-month option.

The proposed dues structure would provide a half-year dues rate for the initial membership “year” covered by the Group Pilot Program contract and a full year rate for the second year. The 18-month option extends the viable sales timeframe each year to support growth in the Group Channel and better aligns with the academic calendar year to make it more attractive to groups who qualify for the Academic Leadership Pilot Program. The membership would revert back to the standard dues structure after the initial period.

The Board **voted to approve** implementation of an 18-month Group Membership Pilot Program (encompassing the original Group Pilot, the Academic Leadership Pilot, and the Resident Group Pilot) membership agreement for new physician and resident groups that begin on or after July 1 of the current membership year.

- **Growth by Design and IHMI Update** – The Board **heard** a presentation from Laurie McGraw, SVP, Health Solutions, on the Growth by Design Framework and new Integrated Health Model Initiative (IHMI) including: the need for an infrastructure that supports interoperability between medical terminologies; the fact that the AMA can convene medicine and technology around market-driven solutions that are meaningful to clinical practice; IHMI is a master coding system that semantically integrates existing code sets and enables the aggregation of clinically valid data to 1) inform patient and physician decisions; 2) assemble longitudinal health records; 3) define, compute, and compare outcomes; and 4) develop and evaluate new care and payment models for quality care.
- **AMA Diversity Initiatives** – The Board **heard** a report from Robert W. Davis, Senior Vice President, Human Resources and Corporate Services, which highlighted the AMA’s diversity initiatives, both internal and external. At the AMA we believe diversity is not just about race, gender, disability or veterans status, which are areas where we are required to track for the government; it’s more about how these factors in addition to age, religion, sexual orientation, nationality all work together to shape and form individual: 1) thoughts/ideas; 2) skills; 3) perspectives, 4) experiences; and 5) approaches. All of this adds a richness that inclusion brings to the work and to our colleagues. AMA workforce dynamics initiatives include: 1) talent management (affirmative action and outreach); 2) relationships (Rehabilitation Institute; participation in job fairs including veterans; and a new internal veterans employee group which began in 2016); and 3) the new 2017 “Unconscious Bias” training initiative.

Highlights of the external initiatives included: 1) launched Health Equity video at National Minority Forum (exposure to more than 200 organizations); 2) spearheaded development of Health Equity Strategy Initiative, a framework for advancing an enterprise-wide strategy to

increase access to care and coverage for vulnerable populations, preparing physicians to work with diverse communities and increasing workforce diversity in medicine; 3) increased HOD delegate representation among all minorities and significantly increased representation of minority alternate delegates within the Hispanic population; 4) added open-ended diversity personal statement and demographic questions to the 2017 AMA Nomination form to ensure the capture of all aspects of diversity and inclusion; and 5) implemented diversity and inclusion core values within the Brand Campaign.

The presentation noted that the AMA must strive to be an organization that is mindful of and responsive to the diversity of its employees, members and the patient population we serve; an organization in which diversity and inclusion are integral and inherent to the success of its mission. Efforts to accomplish this include: 1) identifying focus areas in which diversity and inclusion initiatives can contribute to the overarching strategy; 2) leveraging market analysis to learn and apply diversity messaging among its customers; 3) leading brand positioning and messaging; and 4) advocacy.

- **JAMA Network** – The Board **heard** a presentation from Howard Bauchner, MD, Editor-in-Chief, and Tom Easley, MD, Publisher, JAMA Network (JN), highlighting recent changes including: redesign of the JN Website; addition of cascade options which allow manuscript submissions to be passed along from JAMA to one of its other journals; addition of an Article Home Page to view an article and tables side-by-side or independently; articles linked to CME credits; Impact Factor increased from 38 to 44; the reach of JN, from 310,000 subscribers, over 610,000 on social networks, 100,000+ podcast listeners, and over 30 million downloads; shift from print-focused to online/digital first, multi-platform, from pharma-centric print advertising to digital license, institution-driven, from primarily U.S. market to a global market; 13 JN articles placed in the Top 100 Articles as ranked by Altmetrics, including the article ranked as #1; new revenue growth must come from products beyond the core set of clinical research journals; introduction of JAMA Network Open; and policies for open access - a reversal of traditional business model, where manuscripts are submitted, accepted, and author pays a fee for publication – and author retains copyright to research article.
- The Board **heard** informational reports from the President, President-Elect, Immediate Past President, Chair, Chair-Elect, Immediate Past Chair, and the EVP on their recent representational visits and other activities. In addition, the Board **received** checklists from the other Trustees on their recent representational visits.
- **EVP Report** – The Board **heard** a report from James L. Madara, MD, EVP, CEO including: highlights of meetings attended since the April BOT meeting; Value Incentives and Systems Innovation Collaboration with National Academy of Medicine discussion resulting in identifying the two issues which may have the greatest impact of change in healthcare as 1) data – liquidity, interoperability, and clinical meaningfulness; and 2) harmonization of administrative requests, including fewer measures and reporting among payers. Data, in the field of medicine, is currently not aggregated, takes away enormous amounts of time, is not organized for clinical efficiency and has poor cyber protection; the Integrated Health Model and SWITCH projects aim to fill this space.

- **Change of Registered Agent** – The Board **received** a memo noting that our recently retired General Counsel, Jon N. Ekdahl, served as the Registered Agent of the American Medical Association. The Registered Agent is authorized to accept a subpoena, summons or complaint in the event someone sues the AMA. Having a registered agent reduces the possibility that a process server would appear on the doorstep of a Trustee with legal papers against the AMA.

Our AMA needs to file with the Illinois Secretary of State's Office our designation of a new registered agent for the corporation. The AMA's General Counsel has historically served as registered agent, and it is appropriate that Brian D. Vandenberg should be so designated. Illinois corporate law requires that the Board of Trustees make such a designation by Resolution. (Attachment A)

The Board **voted to adopt** a Resolution appointing Brian D. Vandenberg to serve as Registered Agent of our AMA, and authorize a filing to this effect.

- **Approval of Foreign Travel** - The Board **voted to approve** foreign travel as follows:

September 13-15, 2017, World Medical Association (WMA), Tokyo, Japan. Dr. Gurman requested approval to attend the Tokyo conference on end of life issues that has been announced by the WMA as part of a review of its policy on euthanasia and physician-assisted dying. Following a Latin American regional conference held in Rio de Janeiro in March, further regional debates are to be held in Tokyo and the Vatican City. The Tokyo conference in September (13th-15th) and the Vatican conference in November (16th-17th) will feature speakers from across the two regions discussing the ethical dilemmas relating to end of life issues. The Tokyo event, hosted by the Japan Medical Association, will be part of the General Assembly of the Confederation of Medical Associations in Asia and Oceania. The theme of the debate will be terminal illness in aging. There will be no reimbursement for expenses.

September 4, 2017, World Medical Association (WMA), Stockholm, Sweden. Dr. Stack is currently a member of the WMA Declaration of Geneva (DoG) Workgroup and requests permission to continue his representation on behalf of the AMA. The DoG is the WMA's formal declaration of the profession of Medicine's contemporary Hippocratic Oath. The Swedish Medical Association will host an in-person meeting in Stockholm to finalize its work. Staff in International Medicine indicates that work of the group is nuanced and has steadily built on successive discussions over two years. Substituting a new representative from the AMA would be disruptive to the efficient and effective conclusion of the effort. Expenses will be borne by the Board Representation budget.

October 10-14, 2017, Chicago, IL, World Medical Association (WMA). Dr. Stack requested permission to attend the WMA Council and General Assembly meetings as a member of the Declaration of Geneva Workgroup. International Medicine staff indicated that, as host for the General Assembly meeting this fall, the AMA will have a unique role associated with the WMA's approval and publicity of this revised statement of physician professionalism. Expenses will be borne by the Board Representation budget.

- **Approval of Minutes** – The Board **voted to approve** the following minutes of the Board meetings and conference calls: January 5, 2017; February 27, 2017; March 1-April 2, 2017; and May 17, 2017.

- **Review of Delegates Handbook** – The Board **discussed** the reports and resolutions in the House of Delegates Handbook to be considered by reference committees during the 2017 Annual Meeting of the House of Delegates.
- **Awards and Nominations Committee** - The Board **considered** the report from the Awards/Nominations Committee and **voted** to **nominate and/or appoint** to the following: 1) American Board of Allergy and Immunology; 2) American Board of Orthopedic Surgery; 3) ACGME Board of Directors; 4) ACGME Review Committees for Family Medicine and Pathology; 5) National Board of Medical Examiners; 6) CPT Advisory Committee and CPT Health Care Professionals Advisory Committee; and 7) ratified the New Student Representative to the AMA Foundation Board of Directors. The Board also **approved** recipients of the 2018 Medical Executive Lifetime Achievement Award. See Attachment B for a list of all individuals appointed/nominated.

The Board also **approved** the following: 1) revisions **as amended** in the Demographics section of the nomination form requested by the Young Physicians Section (see Attachment C); and 2) a process to be decided by the Board Chair and Awards and Nominations Committee Chair to accommodate earlier nominations of MSS candidates by the end of the first quarter (March 31) of each year.

Secretary Note: Drs. Harmon and Kridel agreed on a process that will be presented to the Board at the November 2017 meeting for approval.

The Board **accepted** the following as informational: 1) more information is needed to fully assess a response from the Committee on the National Residency Matching Program Student Seat for recommendations to the Board; and 2) that the Committee had **discussed** the importance of developing reporting requirements and performance criteria for the selected nominees/appointees and to incorporate those in to the nominations process; prioritization of nominations presented for Board approval; and the development of a cadre of candidates for consideration.

- **Review of Late House Materials** – The Board **discussed** late materials to be considered during the 2017 Annual Meeting of the House of Delegates.
- **Review of Reference Committee Reports** – The Board **discussed** the reports of the reference committees to be presented to the House of Delegates for consideration and action at the 2017 Annual Meeting of the House of Delegates.
- **Council on Legislation** – The Board **welcomed** E. Coy Irvin, MD, Chair and Scott Ferguson, MD, Vice-Chair of the Council on Legislation who presented the Council’s report of its June 9, 2017 meeting and recommendations on the following items of business:
 - 1) Drug Pricing and Access. The Council reviewed federal legislation and revised state model legislation to promote affordable drug pricing and access. On May 16, 2017, S. 1131/H.R. 2439, the “Fair Accountability and Innovative Research (FAIR) Drug Pricing Act of 2017,” was introduced by Senators Tammy Baldwin (D-WI) and John McCain (R-AZ), and Representative Janice Schakowsky. The legislation would require drug manufacturers to notify the U.S. Department of Health and Human Services (HHS) and submit a

transparency and justification report 30 days before a manufacturer increased the price of certain drugs by more than 10 percent during a twelve-month period. The bill would also require manufacturers to provide: a justification for each price increase that took place during the year; manufacturing, research, and development costs for the qualifying drug; net profits attributable to the qualifying drug; marketing and advertising spending on the qualifying drug; and other information as deemed appropriate. The bill would not prohibit a manufacturer from increasing prices. HHS would be required to publish these reports—excluding any proprietary and confidential information—in an online format. If manufacturers failed to comply with the reporting requirement, they would be subject to a fine.

During the Board's April 2017 meeting, the Board adopted the Council's recommendation to approve a new AMA model state bill titled, "An Act to Increase Drug Cost Transparency and Protect Patients from Surprise Drug Cost Increases during the Plan Year." Upon adoption, the Council received comments from a Board member regarding additional issues the Council should consider addressing in future iterations of the model bill, including: providing physicians and clinicians, in addition to patients, with information at the point of care; integrating such information into the electronic health record to pop up at the time of prescribing; and, as physicians are increasingly being measured on total costs of care for different diagnostic groups, they also may need to know what the health plans' costs are, including discounts, rebates, etc. To address these concerns, revisions have been made to sections 2(e), 4(b)(x), and 5(b) of the model bill for the Board's consideration and approval.

The Board **voted** that our AMA: 1) **support** H.R. 2439/S. 1131, the "Fair Accountability and Innovative Research (FAIR) Drug Pricing Act of 2017;" and, 2) **adopt** revised model state legislation titled, "An Act to Increase Drug Cost Transparency and Protect Patients from Surprise Drug Cost Increases During the Plan Year." (Attachment D)

- 2) Transparency in Electronic Health Records Systems Costs. The Council considered draft model state legislation in response to policy D-478.972 adopted at the 2016 Interim Meeting. This policy calls for developing "model state legislation to eliminate pricing barriers to [electronic health record] EHR interfaces and connections to Health Information Exchanges...." The draft model bill would require that an EHR seller disclose the following information on the seller's website, in marketing materials, and in writing upon request: information as to the data sharing capabilities included when a health care provider purchases an EHR system; the costs to a health care provider to purchase supplementary EHR capabilities, including detailed examples of fees in dollar figures charged to health care providers to connect to registry databases, health information exchanges, other EHR systems, and public health agencies; whether these fees are fixed, recurring, or assessed per transaction; and any additional fees imposed by the seller to purchase, license, implement, maintain, upgrade, use, or otherwise enable and support the use of the EHR system. In addition, the draft model bill would make the violation of these disclosure requirements a deceptive practice in the state where the EHR is purchased and create a private right of action for a health care provider.

The Board **voted** that our AMA **adopt** model state legislation titled, the "Transparency in Electronic Health Record Systems Act." (Attachment E)

- 3) Most Favored Nation Clauses. The Council considered draft model state legislation intended to address the anticompetitive effect of “most favored nations” (MFN) clauses in physician contracts. The AMA has for many years expressed concern that most health insurance markets in the U.S. are highly concentrated, i.e., dominated by just a few health insurers, and, in some cases, by a single insurer. This dire lack of competition hurts both patients and physicians. Competition in health insurance markets could improve if new health insurers faced fewer barriers to enter into highly concentrated markets. Some dominant insurers have made it very difficult for new health insurers to enter their markets by placing MFN clauses in their physician contracts. MFNs take many forms, but a common type requires the physician to sell his/her services to the dominant insurer on pricing terms at least as favorable as the terms on which he/she sells to any other insurer. For example, a physician signs a contract with Insurer A, which contains an MFN clause. The physician later is thinking about signing a contract with Insurer B, which is seeking to break into the market. Insurer B will pay the physician less than Insurer A, but the physician might be willing to accept the lower rate for a number of reasons, e.g., Insurer B will be a better business partner than Insurer A, or maybe Insurer B can help him/her use up excess capacity. Because of the MFN, the physician will, however, have to give Insurer A the same discount that it would give Insurer B if the physician signs with Insurer B. The MFN will make it difficult for Insurer B to enter Insurer A’s market because the physician may not want, or even be able, to give that same discount to Insurer A. In this way, a dominant health insurer can use an MFN to help keep potential rivals out of its market.

Because of its anticompetitive effects, a number of state medical associations have pursued MFN legislative strategies. This model bill is designed to help these and other state medical associations in this pursuit. The model legislation would prohibit dominant health insurers from: forcing physicians and health care providers to give discounts to dominant insurers that the physicians and providers may have given to other insurers or payers; prohibiting physicians and providers from agreeing to accept payments from other insurers and payers than are lower than rates received from the dominant insurer; and requiring a physician or provider to disclose to the health insurer payment amounts the physician or provider receives from other insurers and payers.

The Board **voted** that our AMA **adopt** model state legislation titled, the “Prohibiting Most Favored Nations Clause Act.” (Attachment F)

- 4) Hospital Referral Arrangement Disclosures. The Council considered draft model state legislation to address concerns raised by state medical associations when hospitals buy physician practices and then pressure the employed physicians only to refer patients to hospital services and facilities. While physician and health professional self-referral is highly regulated by federal and state laws, and continues to be the subject of legislative initiatives, less attention has been given to the fact that hospitals may control or direct patient referrals. As such, a hospital’s control over referrals may raise concerns similar to those that some have voiced with regard to physician and health care professional self-referral. This model bill would place a disclosure requirement on applicable hospitals to address these concerns. The model legislation also prohibits a hospital from interfering with or restricting a referring physician’s communication with a patient regarding referral options, and includes an anti-retaliation clause.

The Board **voted** that our AMA **adopt** model state legislation titled, the “Hospital Self-Referral Disclosure and Communications Act.” (Attachment G)

- The Board **heard** an informational update from Dr. Otmar Kloiber, Secretary General of the World Medical Association. Dr. Kloiber expressed appreciation for the continuing support of our AMA and highlighted the upcoming WMA General Assembly meeting here in Chicago in October. This will be a scientific session and medical education development spearheaded by the AMA. Highlighted two policy developments with the help of AMA and staff: 1) declaration of Taipei finalized after 4 years work, research on human beings, using data and bio banks, journey to produce a policy gives a direction to physicians on what do to with data and how to collect which may serve as a blue print for other governments; and 2) declaration of Geneva – 1948 first policies of the WMA newly founded called the new Hippocratic Oath. This Oath has been fairly untouched, take a look to see if there is something missing: a) patient autonomy; b) by reference to science base for medicine, evidenced based; c) teaching obligation – coming from the commercialization of medicine; and d) sharing of information and medical ethics; looking at global oath of physicians on medical ethics. The oath is to be revised at the October meeting in Chicago. Dr. Kloiber also thanked AMA volunteers – Dr. Heyman – for a leadership course in the US at the Mayo Clinic in Jacksonville in which Dr. Coble was also involved; and with advice from our past officers many from the AMA, many other countries have increased their financial support of WMA.

Dr. Kloiber was joined by Dr. Ardis Hoven current Chair of WMA and former AMA President. Dr. Hoven’s comments included: that the work of the WMA is not well known to the physicians of the US and that we have a responsibility of making sure the work of the WMA and the global outreach to the world; the WMA houses much of the ethical opinions on what we do with medicine, people are recognizing this now; the WMA has been involved in health care in distress for a long time, when you begin to hear the numbers it is frightening, we have to continue to push in this area, in the areas of conflict when a physician or a group of physicians are in danger or are incarcerated. We are also dealing with end of life, palliative care, and physician suicide. A meeting of the German Medical Association, WMA, and the Vatican will produce discussions but no policy paper. Dr. Hoven noted that there are challenges in dealing with colleagues from around the world such as language, culture. She also recognized the former presidents, recognized and thanked AMA staff, Robin Menes and Ellen Waterman. Dr. Hoven is looking forward to the October WMA meeting in Chicago and encouraged the Board to attend. Dr. Hoven also announced that Dr. Yok Kura from Japan will be the new president of WMA at that meeting.

The Chair noted that AMA will pay expenses for Board members to attend the WMA Assembly in Chicago, October 11-4, 2017.

- **Intra-Board Committees – Closed and Executive Sessions**
The Board also considered reports from the Audit, Compensation, Executive, Finance, and Governance and Self-Assessment Committees in either Closed or Executive Sessions. The Board voted to **approve** the recommendations of these Committees as submitted.

The meeting adjourned on Wednesday, June 14, at 7:50 am (Central).

Patrice A. Harris, MD, MA, Chair

Jack Resneck, Jr., MD, Secretary