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HOD Comm on Compensation of the Officers
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607# Discounted / Waived CPT Fees as an AMA Member Benefit and for Membership Promotion

# Contained in the Handbook Addendum
REPORT OF THE BOARD OF TRUSTEES

B of T Report 1-A-18

Subject: Annual Report

Presented by: Gerald E. Harmon, MD, Chair

Referred to: Reference Committee F
(Julia V. Johnson, MD, Chair)

The Consolidated Financial Statements for the years ended December 31, 2017 and 2016 and the Independent Auditor’s report have been included in a separate booklet, titled “2017 Annual Report.” This booklet is included in the Handbook mailing to members of the House of Delegates and will be discussed at the Reference Committee F hearing.
## FINANCIAL HIGHLIGHTS

Years ended December 31

<table>
<thead>
<tr>
<th>(Dollars in millions)</th>
<th>2017</th>
<th>2016</th>
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<tbody>
<tr>
<td>Revenues</td>
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<tr>
<td>Operating results</td>
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<td>Non-operating items</td>
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<td>Change in temporarily restricted equity</td>
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<tr>
<td>Change in association equity</td>
<td>$ 70.7</td>
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</tbody>
</table>

Association equity at year-end $ 559.7 $ 489.0

Employees at year-end 1,033 983

### Association operating results

*(in millions)*

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<th>Year</th>
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<th>1995</th>
<th>1997</th>
<th>1999</th>
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<td>$30.3</td>
<td>$24.4</td>
<td>$20.3</td>
<td>$13.6</td>
</tr>
</tbody>
</table>

*Pro forma operating results from 2013 exclude $33 million in nonrecurring charges relating to the AMA’s headquarters relocation. The reported net operating loss, after including those charges, is $15.1 million.*
Continuous improvement is perhaps the concept most responsible for pushing medical knowledge and professionalism forward. This year we write from the vantage point of an organization that has fully embraced this notion and is now seeing powerful results.

As demonstrated by a sweeping range of accomplishments delivered in 2017—from helping block multibillion dollar health insurance company mega-mergers in court to re-launching our web-based graduate competency training curriculum with its almost 20 percent increase in participation—the American Medical Association is having a measurable positive impact on the lives of patients and physicians.

Standing as an innovative and proactive force, today we are an organization driven like no other by evidenced-based research, strategic analysis and insight, and our unmatched commitment to understanding and amplifying the physician voice in arenas that matter most: advocacy, health policy, technology, life-long learning, governance, medical ethics, public health and clinical care.

As you view the AMA’s achievements from 2017, we are confident you will find the scale and relevance of our long-term investment in the nation’s health inspiring. In 2017, for example, we saw collaboration soar as the AMA, working with such notable allies as the American Heart Association, the Mayo Clinic and Stanford University, to name but a few, was instrumental in launching successful initiatives such as Target: BP™ and the first-ever American Conference on Physician Health.

We developed a proof-based recruitment campaign, underscoring the power and importance of AMA membership in moving medicine forward. We saw our innovation ecosystem continue to expand and propel major efforts like the Integrated Health Model Initiative™, with its focus on interoperability and more effective patient care, into the marketplace with tremendous promise and a blue-chip roster of participants on board. And we continued fine tuning our strategy to articulate more fully the AMA’s essential arcs of expertise: tools for the field, professional development and improved care for chronic disease.

With our strong performance in 2017 including positive financial operating results for the 17th time in the last 18 years and an increase in membership for the seventh straight year, the AMA’s sights are set on making even greater strides on the road ahead. In this report you will learn how our focus on results, innovation and collaboration have kept us on course for success.

We are privileged to be guided by a powerful mission to promote the art and science of medicine and the betterment of public health. In 2017 we protected access to coverage for millions of patients—going forward the AMA will continue developing significant ways to make health care delivery efficient, sustainable and fair, and we will continue working relentlessly to make patients’ and physicians’ lives better.
RESULTS THAT MATTER: WHERE WE MADE OUR MARK

Battling an epidemic
The AMA Opioid Task Force made strong inroads in helping the nation’s physicians battle one of the deadliest epidemics of our time. We can now report that, in addition to the AMA developing resources and advocating for practical policy changes, we saw meaningful progress: fewer opioids being prescribed, prescription drug monitoring program use increasing, and more physicians certified to provide office-based treatment for opioid disorder.

Putting patients before politics
In 2017 the AMA empowered physicians and patients to contact Congress and to work with us to help preserve coverage for the 20 million Americans who gained coverage through the Affordable Care Act. We launched the website patientsbeforepolitics.org to cut through the noise surrounding this all-important debate on access to health insurance. Generating more than 7 million actions—including calls, emails and social interactions—this grassroots campaign resonated loudly and helped shape the health care debate on Capitol Hill.

HEALTH REFORM DEBATE: DOMINANT SHARE OF VOICE IN THE MEDIA AMONG TOP 10 ADVOCACY PEERS
Based on the AMA’s “Health Reform Share of Voice Analysis” (Jan. 1–Sept. 30, 2017)
Having physicians’ backs

The AMA was instrumental in helping stop two separate health insurance company mega-mergers. The courts listened when organized medicine advocated for competition—not consolidation—in health insurance markets. Blocking the proposed Anthem-Cigna merger alone saved physicians at least $500 million in payments annually.

But the AMA’s effectiveness in protecting physicians’ interests didn’t end there. Our legal teams and policy experts worked together to achieve important victories defending physicians’ right to free speech, and medical staff representation and independence. They also delivered more than 130 state legislative and regulatory wins on issues ranging from unfair health insurer practices to the promotion of meaningful medical liability reform.

Expanding our reach

2017 earned media metrics

98,823
Total placements across all mediums in national, local, trade and new media outlets

$560 million
Estimated publicity value

$60 billion+
Estimated traditional and online media impressions across print publications, radio, television, news services, news websites and blogs

Making an impact

The JAMA Network™ continues to increase the amount of content produced, formats distributed, audience engagement, and the impact our content has on research and practice. In 2017 JAMA Oncology registered a debut impact factor of 16.6—the highest ever debut for a journal in clinical medicine—reflecting that journal’s immediate impact and impressive engagement. JAMA Cardiology, our other new specialty journal, will receive its debut impact factor in 2018.

JAMA Network downloads 70 million+
Times JAMA content viewed 31 million+
Podcasts downloaded and listened to 2 million+
JAMA’s impact factor* 44.4
JAMA Oncology debut impact factor* 16.6

* The impact factor, which is a publishing industry standard, is a measure of the frequency with which the average article in a journal has been cited in a particular year.

Establishing health systems science

Having helped health systems science gain recognition as the third pillar of medical education, alongside basic and clinical science, the AMA is now seeing future physicians acquire the non-clinical background needed to succeed in medicine today. Underscoring this movement, Health Systems Science, first edition, developed by the AMA and the Accelerating Change in Medical Education Consortium, has already been adopted by 12 medical schools in the United States and sold thousands of copies around the world.

Helping physicians optimize payments

By surveying 1,000 practicing physicians involved in practice decisions related to the Centers for Medicare & Medicaid Services (CMS) Quality Payment Program, The AMA revealed that, under the new rules of the Medicare and CHIP Reauthorization Act of 2015, 90 percent of physicians didn’t know what steps to take next. Based on the valuable insights our research yielded, the AMA developed educational and training resources to help physicians and their practices carve successful paths forward (if participating in the CMS Merit-based Incentive Payment System), and launched a comprehensive marketing and communications campaign to create awareness among physicians about this new payment program.

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INNOVATION WITH PURPOSE: ADDRESSING UNMET NEEDS

Transforming health care

To unleash a new era of better and more effective patient care, the AMA in 2017 launched the ambitious Integrated Health Model Initiative™ (IHMI), a collaborative effort across a broad expanse of health care and technology stakeholders.

While addressing critical chronic diseases, IHMI will enable care models and technical solutions to be built on truly meaningful data elements, such as patient function, state and goals—elements that will allow health care efforts to focus on outcomes and achieving patient wellness while facilitating unparalleled semantic interoperability. Released to the public in late 2017, IHMI closed the year with more than 1,000 participants and 17 collaborating organizations onboard and eagerly looking to make a difference.

AMOUNT OF TIME PRIMARY CARE PHYSICIANS SPEND EACH WORKDAY ON DATA ENTRY AND OTHER EHR-RELATED TASKS

As revealed in a study co-authored by AMA senior staff and published in the Annals of Family Medicine

5.9 HRS
Placing new ideas in the spotlight

The AMA continued raising its profile with the most inspiring change-makers both inside and outside of health and medicine. The AMA was a global sponsor of TEDMED 2017, where we unveiled “AMA Doc Talk,” a new podcast series that illuminates the very real challenge of helping physicians handle difficult conversations with patients.

Leading the adoption of digital medicine

In establishing the Digital Medicine Payment Advisory Group, the AMA again led the way in pushing for actionable, real-world solutions to help facilitate improved digital medicine adoption. This advisory group—composed of 14 recognized experts with years of hands-on experience integrating digital medicine services into clinical practice—is currently working to identify effective payment and coverage strategies with special emphasis placed on coding, coverage and payment for remote patient monitoring services.

Putting our expertise and knowledge to work

In 2017 the AMA continued growing our innovation ecosystem in fertile new directions, and in ways that are radically expanding our understanding of the health care landscape’s deep and complex interconnections.

Extending to include innovative forces like Health2047, our flagship Silicon Valley-based integrated innovation studio, and MATTER, a Chicago-based health technology incubator and home to more than 200 digital start-ups—the AMA ecosystem is providing us with spectacular insights and opportunities to improve health care.

One example of our ecosystem at work is Health2047’s successful launch of Akiri, Inc.™ (formerly Health2047 Switchco, Inc.), the new company working to bring the first network-as-a-service platform to the health care industry. Known as Akiri Switch™, this platform will enable health information to move seamlessly and securely throughout the U.S. health care system.

Bringing the physician voice to technology

Developed to match companies and developers with physician entrepreneurs, the AMA Physician Innovation Network officially launched in late 2017. In just three months some 2,070 users (companies and physicians) joined the network and more than 1,000 connection requests were generated. An excited digital health community offered clear signals that it’s hungry for physician-driven innovations, publishing articles with titles like “Health IT Infrastructure Improves with AMA Collaboration Platform” (HIT Infrastructure) and “AMA’s New Online Platform Looks to Bring Together Docs, Health Tech Companies” (Healthcare Informatics).
THE AMA IS PARTNERING WITH 11 RESIDENCY PROGRAMS LOOKING TO BRING ITS BURNOUT ASSESSMENT TO THEIR INSTITUTIONS

Providing new information to help reduce burnout in this critical but previously untapped area

POWERED BY COLLABORATION: TOGETHER WE ACCOMPLISH MORE

Ensuring safe, effective health technologies

**Xcertia**, the joint mobile health app collaborative pioneered by the AMA, the American Heart Association, DHX Group, and the Healthcare Information and Management Systems Society (or HIMSS), gained significant notice in 2017. Highlighted in *The Wall Street Journal*, Xcertia, with its 32 members—including IBM Watson, Accenture and the Mayo Clinic—is quickly progressing toward its goal of setting standards that foster safe, effective mobile health technologies.

TARGET: BP™

Moving millions toward blood pressure control

In collaboration with the American Heart Association (AHA) and the Ad Council, the AMA launched an evocative patient-facing high blood pressure campaign, which has already attracted more than 400,000 visitors to loweryourhbp.org and over $4.7 million in donated national media placements.

Also, following the release of a new hypertension guideline in late 2017, the AMA and AHA provided solid guidance to physicians and care teams, generating more than 500,000 acts of engagement via a variety of platforms, including the AMA/AHA jointly produced Target: BP™ web platform, which contains vetted resources and information designed to make tighter blood pressure control achievable.
Putting future physicians ahead of the curve

In 2017 medical education leaders gathered for our AMA ChangeMedEd™ conference, which included presentations on the emergence of health systems science, innovative uses of technology and a range of other game-changing ideas.

To prepare tomorrow’s physicians to thrive, the AMA Accelerating Change in Medical Education Consortium implemented multiple innovations, including an EHR learning platform that is now in use at five schools. Consortium leaders were also very active in 2017, making 45 presentations at 28 national conferences, and writing and publishing 16 papers in peer-reviewed scientific literature on various aspects of the group’s groundbreaking work.

Increasing prediabetes awareness

The AMA and the American Diabetes Association extended our ongoing collaboration to also include tech heavyweight Samsung. Together we created a first-of-its-kind mobile public awareness experience for U.S. adults. The initial five-week campaign far exceeded expectations by yielding 555,000 completed prediabetes risk assessments.

In addition, the AMA guided more than 40 health care organizations in developing prevention strategies for type 2 diabetes, including providing project support for those health systems seeking to establish their own CDC-recognized National Diabetes Prevention Program.

Helping physicians protect and serve patients

Working with Accenture, the AMA continued to help physicians enhance security for their patients by conducting a cybersecurity survey of 1,300 U.S. physicians. The survey revealed that four in five physicians have experienced a cyberattack in their practices. In response, the AMA is now providing information to assist physicians in improving cybersecurity measures.

LexisNexis® Risk Solutions and AMA Business Solutions, a subsidiary of the AMA, tackled the complex challenge of inaccurate and outdated provider directories. Our collaboration produced VerifyHCP™, a one-stop online interface that lets physicians and practice managers verify and update their data with vastly improved efficiency. Since launch, VerifyHCP has almost 200 provider plan participants and manages nearly 200,000 unique clinician profiles.

Making physician health a priority

In October 2017 the AMA, together with Stanford University School of Medicine and the Mayo Clinic, launched the first-ever American Conference on Physician Health to rave reviews. Held in San Francisco, this inaugural event brought together more than 400 physicians, academics, researchers and thought leaders from around the country to share ideas and seek solutions to improve physician wellness.

In 2017 we held two Joy in Medicine™ conferences. These multi-stakeholder conferences brought together nearly 100 participants to discuss issues relevant to physician burnout, including interventions and ideas for change.

Prevent Diabetes STAT

Increasing prediabetes awareness

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2017 MANAGEMENT’S DISCUSSION AND ANALYSIS
Introduction

The objective of this section is to help American Medical Association (AMA) members and other readers of our financial statements understand management’s views on the AMA’s financial condition and results of operations. This discussion should be read in conjunction with the audited consolidated financial statements and notes to the consolidated financial statements.

Results from operations

(in millions)

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<tr>
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<td>$13.6</td>
</tr>
<tr>
<td>2017</td>
<td>$13.8</td>
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</tbody>
</table>

Improving the health of the nation is at the core of the AMA’s work to enhance the delivery of care and enable physicians and health teams to partner with patients to achieve better health for all. The focus of our efforts is on creating thriving physician practices, creating the medical school of the future and improving health outcomes.

In 2017, AMA continued to maintain its focus on Practice Sustainability and Professional Satisfaction, working with physicians to advance initiatives that will help them navigate and succeed in a continually evolving environment; Accelerating Change in Medical Education by collaborating with medical schools to create a system that trains physicians to meet the needs of today’s patients and to anticipate future changes; and Improving Health Outcomes by enabling physicians and health teams to partner with patients, communities and public and private-sector organizations to enhance the delivery of care and achieve better health for all.

In a challenging environment, the AMA continued to deliver strong advocacy results in 2017. The AMA was successful in efforts to protect access to coverage for millions of Americans, defend key patient protections, and preserve the safety net for our nation’s most vulnerable patients. The AMA was instrumental in blocking two mega-health insurance mergers that would have had negative effects on patients and physicians. Physicians stood to lose an estimated $500 million in annual payments from just the Anthem-Cigna merger alone. The AMA sought and achieved numerous improvements to the Medicare Quality Payment Program (QPP) regulations to help physicians succeed with the transition. Last year, the AMA launched a campaign to address the prior authorization burden physicians and their staff experience and continued to achieve positive outcomes on other administrative and regulatory burdens, including Medicare audits and virtual credit card payment mandates. Finally, the AMA continued efforts to end the opioid epidemic that is having a devastating impact across the United States, making inroads on reducing opioid prescribing, increasing physician education, and improving the availability of naloxone.

AMA’s innovation enterprise, Health2047, has made substantial progress on key projects, including the spinout of a new company, Health2047 SwitchCo, Inc. (SwitchCo), which will build and deploy trusted infrastructure for private data transport, optimized for healthcare data. The studio will continue to enhance AMA’s ability to define, create, develop and launch, with partners, a portfolio of products and technologies that will have a profound impact on many aspects of the U.S. health care system and population health, with a central goal of helping physicians in practice.

2017 saw many other important new initiatives, such as the successful launch of the Integrated Health Model Initiative and Membership Moves Medicine and brand campaign, laying the groundwork for the launch of JAMA Network Open; expansion of the education center, continued physician engagement efforts and expansion of digital marketing; as well as enhancing infrastructure support for new initiatives and the strategic focus areas. In 2017, AMA is reporting $13.8 million in net operating income, reflecting continued growth in revenue offset by additional investment in the focus areas, core activities and new initiatives.

The AMA is committed to its responsibility to ensure that the organization focuses its finite resources on its core activities and strategic focus areas while improving the quality and breadth of products and services for physicians and medical students. Our physicians’ and medical students’ presence and voice are central to the overall success of our AMA.
Our AMA’s strategy requires continued focus and integration within and across all components of the AMA Equation: the House of Delegates; membership; physician practice tools; advocacy; and research and education.

The following pages discuss the 2017 consolidated results from operations, financial position and cash flows, as compared to 2016. Additional detailed discussion of operating unit results is included in the section titled “Group Operating Results.”

Consolidated financial results

The chart below provides pro forma results from operations and excludes the $33 million in nonrecurring charges related to the headquarters relocation in 2013.

Results from operations
(in millions)

Revenues
In 2017, total revenues improved by $23.9 million over the prior year, due to continued growth in AMA’s royalties and journal site licensing. Advertising revenue and coding book sales declined again during 2017, reflecting a continued transition from print journals and books.

The number of AMA dues-paying memberships increased in 2017 by 1.8 percent, achieving seven years of consecutive growth in members. Similar to the prior year, increases occurred in lower dues-paying categories such as group memberships, sponsored memberships and half-year dues, resulting in a small dues revenue decline of 3 percent.

Consolidated investment income increased slightly in 2017, reflecting larger investable balances. Interest rates continued at historic low levels.

Cost of products sold and selling expenses
All variable expenses related to the production, distribution and sale of periodicals, books, coding products and licensed products are included in the cost of products sold and selling expense categories. Examples include paper, sales commissions, promotional activities, distribution costs and third-party editorial costs.

In 2017, cost of products sold and selling expenses decreased $1.9 million. A substantial portion of the decrease is from reduced production costs related to the lower volume of book sales and fewer journal advertising pages.

Contribution to general and administrative expenses
Cost of products sold and selling expenses are deducted from revenues to determine the amount of money available for the general and administrative expenses of the organization. Contribution to general and administrative expenses measures the gross margin derived from revenue-producing activities.

The contribution to general and administrative expenses increased $25.8 million to $319.4 million in 2017, with Books and Digital Content accounting for most of the change. Revenue improvements from royalties, offset by the declining book sales discussed above, were the key factors.

General and administrative expenses
(in millions)

General and administrative expenses rose $25 million in 2017, or just over 9 percent.

Compensation and benefits increased $9 million, with higher compensation and employee health care expense offset by lower pension and retiree health costs. Compensation, including temporary help, was $7.3 million higher in 2017, a 4.5 percent increase. Health2047 accounted for $0.8 million of that increase in its continued expansion of operations. Increased incentive compensation accounted for another $1.2 million as the salary base increased and key performance
indicators were achieved in 2017. Excluding both the higher incentive and Health2047 costs, AMA salaries rose 4 percent in 2017, approximately half for merit increases and the remaining half for additions to support key initiatives.

Occupancy costs increased $1 million in 2017, reflecting the absence of a large property tax refund in 2016.

Technology costs increased $1.8 million in 2017, largely related to third party hosting and implementation of outsourced solutions for platforms such as the scientific journals, the education center and the new AMA website, as well as software amortization of new solutions.

Outside professional services were largely unchanged in 2017.

Marketing and promotion expenses rose $8.7 million, largely related to four campaigns, the brand and Membership Moves Medicine campaign; the healthcare reform campaign, the AMA-American Heart Association awareness campaign and the new hypertension guidelines campaign.

A $3.5 million increase in other operating expenses reflects a $1.8 million increase in grants and contributions, including a grant to assist in the development of a teaching electronic medical record (tEMR) and grants to areas devastated by hurricanes. Costs associated with a new venture to improve physician directories and a write-off of developed software were the other large factors in the overall increase.

Operating results before income taxes
The AMA achieved a $22.1 million pre-tax operating income in 2017. This compares to $21.3 million in 2016. A 7.4 percent increase in revenue was almost entirely offset by the general and administrative expense increases described above.

Income taxes
Taxes increased $0.6 million in 2017 as a result of a $1.1 million tax provision in Health2047, largely related to the spinout of SwitchCo, offset by a small tax benefit related to the change in federal corporate tax laws.

Net operating results
Operating income totaled $13.8 million in 2017, up slightly from the prior year, with improvements from increased revenue largely offset by higher expenses.

Non-operating items
The AMA reported a $45.3 million gain in the fair value of its portfolio during 2017 after a $24.1 million gain in 2016. AMA also reported $0.1 million in other non-operating revenue in 2017.

Revenue in excess of expenses
Revenues were $59.2 million greater than expenses in 2017, a combination of the $13.8 million operating income plus $45.4 million in non-operating gains. Revenues exceeded expenses by $37.7 million in 2016.

Change in association equity
Accounting standards require organizations to recognize deferred actuarial losses and prior service credits or charges for defined benefit postretirement plans as a charge or credit to equity. In 2017, the net credit to equity related to defined benefit postretirement plans totaled $11.4 million. Portfolio returns in the pension plan were better than the actuarial expectation, and claims experience in the retiree health plan were lower than the actuarial expectation, both resulting in actuarial gains. Recognition of actuarial losses and prior service credits in the postretirement health care plan added to the gains. The gains were partially offset by actuarial losses in both the pension plan and the postretirement health care plan resulting from year-end lower interest rates that increase the present value of plan liabilities. Deferred taxes on the credit reduced the overall gain.

In 2016, the net credit to equity related to defined benefit postretirement plans totaled $0.4 million. Actuarial losses in both the pension plan and the postretirement health care plan resulted from year-end lower interest rates that increase the present value of plan liabilities as well as participant changes. Portfolio returns in the pension plan were less than the actuarial expectation, and claims experience in the retiree health plan were higher than the actuarial expectation, both resulting in additional charges. Recognition of actuarial losses and prior service credits in the postretirement health care plan more than offset the losses. Deferred taxes on the credit slightly increased the gain.

The AMA reported a $70.6 million increase in unrestricted association equity in 2017. This reflects the amount by which revenues were greater than expenses, plus the credits to equity for changes in defined benefit postretirement plans discussed above. After adding a $0.1 million increase in temporarily restricted equity in 2017, total equity increased $70.7 million.

In 2016, total equity increased by $38 million, with $37.7 million of revenues in excess of expenses and $0.4 million in credits to equity for changes in defined benefit postretirement plans slightly reduced by a $0.1 million decrease in temporarily restricted equity.
Financial position and cash flows

The AMA’s assets include cash, cash equivalents and investments; operating assets such as accounts receivable, inventory and prepaid expenses; fixed capital such as equipment, computer hardware and software; and other assets. AMA assets are supported by association equity, operating liabilities and deferred revenue.

<table>
<thead>
<tr>
<th>Assets (in millions)</th>
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<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>2016</td>
</tr>
<tr>
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<tr>
<td>$21.2</td>
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<td>$20.1</td>
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<tr>
<td>$701.4</td>
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</table>

The AMA’s total assets increased $92.4 million in 2017. This includes a $75.1 million increase in cash and investments resulting from $29.7 million in free cash flow plus a $45.3 million gain in the fair value of investment securities.

Fiduciary funds are premium payments from insurance customers not yet remitted to the carriers and funds held by the AMA for third parties for future use as approved by that third party. This approximates the offsetting liability titled insurance premiums and other fiduciary funds payable.

Operating assets increased $17.6 million in 2017. This is entirely due to a $19.5 million increase in accounts receivable from higher fourth quarter royalty revenue, partially offset by a reduction in deferred taxes. Changes in operating assets from year to year are largely due to timing of cash receipts and payments.

Property and equipment net book value decreased $1.7 million, as $10.7 million in new capital assets was exceeded by annual depreciation and amortization of existing capital assets.

Operating liabilities decreased slightly in 2017. One reason is in part due to favorable portfolio performance, which led to the pension liability being recorded as a prepaid expense.

AMA received tenant improvement allowances from new or renegotiated leases in Washington D.C. and New Jersey during 2017 and had received similar concessions in 2013 related to the headquarters building. The tenant improvement allowances are recorded as a deferred lease obligation and are amortized over the life of the individual leases.

Changes in deferred rent reflect the difference between the amounts recorded as expense and the amounts paid on all current leases. AMA records rent expense leases ratably over the period AMA took possession of the premises through the lease termination date. Amounts expensed but unpaid are considered a deferred rent obligation and will be reduced over the term of the lease.

Deferred revenue represents funds received during the year that will not be recognized as income until the following year or thereafter. These amounts vary, as well as accounts payable and accrued expenses, depending on the timing of cash receipts and payments.

Cash flows

Cash and cash equivalents were up $19.1 million in 2017, and $4.7 million in the prior year. This comparison may cause misleading conclusions, as the change in cash and cash equivalents includes reductions for amounts invested in marketable securities, as well as cash inflows from non-operating activities.

Free cash (in millions)

Free cash flow measures the AMA’s ability to fund operations, capital expenses and major programmatic initiatives from funds generated from operations. This measure excludes non-operating gains and losses.

Free cash in 2017 totaled $29.7 million, $10 million greater than the 2016 results, impacted by a one-time payment for a licensing agreement that will be recognized as revenue over future licensing periods.
The reserves and operating funds above do not include cash and investments in the for-profit subsidiaries, and reflect only the not-for-profit entity’s cash and investment portfolio values.

As of year-end 2017, permanent reserves were $583.8 million compared to $510.8 million in 2016, a $73 million increase. That increase was the result of a $26.6 million transfer of 2016 excess operating funds to reserves plus a $46 million gain in the market value of the reserve portfolio. Operating funds totaled $72.2 million in 2017, down $16 million from 2016.

The AMA has established a required minimum reserve investment portfolio level that is adequate to cover 100 percent of annual general and administrative expenses (excluding grant expenses) plus an amount sufficient to pay long-term pension and postretirement liabilities. Operating funds, coupled with operating assets, are to be maintained at a level that allows payment of all operating liabilities.

The minimum reserve portfolio level is designed to ensure that the AMA can always meet its long-term obligations for pension and postretirement health care, as well as provide that the AMA could continue operations for at least one year in the case of a catastrophic occurrence.

Reserve portfolio funds also provide the AMA with the ability to fund major strategic spending initiatives not within the operating budget. Spending from the reserve funds is limited to the amount by which reserves exceed the minimum requirement. The Board of Trustees must authorize any use of reserves.
Membership
The Membership group's total revenue includes both net membership dues and interest expense on lifetime memberships. Net membership dues is equal to the gross dues revenue collected, reduced by commissions paid to state societies, and is the membership dues revenue reported on the statement of activities.

The AMA achieved its seventh consecutive year of increases in the number of dues-paying members, although total dues revenue declined slightly in 2017. The number of dues paying members increased 1.8 percent in 2017, and total membership increased 1.2 percent and 2.6 percent in 2017 and 2016, respectively.

Gross dues revenue was $37.9 million, a $1.4 million decrease from 2016, as membership increased in categories with lower average dues rates, such as group practices, residents and sponsored memberships. Commissions and incentives paid to state societies totaled $0.1 million in 2016. Interest expense on lifetime memberships was $0.1 million in both 2017 and 2016.

Investments (AMA-only)
AMA-only investment income includes dividend and interest earnings on the AMA's portfolio. Investment income in AMA's active subsidiaries is included in the Publishing, Health Solutions and Insurance results.

Investments' income was $10.7 million in 2017, a $1 million increase over the prior year, mainly due to an increase in the investable fund balances. Continued low interest rates have resulted in reduced levels of income in the portfolio during the last several years.

The net gain or loss on investments is not included in operating results, but reported as a non-operating item. This amount is in addition to the investment income discussed above, and totals a gain of $45.3 million in 2017, compared to a $24.1 million gain in 2016. The total investment return on the portfolio was 9.4 percent. The 2017 return compares to a composite benchmark index of 10.6 percent. AMA's portfolio is balanced almost equally between equity and fixed income. AMA does not invest in passive index funds due to the prohibition on tobacco-related investing. Passive index funds have substantially outperformed active management for the last several years.

Other revenues
Other revenues are derived from grants and other fee income. These decreased $0.3 million in 2017, largely due to reduced grant income in the core activities.

Contribution margin (net expenses)
Contribution margin equals unit revenues minus cost of products sold, selling expenses, and direct general and administrative expenses such as compensation, occupancy, travel and meetings, technology costs and professional services.

Net expenses equals total spending, net of any revenue produced by the unit, such as grants or other fee income. Total contribution margin and net expenses equals consolidated operating results before income taxes. The charts below separate groups with contribution margin from groups with net expenses.
The contribution margin generated by Membership, Publishing, Health Solutions and Insurance, as well as Investments, provides the funding for all mission-related activities of the AMA as well as funding for all administration and support operations required to run the organization. Membership continues to provide over 13 percent of those funding needs.

Membership
Membership’s contribution margin decreased $2.7 million in 2017 due to the combination of a dues revenue decline, increased solicitation costs for marketing efforts and implementation of a digital marketing program for membership.

Investments (AMA-only)
The $0.8 million increase in contribution margin was largely due to the $1 million revenue improvement, slightly offset by increased costs associated with managing two reserve portfolios, one for core reserves and one for reserves in excess of the minimum required level. The latter portfolio will have a more aggressive asset allocation than the core portfolio.

Publishing, Health Solutions and Insurance
Publishing, Health Solutions and Insurance results were up $25.6 million in 2017. Royalty and credentialing revenue increases, offset by a decline in coding book sales volume and lower publishing revenue, were the major factors.

Contribution margin declined $1.7 million in Publishing, as revenue losses in advertising and print subscriptions were somewhat offset by cost reductions put in place to mitigate the impact of the revenue decline.

Database Products reported a $4.8 million improvement due mainly to increased revenue but also the absence of additional costs for improving the quality of the physician masterfile incurred in the prior year.

Books and Digital Content contribution margin rose $23.3 million, largely on the strength of continued growth in royalties, offset by costs associated for a new CPT editorial system.

The Insurance Agency/Affinity Products margin was up slightly, with cost reductions more than compensating for the declining revenue.

The Integrated Health Model Initiative (IHMI) was launched in 2017 and is a platform for bringing together the health and technology sectors around a common data model. A common data model for the health system can collect, organize, exchange and analyze critical data elements, equipping clinicians with essential information to shift care plans towards achieving outcomes that are more relevant to a patient’s quality of life and consistent with the patient’s lifestyle, goals, and health status. Given the high economic and societal burden of chronic diseases, IHMI will initially prioritize its resources and efforts in clinical areas such as hypertension, diabetes and asthma.

Other business operations margin was largely unchanged.

Strategic Focus Areas and Core Operations
The Strategic Focus Areas include direct costs associated with the units for Improving Health Outcomes (IHO), Accelerating Change in Medical Education (ACE), and Enhancing Professional Satisfaction and Practice Sustainability (PS2).

IHO involves AMA focusing on two of the nation’s most prevalent issues: cardiovascular disease and type 2 diabetes, and setting a course of innovation and action to develop, enhance and implement strategies aimed at reducing the
disease and cost burden associated with these selected conditions. More than 400 medical practices, providers and health systems are now participating in Target: BP, the joint national initiative of the AMA and the American Heart Association (AHA), aimed at reducing the number of American adults who die from heart attacks and strokes every year.

To help prevent type 2 diabetes, the AMA and the Centers for Disease Control and Prevention (CDC) developed a toolkit to help health care teams screen, test and refer at risk patients to in-person or online diabetes prevention programs (DPP’s). The AMA is also partnering with the CDC and YMCA to increase physician screening and testing of patients for prediabetes as well as working to achieve coverage for diabetes prevention programs, after AMA’s success in expanding the Medicare DPP coverage.

Through ACE, in 2013 the AMA launched a multi-year $11 million grant program with 11 medical schools aimed at bringing innovative changes to medical education. The consortium of schools was expanded later by an additional 21 schools selected from more than 100 medical schools that applied. A critical component of this initiative was the establishment of a learning collaborative so that best practices can be developed, shared and implemented in medical schools across the country.

To fully serve patients today and into the future, physicians need to understand the content of health systems science. This new discipline includes understanding how to improve health care quality, increase the value of care provided, enhance patient safety, deliver population-based medical care and work collaboratively in teams. AMA’s Accelerating Change in Medical Education Consortium, with Health Systems Science, has created the first textbook that focuses on providing a fundamental understanding of how health care is delivered, how health care professionals work together to deliver that care, and how the health system can improve patient care and health care delivery.

In PS2, the AMA is investing significant resources in evaluating a path to long-term sustainability of and satisfaction with medical practice. The goals of this initiative are to promote successful models in both the public and private sectors; create tools focused on helping physicians implement practice improvements, improving the usability of electronic health records, shaping the evolution of payment models for sustainability and satisfaction, and promoting physician representation and leadership in the governance structure of hospitals and health systems. The AMA’s STEPS Forward™ practice transformation series is a collection of interactive, educational modules developed by physicians to help physicians address common challenges in their practices. A variety of the modules focuses on preventing physician burnout.

The AMA also offers many opportunities for physicians to enhance their leadership skills and engage in leadership opportunities. Identifying key challenges physicians face with health IT and focusing on improved usability and interoperability is another major initiative. The digital health strategy will continue to focus on research, initiatives, and strategic partnerships that aim to improve health care technology and help physicians influence and adopt digital health solutions. As a dues paying member and founder of Xcertia, Sequoia/Carequality and the CARIN Alliance, AMA helps lead in the area of interoperability.

The Strategic Focus Areas continued to expand staff and operations during 2017, the fifth full year of implementation of AMA’s new strategic plan. Most of the $3.3 million net expense increase in 2017 was due to marketing expenses in hypertension and pre-diabetes programs as well as a final payment on a grant to assist in the development of a teaching electronic medical record (tEMR).

Core Operations includes three groups: Advocacy; Health, Science and Core Medical Education; and Communications and Marketing.

The Advocacy Group includes federal and state level advocacy to enact laws and advance regulations on issues important to patients and physicians; economic, statistical and market research to support advocacy efforts; political education for physicians; grassroots advocacy; and maintaining relations with the federation of medicine. In 2017, Advocacy net spending totaled $26.5 million, up $2.1 million from the prior year, reflecting costs related to the 2017 campaign advocating support of AMA health system reform objectives and opposing the AHCA. Continuing efforts to reduce onerous rules for implementation of MACRA, establishment of a national task force to engage physicians to curb opioid abuse, convening a task force on MACRA adoption and research on prior authorization, to name a few, also increased costs in 2017.

Health, Science and Core Medical Education includes Science; Core Medical Education; Ethics; and Grants. The group is involved in developing AMA policies on scientific issues for the House of Delegates (HOD); public health advocacy; defining or influencing standards for undergraduate, graduate and continuing medical education; establishing and disseminating ethical standards for the profession; enhancing quality of care and patient safety; and providing support for the Councils on Ethical and Judicial Affairs, Science and Public Health and Medical Education. In 2016, this group successfully spearheaded the adoption of the modernized AMA Code of Medical Ethics. A major initiative for this group is education delivery services for the education center, providing a digital platform for lifelong professional development, which caused a $1 million net expense increase in Health, Science and Core
Medical Education. The remaining increase is largely due to support for the campaign to expand GME slots.

Communications and Marketing focuses its efforts on enhancing the AMA’s brand image; informing the public about the AMA’s positions and policies; supporting the AMA’s advocacy efforts and maintaining effective member communications. Net expenses were up $5.4 million in 2017, mainly due to continued higher spending on major initiatives, the brand and Membership Moves Medicine campaigns. AMA continues to sponsor major health care events such as TEDMED and Health 2.0 challenges as part of its influencer campaign.

Governance
Governance includes the Board of Trustees and Officer Services, the HOD, Sections and Special Constituencies and International units. The Board of Trustees unit includes costs related to governance activities as well as expenses associated with support of the Strategic Focus Areas and Core Operations. The HOD, Sections and Special Constituencies and International unit includes costs associated with annual and interim meetings, groups and sections and other HOD activities, as well as costs associated with AMA’s involvement in the World Medical Association.

In 2017, Governance net spending increased $0.8 million, with a $0.5 million increase in the Board of Trustees unit and a $0.3 million increase in the HOD and Sections and Special Constituencies and International unit.

Administration and operations
These units provide administrative and operational support for Publishing, Health Solutions and Insurance, Membership and all other operating groups. Net expenses increased by $4.3 million in 2017, or 6.2 percent. The Physician Engagement and Portfolio Management unit was expanded in 2017 to add digital marketing and enhanced physician outreach, causing a $3 million net expense increase. This expansion is focused on improving the customer experience, reaching our members based on their interests and substantially enhancing communication of AMA’s important contributions to physicians’ professional life and the health care system. Senior Executive Management costs were up $1.8 million of which $0.9 million was due to contributions for disaster relief in areas impacted by hurricanes. The majority of the remaining cost increase was due to expanded use of third party consultants on major new initiatives.

Affiliated organizations
Affiliated Organizations represent either grant or in-kind service support provided by the AMA to other foundations and societies. In some cases, the AMA is reimbursed for services provided. Net expenses were unchanged in 2017.

Unallocated overhead
The net expenses in this area include costs not allocated back to operating units such as corporate insurance and actuarial services, employee incentive compensation, valuation allowances or other reserves. In 2017, these expenses totaled $16.8 million, up from $15.2 million in 2016. Higher incentive compensation accounted for the entire increase.

Health2047
In 2015, the AMA Board approved the use of reserves to establish this subsidiary with plans to use third-party resources to assist in funding key projects in future years.

Health2047 is a Silicon Valley-based innovation enterprise developing and commercializing solutions in the areas of data liquidity, chronic care, productivity, and payments to significantly change U.S. healthcare at the system level.

Health2047 will provide strategic insights through privileged access to the AMA and its physician network, help execute in product development and bring massive channel strength, all within a culture that can rapidly innovate and have the capacity to pursue multiple products and create a portfolio.

The innovation studio began operations in mid-2015 with a formal launch of the studio in early 2016. Development of initial projects is underway with strong market interest expressed by major corporations. In 2017, Health2047 spun out a new company, Health2047 SwitchCo, Inc. (doing business as Akiri in 2018), in order to commercialize efforts to build and deploy trusted infrastructure for permissions-based secure transport of health data. AkiriSwitch (the platform name) employs blockchain technology. Akiri began with a Series A investment, a core group of founding executives, and significant market interest in its open approach to building trusted infrastructure for private data transport. Akiri has quickly built out its engineering bench, attracting key engineering talent from recognized market innovators. The $10.4 million in net expenses reflects the results of both companies.

The summary of group operating results is included on the following page.
American Medical Association group operating results

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<td>$39.1</td>
<td>$25.3</td>
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<td>(6.6)</td>
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<td>Strategic Planning and Health Analytics</td>
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<td><strong>Total</strong></td>
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<td>(15.2)</td>
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<td><strong>Consolidated – excluding Health2047</strong></td>
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<td>323.7</td>
<td>32.5</td>
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<tr>
<td>Health2047</td>
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<td>(6.6)</td>
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<td><strong>Consolidated</strong></td>
<td>$347.6</td>
<td>$323.7</td>
<td>$22.1</td>
<td>$21.3</td>
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2017
CONSOLIDATED
FINANCIAL
STATEMENTS
American Medical Association and subsidiaries

CONSOLIDATED STATEMENTS OF ACTIVITIES

Years ended December 31

<table>
<thead>
<tr>
<th>(in millions)</th>
<th>2017</th>
<th>2016</th>
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<tr>
<td><strong>Revenues</strong></td>
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<tr>
<td>Membership dues</td>
<td>$37.9</td>
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<td>Advertising</td>
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<td>Periodical print subscription revenues</td>
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<td>Periodical online revenues</td>
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<td>Books, newsletters and online product sales</td>
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<td>Royalties and credentialing products</td>
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<td>131.7</td>
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<tr>
<td>Insurance commissions</td>
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<td>36.0</td>
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<td>Investment income (Note 4)</td>
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<td>Grants and other income</td>
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<td>10.3</td>
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<tr>
<td><strong>Total revenues</strong></td>
<td><strong>347.6</strong></td>
<td><strong>323.7</strong></td>
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<table>
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<th><strong>Expenses</strong></th>
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<td>Cost of products sold and selling expenses</td>
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<td>30.1</td>
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<tr>
<td><strong>Contribution to general and administrative expenses</strong></td>
<td><strong>319.4</strong></td>
<td><strong>293.6</strong></td>
</tr>
</tbody>
</table>

| **General and administrative expenses** |         |         |
| Compensation and benefits | 171.0   | 162.0   |
| Occupancy | 18.4    | 17.4    |
| Travel and meetings | 14.4    | 13.1    |
| Technology costs | 23.0    | 21.2    |
| Marketing and promotion | 20.0    | 11.3    |
| Professional services and consulting | 28.7    | 29.0    |
| Other operating expenses | 21.8    | 18.3    |
| **Total general and administrative expenses** | **297.3** | **272.3** |

| **Operating results before income taxes** |         |         |
| Income taxes (Note 9) | 8.3      | 7.7      |
| **Net operating results** | **13.8** | **13.6** |

| **Non-operating items** |         |         |
| Net gain on investments (Note 4) | 45.3    | 24.1    |
| Other | 0.1      | -       |
| **Total non-operating items** | **45.4** | **24.1** |

| **Revenues in excess of expenses** |         |         |
| Changes in defined benefit postretirement plans, other than periodic expense, net of tax (Notes 7, 8 and 9) | 11.4    | 0.4     |
| **Change in association equity – unrestricted** | **70.6** | **38.1** |

| **Change in temporarily restricted association equity** |         |         |
| Restricted contributions | 0.3      | 0.3      |
| Net assets released from restriction | (0.2)   | (0.4)   |
| **Change in association equity – temporarily restricted** | **0.1**  | **(0.1)** |
| **Change in association equity** | **70.7** | **38.0** |
| Association equity at beginning of year | 489.0    | 451.0    |
| **Association equity at end of year** | **$559.7** | **$489.0** |

See accompanying notes to the consolidated financial statements.
# CONSOLIDATED STATEMENTS OF FINANCIAL POSITION

As of December 31

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<th>2017</th>
<th>2016</th>
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<tbody>
<tr>
<td><strong>Assets</strong></td>
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<tr>
<td>Cash and cash equivalents</td>
<td>$48.0</td>
<td>$28.9</td>
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<td>Fiduciary funds (Note 2)</td>
<td>20.1</td>
<td>21.2</td>
</tr>
<tr>
<td>Accounts receivable and other receivables, net of an allowance for doubtful accounts of $0.1 in 2017 and 2016</td>
<td>59.6</td>
<td>40.1</td>
</tr>
<tr>
<td>Inventories</td>
<td>2.3</td>
<td>2.4</td>
</tr>
<tr>
<td>Prepaid expenses and deposits</td>
<td>5.9</td>
<td>5.3</td>
</tr>
<tr>
<td>Deferred income taxes (Note 9)</td>
<td>4.4</td>
<td>6.8</td>
</tr>
<tr>
<td>Investments (Note 4)</td>
<td>653.4</td>
<td>597.4</td>
</tr>
<tr>
<td>Property and equipment, net (Note 6)</td>
<td>47.1</td>
<td>48.8</td>
</tr>
<tr>
<td>Prepaid pension costs (Note 8)</td>
<td>1.1</td>
<td>-</td>
</tr>
<tr>
<td>Other assets (Note 5)</td>
<td>6.8</td>
<td>5.4</td>
</tr>
<tr>
<td><strong>Total Assets</strong></td>
<td><strong>$848.7</strong></td>
<td><strong>$756.3</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>2017</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Liabilities, deferred revenue and association equity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Liabilities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accounts payable and accrued expenses</td>
<td>$16.7</td>
<td>$15.9</td>
</tr>
<tr>
<td>Accrued payroll and employee benefits (Notes 7 and 8)</td>
<td>135.9</td>
<td>139.6</td>
</tr>
<tr>
<td>Insurance premiums and other fiduciary funds payable</td>
<td>20.5</td>
<td>20.7</td>
</tr>
<tr>
<td>Income taxes payable (Note 9)</td>
<td>1.9</td>
<td>0.8</td>
</tr>
<tr>
<td>Deferred tenant improvement allowances (Note 10)</td>
<td>17.1</td>
<td>17.1</td>
</tr>
<tr>
<td>Deferred rent obligations (Note 11)</td>
<td>22.5</td>
<td>21.3</td>
</tr>
<tr>
<td><strong>Total Liabilities</strong></td>
<td><strong>214.6</strong></td>
<td><strong>215.4</strong></td>
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</table>

<table>
<thead>
<tr>
<th></th>
<th>2017</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deferred revenue</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Membership dues</td>
<td>17.0</td>
<td>18.3</td>
</tr>
<tr>
<td>Subscriptions, licensing and royalties</td>
<td>54.4</td>
<td>31.7</td>
</tr>
<tr>
<td>Grants and other</td>
<td>3.0</td>
<td>1.9</td>
</tr>
<tr>
<td><strong>Total Deferred Revenue</strong></td>
<td><strong>74.4</strong></td>
<td><strong>51.9</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>2017</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Association equity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unrestricted</td>
<td>558.0</td>
<td>487.4</td>
</tr>
<tr>
<td>Temporarily restricted</td>
<td>1.7</td>
<td>1.6</td>
</tr>
<tr>
<td><strong>Total Association Equity</strong></td>
<td><strong>559.7</strong></td>
<td><strong>489.0</strong></td>
</tr>
</tbody>
</table>

See accompanying notes to the consolidated financial statements.
American Medical Association and subsidiaries

CONSOLIDATED STATEMENTS CASH FLOWS

Years ended December 31

(in millions)  

<table>
<thead>
<tr>
<th></th>
<th>2017</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cash flows from operating activities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Change in association equity</td>
<td>$70.7</td>
<td>$38.0</td>
</tr>
<tr>
<td>Adjustments to reconcile change in association equity to net cash provided by operating activities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depreciation and amortization</td>
<td>11.9</td>
<td>11.0</td>
</tr>
<tr>
<td>Pension and postretirement health care expense</td>
<td>8.3</td>
<td>9.3</td>
</tr>
<tr>
<td>Net gain on investments</td>
<td>(45.3)</td>
<td>(24.1)</td>
</tr>
<tr>
<td>Noncash credit for changes in defined benefit postretirement plans other than periodic expense, net of tax</td>
<td>(11.4)</td>
<td>(0.4)</td>
</tr>
<tr>
<td>Other</td>
<td>0.4</td>
<td>-</td>
</tr>
<tr>
<td>Changes in assets and liabilities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accounts receivable and other receivables</td>
<td>(19.5)</td>
<td>(5.1)</td>
</tr>
<tr>
<td>Fiduciary funds, net of payable</td>
<td>0.9</td>
<td>(0.5)</td>
</tr>
<tr>
<td>Inventories</td>
<td>0.1</td>
<td>0.2</td>
</tr>
<tr>
<td>Prepaid expenses and deposits</td>
<td>(0.6)</td>
<td>0.8</td>
</tr>
<tr>
<td>Deferred income taxes</td>
<td>(0.6)</td>
<td>(0.4)</td>
</tr>
<tr>
<td>Accounts payable, accrued liabilities and income taxes</td>
<td>1.4</td>
<td>-</td>
</tr>
<tr>
<td>Deferred rent obligations and tenant improvement allowances</td>
<td>1.2</td>
<td>(1.4)</td>
</tr>
<tr>
<td>Deferred revenue</td>
<td>22.5</td>
<td>2.1</td>
</tr>
<tr>
<td>Net cash provided by operating activities</td>
<td>40.0</td>
<td>29.5</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>2017</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cash flows from investing activities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Purchase of property and equipment</td>
<td>(10.3)</td>
<td>(9.8)</td>
</tr>
<tr>
<td>Purchase of investments</td>
<td>(331.7)</td>
<td>(404.3)</td>
</tr>
<tr>
<td>Proceeds from sale of investments</td>
<td>321.1</td>
<td>389.3</td>
</tr>
<tr>
<td>Net cash used in investing activities</td>
<td>(20.9)</td>
<td>(24.8)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>2017</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Net change in cash and cash equivalents</strong></td>
<td>19.1</td>
<td>4.7</td>
</tr>
<tr>
<td>Cash and cash equivalents at beginning of year</td>
<td>28.9</td>
<td>24.2</td>
</tr>
<tr>
<td>Cash and cash equivalents at end of year</td>
<td>$48.0</td>
<td>$28.9</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>2017</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Noncash investing activities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accounts payable for property and equipment additions</td>
<td>$0.7</td>
<td>$0.4</td>
</tr>
</tbody>
</table>

See accompanying notes to the consolidated financial statements.
1. Nature of operations

The American Medical Association (AMA) is a national professional association of physicians with approximately 243 thousand members. The AMA serves the medical community and the public through standard setting and implementation in the areas of science, medical education, improving health outcomes, delivery and payment systems, ethics, representation and advocacy, policy development, and image and identity building. The AMA provides information and services to hundreds of thousands of physicians and includes journal and book publishing, physician credentialing, database licensing, insurance and other professional services for physicians.

The AMA classifies all association results as revenues and expenses in the consolidated statements of activities, except non-operating items. Non-operating items include net realized and unrealized gains and losses on investments and other non-recurring income or expense.

Temporarily restricted equity includes contributions for physician liability reform and scope of practice. These funds are restricted for use to areas such as national tort reform campaign efforts and are not available for general use within the AMA.

2. Significant accounting policies

Consolidation policy

The accompanying consolidated financial statements include the accounts of the AMA and its subsidiaries (collectively, the AMA). In 2015, AMA established a new for-profit subsidiary, Health2047, designed to enhance AMA’s ability to contribute to improvements in the U.S. health care system and population health. In 2017, Health2047 established a new for-profit corporation, Health2047 SwitchCo, Inc. (SwitchCo), designed to improve the securing, sharing and use of trusted health data. As of December 31, 2017, Health2047 has consolidated the operations of SwitchCo. All significant intercompany transactions have been eliminated.

Use of estimates

Preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect reported amounts of assets, liabilities, revenues and expenses as reflected in the consolidated financial statements. Actual results could differ from estimates.

Cash equivalents

Cash equivalents consist of liquid investments with original maturities of three months or less and are recorded at cost, which approximates fair value.

Fiduciary funds

One of the AMA’s subsidiaries, the AMA Insurance Agency, Inc. (Agency), in its capacity as an insurance broker, collects premiums from the insured and, after deducting its commission, remits the premiums to the underwriter of the insurance coverage. Unremitted insurance premiums are invested on a short-term basis and are held in a fiduciary capacity. The AMA also collects and holds contributions on behalf of a separate unincorporated entity with $2.4 million and $2.3 million held at December 31, 2017 and 2016, respectively.

Inventories

Inventories, consisting primarily of books and paper for publications, are valued at the lower of cost or market.

Property and equipment

Property and equipment are carried at cost, less accumulated depreciation and amortization. Depreciation is computed using the straight-line method over the estimated useful lives of the assets. Equipment and software are depreciated or amortized over three to 10 years. Leasehold improvements are depreciated over the shorter of the estimated useful lives or the remaining lease term.

Revenue recognition

Membership dues are deferred and recognized as revenue in equal monthly amounts during the applicable membership year, which is a calendar year. Dues from lifetime memberships are recognized as revenue over the approximate life of the member. Prepaid dues are included as deferred revenue in the consolidated statements of financial position.

Licensing and subscriptions to periodicals, site licenses, newsletters or other online products are recognized as revenue ratably over the terms of the subscriptions or service period. Advertising revenue and direct publication costs are recognized in the period the related periodical is issued. Royalties are recognized as revenue over the royalty term.
Income taxes
The AMA is an exempt organization as defined by Section 501(c)(6) of the Internal Revenue Code and is subject to income taxes only on income determined to be unrelated business taxable income. The AMA’s subsidiaries are taxable entities and are subject to income taxes.

Reclassifications
Certain reclassifications have been made in the notes to the consolidated financial statements to conform the 2016 amounts to the 2017 presentation.

3. New accounting standards update

Recently issued accounting standards updates
In May 2014, the FASB issued ASU No. 2014-09, Revenue from Contracts with Customers. This requires an entity to recognize the amount of revenue to which it expects to be entitled for the transfer of promised goods or services to customers. The ASU will replace most existing revenue recognition guidance in U.S. GAAP. The FASB deferred the effective date of the new recognition standard and it is now effective for the AMA for years beginning after December 31, 2018. Early adoption is permitted. The adoption of this standard will not have a material impact on AMA’s consolidated financial statements.

In February 2016, the FASB issued ASU No. 2016-02, Leases. ASU No. 2016-02 requires a lessee to recognize a liability to make lease payments and an asset representing its right to use the underlying asset for the lease term in the statement of financial position for both operating and capital leases. The guidance will be effective for fiscal years beginning after December 15, 2019, and early adoption is permitted. The AMA plans to adopt this standard in 2018 and estimates that approximately $3 million of pension costs will be presented in the income statement separately from the service cost component and outside a subtotal of income from operations. ASU No. 2017-07 is effective for the AMA for years beginning after December 15, 2018, but early adoption is permitted. The AMA plans to adopt this standard in 2018 and estimates that approximately $3 million of pension expense and approximately $4 million of postretirement healthcare expense will be reclassified from operating expense to a separate line in non-operating expenses in the year of adoption. There will be no impact on the consolidated statements of financial position.

4. Investments

Investments include marketable securities and a private equity investment that are carried at fair value.

In determining fair value, the AMA uses various valuation approaches. The FASB’s ASC Topic 820, Fair Value Measurements and Disclosures, establishes a hierarchy for inputs used in measuring fair value that maximizes the use of observable inputs and minimizes the use of unobservable inputs by requiring that the most observable inputs be used when available. Observable inputs are inputs that market participants would use in pricing the asset based on market data obtained from sources independent of the organization. Unobservable inputs are inputs that would reflect an organization’s assumptions about the assumptions market participants would use in pricing the asset developed based on the best information available in the circumstances. The hierarchy is broken down into three levels based on the observability of inputs as follows:

Level 1—Valuations based on quoted prices in active markets for identical assets that the organization has the ability to access. Since valuations are based on quoted prices that are readily and regularly available in an active market, valuation of these products does not entail a significant degree of judgment.

Level 2—Valuations based on one or more quoted prices in markets that are not active or for which all significant inputs are observable, either directly or indirectly.
Level 3—Valuations based on inputs that are unobservable and significant to the overall fair value measurement.

The availability of observable inputs can vary from instrument to instrument and is affected by a wide variety of factors, including, for example, the liquidity of markets and other characteristics particular to the transaction. To the extent that valuation is based on models or inputs that are less observable or unobservable in the market, the determination of fair value requires more judgment.

The AMA uses prices and inputs that are current as of the measurement date, obtained through a third-party custodian from independent pricing services.

A description of the valuation techniques applied to the major categories of investments measured at fair value is outlined below.

Exchange-traded equity securities are valued based on quoted prices from the exchange. To the extent these securities are actively traded, valuation adjustments are not applied and they are categorized in Level 1 of the fair value hierarchy.

Mutual funds are open-ended Securities and Exchange Commission (SEC) registered investment funds with a daily NAV. The mutual funds allow investors to sell their interests to the fund at the published daily NAV, with no restrictions on redemptions. These mutual funds are categorized in Level 1 of the fair value hierarchy.

U.S. government securities are valued using quoted prices provided by a vendor or broker-dealer. These securities are categorized in Level 2 of the fair value hierarchy, as it is difficult for the custodian to accurately assess at a security level whether a quoted trade on a bond represents an active market.

U.S. government agency securities consist of two categories of agency issued debt. Non-callable agency issued debt securities are generally valued using dealer quotes. Callable agency issued debt securities are valued by benchmarking model-derived prices to quoted market prices and trade data for identical or comparable securities. Agency issued debt securities are categorized in Level 2 of the fair value hierarchy.

The fair value of corporate debt securities is estimated using recently executed transactions, market price quotations (where observable) or bond spreads. If the spread data does not reference the issuer, then data that reference a comparable issuer are used. Corporate debt securities are generally categorized in Level 2 of the fair value hierarchy.

Foreign and state government securities are valued using quoted prices in active markets when available. To the extent quoted prices are not available, fair value is determined based on interest rate yield curves, cross-currency basis index spreads, and country credit spreads for structures similar to the bond in terms of issuer, maturity, and seniority. These investments are generally categorized in Level 2 of the fair value hierarchy.

Investments also include investments in a diversified closed end private equity fund with a focus on buyout opportunities in the United States and the European Union. The investment is not redeemable and distributions are received through liquidation of the underlying assets of the fund. It is estimated that the underlying assets will be liquidated over the next four to ten years. The fair value estimates of these investments are based on NAV as provided by the investment manager. Unfunded commitments as of December 31, 2017 totaled $22.9 million.

The following table presents information about the AMA’s investments measured at fair value as of December 31.

In accordance with Subtopic 820-10, investments that are measured at fair value using the NAV per share (or its equivalent) practical expedient have not been classified in the fair value hierarchy. The fair value amounts presented in this table are intended to permit reconciliation of the fair value hierarchy to the amounts presented in the statements of financial position.

<table>
<thead>
<tr>
<th></th>
<th>2017</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Level 1 – Quoted prices in active market for identical securities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Equity securities</td>
<td>$312.1</td>
<td>$271.4</td>
</tr>
<tr>
<td>Fixed-income mutual funds</td>
<td>15.6</td>
<td>13.1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>$327.7</td>
<td>284.5</td>
</tr>
<tr>
<td><strong>Level 2 – Significant other observable inputs</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Debt securities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Corporate</td>
<td>90.4</td>
<td>82.0</td>
</tr>
<tr>
<td>U.S. government and federal agency</td>
<td>200.7</td>
<td>202.4</td>
</tr>
<tr>
<td>Foreign government</td>
<td>30.0</td>
<td>26.8</td>
</tr>
<tr>
<td>U.S. state government</td>
<td>0.3</td>
<td>0.4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>321.4</td>
<td>311.6</td>
</tr>
<tr>
<td><strong>Level 3 – Significant Unobservable inputs</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Other investments measured at NAV</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Private equity fund</td>
<td>4.3</td>
<td>1.3</td>
</tr>
<tr>
<td>Investments</td>
<td>$653.4</td>
<td>$597.4</td>
</tr>
</tbody>
</table>

Interest and dividends are included in investment income as operating revenue while realized and unrealized gains and losses are included as a component of non-operating items.
Investment income consists of:

<table>
<thead>
<tr>
<th></th>
<th>2017</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Investment dividend and interest income</td>
<td>$13.5</td>
<td>$12.0</td>
</tr>
<tr>
<td>Management fees</td>
<td>(2.5)</td>
<td>(2.2)</td>
</tr>
<tr>
<td></td>
<td>$11.0</td>
<td>$9.8</td>
</tr>
</tbody>
</table>

Non-operating items include:

<table>
<thead>
<tr>
<th></th>
<th>2017</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Realized gains on investments, net</td>
<td>$12.0</td>
<td>$1.0</td>
</tr>
<tr>
<td>Unrealized gains on investments, net</td>
<td>33.3</td>
<td>23.1</td>
</tr>
<tr>
<td></td>
<td>$45.3</td>
<td>24.1</td>
</tr>
</tbody>
</table>

5. Other assets

Other assets include investments in mutual funds maintained in separate accounts designated for various nonqualified benefit plans that are not available for operations. Mutual funds are open-ended SEC registered investment funds with a daily NAV. The mutual funds allow investors to sell their interests to the fund at the published daily NAV, with no restrictions on redemptions. These mutual funds are categorized in Level 1 of the fair value hierarchy. The investments totaled $6.8 million and $5.4 million at 2017 and 2016, respectively.

6. Property and equipment

Property and equipment at December 31 consists of:

<table>
<thead>
<tr>
<th></th>
<th>2017</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leasehold improvements</td>
<td>$35.9</td>
<td>$34.3</td>
</tr>
<tr>
<td>Furniture and office equipment</td>
<td>18.2</td>
<td>17.6</td>
</tr>
<tr>
<td>Information technology hardware and software</td>
<td>99.4</td>
<td>93.3</td>
</tr>
<tr>
<td></td>
<td>153.5</td>
<td>145.2</td>
</tr>
</tbody>
</table>

Accumulated depreciation and amortization (106.4) (96.4)

$47.1 $48.8

7. Retirement pension and savings plans

The AMA has a defined benefit pension plan covering eligible salaried and hourly employees. The plan is designed to pay a monthly retirement benefit that, together with Social Security benefits, provides retirement income based on employees’ earnings, age and years of service. Other employers participate in this plan and assets and liabilities are allocated between the AMA and the other employers.

The AMA amended the pension plan to freeze pension benefits as of December 31, 2002. After that date, no individual can become a participant in the plan and no further benefits accrue under the plan. Individuals not vested as of that date were credited for future years of service for vesting purposes only. As a result, the projected benefit obligation is equal to the accumulated benefit obligation for this plan.

The changes in benefit obligation and plan assets were as follows:

<table>
<thead>
<tr>
<th></th>
<th>2017</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Change in benefit obligation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Benefit obligation at beginning of year</td>
<td>$123.6</td>
<td>$122.3</td>
</tr>
<tr>
<td>Interest cost</td>
<td>4.5</td>
<td>4.7</td>
</tr>
<tr>
<td>Benefits paid</td>
<td>(6.6)</td>
<td>(5.3)</td>
</tr>
<tr>
<td>Actuarial loss</td>
<td>2.5</td>
<td>1.9</td>
</tr>
<tr>
<td>Benefit obligation at end of year</td>
<td>$124.0</td>
<td>$123.6</td>
</tr>
<tr>
<td>Change in plan assets</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fair value of plan assets at beginning of year</td>
<td>$119.5</td>
<td>$19.4</td>
</tr>
<tr>
<td>Return on plan assets</td>
<td>12.2</td>
<td>5.4</td>
</tr>
<tr>
<td>Benefits paid</td>
<td>(6.6)</td>
<td>(5.3)</td>
</tr>
<tr>
<td>Fair value of plan assets at end of year</td>
<td>$125.1</td>
<td>$119.5</td>
</tr>
</tbody>
</table>

The funded status and amounts recognized in the AMA’s consolidated statements of financial position at December 31 are:

<table>
<thead>
<tr>
<th></th>
<th>2017</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fair value of plan assets</td>
<td>$125.1</td>
<td>$119.5</td>
</tr>
<tr>
<td>Projected benefit obligation</td>
<td>124.0</td>
<td>123.6</td>
</tr>
<tr>
<td>Prepaid (accrued) pension costs</td>
<td>$1.1</td>
<td>$(4.1)</td>
</tr>
</tbody>
</table>

In accordance with ASC Topic 958-715, Employers’ Accounting for Defined Benefit Pension and Other Postretirement Plans, all previously unrecognized actuarial losses are reflected in the consolidated statements of financial position. Accumulated amounts recognized in unrestricted equity that are not yet recognized as a component of periodic pension expense are:

<table>
<thead>
<tr>
<th></th>
<th>2017</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Actuarial losses</td>
<td>$37.0</td>
<td>$45.1</td>
</tr>
<tr>
<td></td>
<td>$37.0</td>
<td>$45.1</td>
</tr>
</tbody>
</table>

An estimated $3.6 million of this amount will be included as a component of pension expense in 2017.

The weighted-average assumptions used in determining the December 31 benefit assumptions were:

<table>
<thead>
<tr>
<th></th>
<th>2017</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discount rate</td>
<td>3.4%</td>
<td>3.8%</td>
</tr>
</tbody>
</table>
The AMA recognizes pension expense in its consolidated statements of activities. The provisions of ASC Topic 958-715 require the AMA to recognize settlement charges based on the lump-sum benefit payments in 2017 and 2016. The components of pension expense are:

<table>
<thead>
<tr>
<th></th>
<th>2017</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interest cost</td>
<td>$4.5</td>
<td>$4.7</td>
</tr>
<tr>
<td>Expected return on plan assets</td>
<td>(6.9)</td>
<td>(6.9)</td>
</tr>
<tr>
<td>Lump-sum settlement charges</td>
<td>1.4</td>
<td>1.2</td>
</tr>
<tr>
<td>Recognized actuarial loss</td>
<td>3.9</td>
<td>4.1</td>
</tr>
<tr>
<td>Pension expense</td>
<td>$2.9</td>
<td>$3.1</td>
</tr>
</tbody>
</table>

Pension-related changes, other than periodic pension expense, that have been included as a charge or credit to unrestricted equity consist of:

<table>
<thead>
<tr>
<th></th>
<th>2017</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Actuarial gains (losses) arising during period</td>
<td>$2.8</td>
<td>$(3.4)</td>
</tr>
<tr>
<td>Reclassification adjustment for losses reflected in periodic pension expense</td>
<td>5.3</td>
<td>5.3</td>
</tr>
<tr>
<td>Change in unrestricted equity</td>
<td>$8.1</td>
<td>$1.9</td>
</tr>
</tbody>
</table>

Actuarial assumptions used in determining pension expense were:

<table>
<thead>
<tr>
<th></th>
<th>2017</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discount rate</td>
<td>3.8%</td>
<td>4%</td>
</tr>
<tr>
<td>Expected long-term return on plan assets</td>
<td>5.75%</td>
<td>5.75%</td>
</tr>
</tbody>
</table>

To develop the expected long-term rate of return on plan assets for the pension plan, the AMA considered the current level of expected returns on risk-free investments (primarily government bonds), the historical level of risk premium associated with the other asset classes in which the portfolio is invested and the expectations for future returns of each asset class. The expected return for each asset class is then weighted based on the target asset allocation to develop the expected long-term rate of return on assets assumption for the portfolio.

The AMA’s investment strategy reflects the expectation that equity securities will outperform debt securities over the long term. Assets are invested in a prudent manner to maintain the security of funds while maximizing returns within the plan’s investment policy guidelines. The strategy is implemented utilizing actively managed assets from the categories listed below.

The investment goal is to provide a total return that, over the long term, increases the ratio of plan assets to liabilities subject to an acceptable level of risk. This is accomplished through diversification of assets in accordance with the investment policy. Periodic rebalancing occurs after the end of each calendar quarter, as required by the policy.

The target allocations for plan assets are 45 percent equity securities, 50 percent corporate bonds and U.S. Treasury or Agency securities, and 5 percent in cash and cash equivalents.

Equity securities include investments in large-cap, mid-cap, and small-cap companies primarily located in the United States and large- to mid-cap companies outside the United States through investments in mutual funds.

Mutual funds are open-ended SEC registered investment funds with a daily NAV.

Fixed-income securities include primarily investment grade corporate bonds of companies from diversified industries and U.S. Treasury or Agency securities and foreign government securities, either through direct investment in bonds or through common trusts, as well as an allocation to high-yield U.S. corporate bonds, with a target of 4 percent of the portfolio.

The following fair value hierarchy tables present information about the AMA pension plan investments measured at fair value as of December 31.

<table>
<thead>
<tr>
<th></th>
<th>2017</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 1 – Quoted prices in active markets for identical securities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>U.S. equity securities</td>
<td>$45.8</td>
<td>$42.8</td>
</tr>
<tr>
<td>International mutual funds</td>
<td>9.5</td>
<td>9.0</td>
</tr>
<tr>
<td>Fixed-income mutual funds</td>
<td>37.1</td>
<td>36.4</td>
</tr>
<tr>
<td>High-yield fixed income mutual fund</td>
<td>5.1</td>
<td>4.8</td>
</tr>
<tr>
<td>Total</td>
<td>97.5</td>
<td>93.0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>2017</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 2 – Significant other observable inputs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Debt securities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Corporate</td>
<td>9.8</td>
<td>9.6</td>
</tr>
<tr>
<td>U.S. government and agency</td>
<td>16.7</td>
<td>15.7</td>
</tr>
<tr>
<td>Foreign government</td>
<td>1.1</td>
<td>1.2</td>
</tr>
<tr>
<td>Total</td>
<td>27.6</td>
<td>26.5</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>2017</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 3 – Significant unobservable inputs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Marketable investments – all levels</td>
<td>$125.1</td>
<td>$119.5</td>
</tr>
</tbody>
</table>

The AMA currently anticipates making no contribution to the pension plan in 2018, as plan assets are greater than the target of 110 percent of liabilities as calculated for funding purposes. This estimate is based on current tax laws, plan asset performance and liability assumptions, which are subject to change. Any shortfall in plan asset performance from the expected rate of return, or increase in plan liabilities due to lower interest rates, could cause contributions to increase by an amount equivalent to the shortfall in performance or increase in the present value of plan liabilities.
The following pension benefit payments are expected:

<table>
<thead>
<tr>
<th>Year</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>2018</td>
<td>$9.0</td>
</tr>
<tr>
<td>2019</td>
<td>9.0</td>
</tr>
<tr>
<td>2020</td>
<td>9.9</td>
</tr>
<tr>
<td>2021</td>
<td>7.7</td>
</tr>
<tr>
<td>2022</td>
<td>8.2</td>
</tr>
<tr>
<td>2023 – 2027</td>
<td>3.73</td>
</tr>
</tbody>
</table>

The AMA also has a 401(k) retirement and savings plan, which allows eligible employees to contribute up to 75 percent of their compensation annually, subject to Internal Revenue Service (IRS) limits. The AMA matches 100 percent of the first 3 percent and 50 percent of the next 2 percent of employee contributions. The AMA may, in its discretion, make additional contributions for any year in an amount up to 2 percent of the compensation for each eligible employee. Compensation is subject to IRS limits and excludes bonuses and severance pay. AMA matching and discretionary contribution expense totaled $5.6 million and $5.3 million in 2017 and 2016, respectively.

The AMA also maintains a non-qualified, unfunded supplemental pension plan for certain long-term employees. Participation in the plan was closed in 1994. The AMA recognizes the liability in its consolidated statements of financial position. The accumulated benefit obligation and liability totaled $0.4 million in 2017 and 2016. The AMA uses the same discount rates noted above for the pension plan to determine the plan benefit obligation. There was no associated expense for this plan in 2017 and 2016. There were no changes in pension actuarial losses that are not yet reflected in periodic pension expense, but included in unrestricted equity in 2017 and 2016.

The AMA expects to pay approximately $0.4 million in benefits from the supplemental pension plan over the next five years.

8. Postretirement health care benefits

The AMA provides health care benefits to retired employees who were employed on or prior to December 31, 2010. After that date, no individual can become a participant in the plan. Generally, qualified employees become eligible for these benefits if they retire in accordance with provisions similar to the AMA’s pension plan and are participating in the AMA medical plan at the time of their retirement. The AMA shares the cost of the retiree health care payments with retirees, paying approximately 60 to 80 percent of the benefit payments. The AMA has the right to modify or terminate the postretirement benefit plan at any time. Other employers participate in this plan and assets and liabilities are allocated between the AMA and the other employers.

The AMA has applied for and received the federal subsidy to sponsors of retiree health care benefit plans that provides a prescription drug benefit that is actuarially equivalent to Medicare Part D under the Medicare Prescription Drug, Improvement and Modernization Act of 2003. In accordance with ASC Topic 958-715, the AMA initially accounted for the subsidy as an actuarial experience gain to the accumulated postretirement benefit obligation.

The postretirement health care plan is unfunded. In accordance with ASC Topic 958-715, the AMA recognizes this liability in its consolidated statements of financial position.

The following reconciles the change in accumulated benefit obligation and the amounts included in the consolidated statements of financial position at December 31:

<table>
<thead>
<tr>
<th></th>
<th>2017</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Change in benefit obligation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Benefit obligation at beginning of year</td>
<td>$106.4</td>
<td>$100.7</td>
</tr>
<tr>
<td>Service cost</td>
<td>1.7</td>
<td>1.9</td>
</tr>
<tr>
<td>Interest cost</td>
<td>4.0</td>
<td>4.3</td>
</tr>
<tr>
<td>Benefits paid</td>
<td>(3.6)</td>
<td>(3.5)</td>
</tr>
<tr>
<td>Participant contributions</td>
<td>1.0</td>
<td>1.0</td>
</tr>
<tr>
<td>Federal subsidy</td>
<td>0.2</td>
<td>0.2</td>
</tr>
<tr>
<td>Plan amendments</td>
<td>(2.8)</td>
<td>-</td>
</tr>
<tr>
<td>Actuarial (gains) losses</td>
<td>(3.8)</td>
<td>1.8</td>
</tr>
<tr>
<td>Accrued postretirement benefit costs</td>
<td>$103.1</td>
<td>$106.4</td>
</tr>
</tbody>
</table>

The postretirement health care plan accumulated losses and prior service credits not yet recognized as a component of periodic postretirement health care expense, but included as an accumulated charge or credit to equity as of December 31 are:

<table>
<thead>
<tr>
<th></th>
<th>2017</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Actuarial losses</td>
<td>$21.0</td>
<td>$25.3</td>
</tr>
<tr>
<td>Prior service credits</td>
<td>(3.5)</td>
<td>(1.5)</td>
</tr>
<tr>
<td></td>
<td>$17.5</td>
<td>$23.8</td>
</tr>
</tbody>
</table>

An estimated $1 million in prior service credits and $1.2 million of actuarial losses will be included as components of postretirement health care expense in 2018.

Actuarial assumptions used in determining the accumulated benefit obligation at December 31 are:

<table>
<thead>
<tr>
<th></th>
<th>2017</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discount rate</td>
<td>3.7%</td>
<td>4.3%</td>
</tr>
<tr>
<td>Initial health care cost trend</td>
<td>6.22%</td>
<td>6.39%</td>
</tr>
<tr>
<td>Ultimate health care cost trend</td>
<td>4.5%</td>
<td>4.5%</td>
</tr>
<tr>
<td>Year that the rate reaches the ultimate trend rate</td>
<td>2038</td>
<td>2038</td>
</tr>
</tbody>
</table>
The AMA recognizes postretirement health care expense in its consolidated statements of activities. The components of expense are:

<table>
<thead>
<tr>
<th>2017</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service cost</td>
<td>$1.7</td>
</tr>
<tr>
<td>Interest cost</td>
<td>4.0</td>
</tr>
<tr>
<td>Recognized actuarial loss</td>
<td>0.5</td>
</tr>
<tr>
<td>Amortization of prior service credits</td>
<td>(0.8)</td>
</tr>
<tr>
<td>Postretirement health care expense</td>
<td>$5.4</td>
</tr>
</tbody>
</table>

Postretirement health care-related changes, other than periodic expense, that have been included as a charge or credit to unrestricted equity consist of:

<table>
<thead>
<tr>
<th>2017</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Actuarial gains (losses) arising during period</td>
<td>$3.8</td>
</tr>
<tr>
<td>Reclassification adjustment for losses reflected in periodic postretirement health care expense</td>
<td>0.5</td>
</tr>
<tr>
<td>Plan amendments</td>
<td>2.8</td>
</tr>
<tr>
<td>Reclassification adjustment for recognition of prior service credits</td>
<td>(0.8)</td>
</tr>
<tr>
<td>Change in unrestricted equity</td>
<td>$6.3</td>
</tr>
</tbody>
</table>

Actuarial assumptions used in determining postretirement health care expense are the same assumptions noted in the table above for determining the accumulated benefit obligation, except as follows:

<table>
<thead>
<tr>
<th>2017</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discount rate</td>
<td>4.3%</td>
</tr>
<tr>
<td>Initial health care cost trend</td>
<td>6.39%</td>
</tr>
<tr>
<td>Year that the rate reaches the ultimate trend rate</td>
<td>2038</td>
</tr>
</tbody>
</table>

A one-percentage point change in assumed health care cost rates would have the following effect:

<table>
<thead>
<tr>
<th>1% Increase</th>
<th>1% Decrease</th>
</tr>
</thead>
<tbody>
<tr>
<td>Effect on postretirement service and interest cost</td>
<td>$1.3</td>
</tr>
<tr>
<td>Effect on postretirement benefit obligation</td>
<td>$21.8</td>
</tr>
</tbody>
</table>

The following postretirement health care benefit payments are expected to be paid by the AMA, net of contributions by retirees and federal subsidies:

<table>
<thead>
<tr>
<th>Year</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>2018</td>
<td>$2.3</td>
</tr>
<tr>
<td>2019</td>
<td>2.6</td>
</tr>
<tr>
<td>2020</td>
<td>2.8</td>
</tr>
<tr>
<td>2021</td>
<td>3.0</td>
</tr>
<tr>
<td>2022</td>
<td>3.2</td>
</tr>
<tr>
<td>2023 - 2027</td>
<td>19.5</td>
</tr>
</tbody>
</table>

9. Income taxes

The provision for income taxes includes:

<table>
<thead>
<tr>
<th>2017</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Operating</td>
<td></td>
</tr>
<tr>
<td>Current</td>
<td>$8.9</td>
</tr>
<tr>
<td>Deferred</td>
<td>0.6</td>
</tr>
<tr>
<td>Valuation allowance</td>
<td>(1.2)</td>
</tr>
<tr>
<td>Tax expense (credit) related to credits or charges to equity</td>
<td></td>
</tr>
<tr>
<td>Deferred</td>
<td>3.0</td>
</tr>
<tr>
<td>Change in unrestricted equity</td>
<td>$11.3</td>
</tr>
</tbody>
</table>

As prescribed under ASC Topic 740, Income Taxes, the AMA determines its provision for income taxes using the asset and liability method. Under this method, deferred tax assets and liabilities are recognized for future tax effects of temporary differences between the financial statement carrying amounts of existing assets and liabilities and their respective tax basis.

The deferred tax benefit or charge from credits or charges to equity represents the estimated tax benefit from recording unrecognized actuarial losses and prior service credits for both the pension and postretirement health care plans, pursuant to ASC Topic 958-715.

Valuation allowances are provided to reduce deferred tax assets to an amount that is more likely than not to be realized. The AMA evaluates the likelihood of realizing its deferred tax assets by estimating sources of future taxable income and assessing whether or not it is likely that future taxable income will be adequate for the AMA to realize the deferred tax asset. The AMA established an initial valuation allowance in 2009 to reflect the fact that deferred tax assets include future expected benefits, largely related to retiree health care payments, that may not be deductible due to a projected lack of taxable advertising income in future years. Increases or decreases in deferred tax assets, where future benefits are considered unlikely, will result in an equal and offsetting change in the valuation reserve. If the AMA were to make a determination in future years that these deferred tax assets would be realized, the related valuation allowance would be reduced and a benefit to earnings recorded.

Operating tax expense was not materially impacted by changes in the tax law, as a reduction in deferred tax assets of $1.3 million was offset by an equivalent reduction in the valuation allowance. Tax expense related to credits to equity increased by $2 million with an offsetting reduction in deferred tax assets as a result of the change in tax law.
Deferred tax assets recognized in the consolidated statements of financial position at December 31 are:

<table>
<thead>
<tr>
<th></th>
<th>2017</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benefit plans and compensation</td>
<td>$6.9</td>
<td>$11.0</td>
</tr>
<tr>
<td>Other</td>
<td>0.4</td>
<td>(0.1)</td>
</tr>
<tr>
<td>Valuation allowance</td>
<td>(2.9)</td>
<td>(4.1)</td>
</tr>
<tr>
<td></td>
<td>$4.4</td>
<td>$6.8</td>
</tr>
</tbody>
</table>

Cash payments for income taxes were $7.8 million and $8.5 million in 2017 and 2016, respectively.

10. Deferred tenant improvement allowances

As part of the new headquarters lease agreement that commenced in 2013, the AMA received a total of $21.7 million tenant improvement allowance from the landlord in 2012 and 2013. In 2016, AMA renegotiated its office lease in Washington D.C. and received $1.4 million in new tenant allowances. This is in addition to the initial $2.1 million tenant allowance related to the Washington D.C. office space received in 2007. A new lease in New Jersey that was effective in 2017 included $0.2 million in tenant allowances.

Tenant improvement allowances are recorded as a deferred liability on the consolidated statements of financial position and as a cash inflow from operating activities in the consolidated statements of cash flows. Capital expenditures funded by the tenant improvement allowances received are capitalized as leasehold improvements on the consolidated statements of financial position and as capital expenditures in the consolidated statements of cash flows. The tenant allowances are deferred and amortized on a straight-line basis over the life of the leases as a reduction of rent expense.

11. Deferred rent obligations

The headquarters lease agreement included rent abatement through August 2015 as well as rent escalation clauses over the life of the lease. The Washington D.C. and New Jersey office leases also include rent abatement and escalation clauses. AMA is required to recognize rent expense on a straight-line basis beginning on the earlier of the first rent payment or the date of possession of the leased property. The difference between the amounts charged to expense and the rent paid is recorded as a deferred rent obligation and amortized over the lease term.

12. Commitments and contingencies

**Lease commitments**

Rent expense under operating leases, including executory costs and taxes, was $13.3 million and $12.8 million in 2017 and 2016, respectively. Future minimum lease payments as of December 31, 2017 are:

<table>
<thead>
<tr>
<th>Year</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>2018</td>
<td>$10.6</td>
</tr>
<tr>
<td>2019</td>
<td>11.4</td>
</tr>
<tr>
<td>2020</td>
<td>11.6</td>
</tr>
<tr>
<td>2021</td>
<td>11.7</td>
</tr>
<tr>
<td>2022</td>
<td>11.7</td>
</tr>
<tr>
<td>2023 and beyond</td>
<td>76.3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$133.3</strong></td>
</tr>
</tbody>
</table>

All leases have renewal options.

**Contingencies**

In the opinion of management, there are no pending legal actions for which the ultimate liability will have a material effect on the equity of the AMA.
13. Functional expenses

<table>
<thead>
<tr>
<th>Category</th>
<th>2017</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Membership</td>
<td>$12.5</td>
<td>$11.1</td>
</tr>
<tr>
<td>Publishing, health solutions, and insurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Publishing</td>
<td>51.5</td>
<td>52.3</td>
</tr>
<tr>
<td>Database products</td>
<td>10.8</td>
<td>12.0</td>
</tr>
<tr>
<td>Book and digital content</td>
<td>20.9</td>
<td>20.6</td>
</tr>
<tr>
<td>Insurance agency</td>
<td>17.9</td>
<td>18.2</td>
</tr>
<tr>
<td>Integrated health model initiative</td>
<td>2.5</td>
<td>1.4</td>
</tr>
<tr>
<td>Other business operations</td>
<td>2.1</td>
<td>2.3</td>
</tr>
<tr>
<td></td>
<td><strong>105.7</strong></td>
<td><strong>106.8</strong></td>
</tr>
<tr>
<td>Investments</td>
<td>0.8</td>
<td>0.6</td>
</tr>
<tr>
<td>Strategic focus areas and core operations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strategic focus areas</td>
<td>24.9</td>
<td>21.7</td>
</tr>
<tr>
<td>Advocacy</td>
<td>27.1</td>
<td>25.1</td>
</tr>
<tr>
<td>Health, science and medical education</td>
<td>15.7</td>
<td>14.4</td>
</tr>
<tr>
<td>Communications and marketing</td>
<td>22.1</td>
<td>16.7</td>
</tr>
<tr>
<td></td>
<td><strong>89.8</strong></td>
<td><strong>77.9</strong></td>
</tr>
<tr>
<td>Governance</td>
<td>14.2</td>
<td>13.4</td>
</tr>
<tr>
<td>Administration and operations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Information technology</td>
<td>28.1</td>
<td>29.5</td>
</tr>
<tr>
<td>Corporate services</td>
<td>5.8</td>
<td>5.6</td>
</tr>
<tr>
<td>Senior executive management</td>
<td>7.0</td>
<td>5.2</td>
</tr>
<tr>
<td>Physician engagement and</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Portfolio management</td>
<td>14.2</td>
<td>11.2</td>
</tr>
<tr>
<td>General counsel</td>
<td>5.1</td>
<td>5.0</td>
</tr>
<tr>
<td>Finance and risk management</td>
<td>6.7</td>
<td>6.6</td>
</tr>
<tr>
<td>Human resources</td>
<td>5.1</td>
<td>4.7</td>
</tr>
<tr>
<td>Strategic planning and health analytics</td>
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</tr>
<tr>
<td>Other</td>
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<td>16.3</td>
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</tr>
<tr>
<td></td>
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<td><strong>$302.4</strong></td>
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14. Subsequent events

ASC Topic 855, *Subsequent Events*, establishes general standards of accounting for and disclosure of events that occur after the balance sheet date but before financial statements are issued or are available to be issued. For the year ended December 31, 2017, the AMA has evaluated all subsequent events through February 28, 2018, which is the date the consolidated financial statements were available to be issued.
INDEPENDENT AUDITORS’ REPORT

The Board of Trustees of American Medical Association

We have audited the accompanying consolidated financial statements of the American Medical Association (the “AMA”) and subsidiaries, which comprise the consolidated statements of financial position as of December 31, 2017 and 2016, and the related consolidated statements of activities and of cash flows for the years then ended, and the related notes to the consolidated financial statements.

Management’s Responsibility for the Consolidated Financial Statements

Management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditors’ Responsibility

Our responsibility is to express an opinion on these consolidated financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditor’s judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the AMA’s preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the AMA’s internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of the American Medical Association and subsidiaries as of December 31, 2017 and 2016, and the results of its activities and changes in its equity and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Deloitte & Touche LLP
Chicago, Illinois
February 28, 2018

Written Statement of Certification of Chief Executive Officer and Chief Financial Officer

The undersigned hereby certify that the information contained in the audited financial statements of the American Medical Association for the years ended December 31, 2017 and 2016 fairly presents, in all material respects, the financial condition and the results of operations of the American Medical Association.

James L. Madara, MD
Executive Vice President and Chief Executive Officer

Denise M. Hagerty
Senior Vice President and Chief Financial Officer

February 28, 2018
2017–2018 OFFICERS AND TRUSTEES
2017–2018 AMA BOARD OF TRUSTEES
AND EXECUTIVE LEADERSHIP

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Executive Vice President and
Chief Executive Officer

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Jesse M. Ehrenfeld, MD, MPH
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Patrice A. Harris, MD, MA

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Chair
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S. Bobby Mukkamala, MD
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Gerald E. Harmon, MD (ex-officio w/vote)
Jack Resneck Jr., MD (ex-officio w/vote)
Patrice A. Harris, MD, MA (ex-officio w/vote)

Note: Drs. Harmon, Resneck and Harris serve on all committees, except where otherwise noted, as ex-officio members without vote. Dr. Barbe serves on all committees as an ex-officio member with vote.
REPORT OF THE BOARD OF TRUSTEES

Subject: AMA 2019 Dues

Presented by: Gerald E. Harmon, MD, Chair

Referred to: Reference Committee F
(Julia V. Johnson, MD, Chair)

Our American Medical Association (AMA) last raised its dues in 1994. AMA continues to invest in improving the value of membership. As our AMA’s membership benefits portfolio is modified and enhanced, management will continually evaluate dues pricing to ensure optimization of the membership value proposition.

RECOMMENDATION

2019 Membership Year

The Board of Trustees recommends no change to the dues levels for 2019, that the following be adopted and that the remainder of this report be filed:

13 Regular Members $ 420
14 Physicians in Their Second Year of Practice $ 315
15 Physicians in Military Service $ 280
16 Physicians in Their First Year of Practice $ 210
17 Semi-Retired Physicians $ 210
18 Fully Retired Physicians $ 84
19 Physicians in Residency Training $ 45
20 Medical Students $ 20

(Directive to Take Action)

Fiscal Note: No significant fiscal impact.
At the 2017 Annual Meeting, the American Medical Association (AMA) House of Delegates adopted Policy H-140.837, “Anti-Harassment Policy” (see Appendix for full text). The policy was proffered by Board of Trustees Report 23-A-17, which provided that:

Upon adoption of the Anti-Harassment Policy, the Board will establish a formal process by which any delegate, AMA Entity member or AMA staff member who feels he/she has experienced or witnessed conduct in violation of this policy may report such incident. Additionally, the Board will consider and prepare for future consideration by the HOD, potential corrective action and/or discipline for conduct in violation of this policy, which may include, but shall not be limited to, referral of the matter to the applicable delegation, expulsion from AMA meetings, or expulsion from the HOD.

Board of Trustees Report 23-A-17 also noted that AMA Human Resources policies establish zero tolerance regarding harassment with respect to AMA personnel, agents, and nonemployees, including AMA members. This report of the Board of Trustees recommends procedures to fully implement the anti-harassment policy with respect to conduct during meetings of the House of Delegates, councils, sections, and all other AMA entities, such as the RVS Update Committee (RUC) and CPT Editorial Panel.

DISCUSSION

Professional associations’ anti-harassment policies are designed to support the open exchange of ideas central to their mission and to ensure that those who participate in association activities “enjoy an environment free from all forms of discrimination, harassment, and retaliation” [1]. Surprisingly few professional associations have published anti-harassment policies. These associations have established mechanisms to address allegations of harassment that designate the association officer(s) or other association authority to whom incidents should be reported, provide for confidential investigation of alleged inappropriate conduct, and define sanctions that may be imposed if conduct is found to violate association policy [1-5].

The Board notes that the AMA’s existing mandatory recurring anti-harassment training includes not only staff, but also members of the Board and all AMA councils and section governing councils. It is the Board’s hope that this training will educate AMA leaders on what is and is not acceptable behavior, to help ensure the absence of harassing behavior in connection with meetings of AMA entities. However, given our zero tolerance policy for such behavior, we believe that a formal process for reporting, investigation and resolution should be established.
AMA Human Resources Policy 015 provides that a complaint of harassment by an AMA staff member be reported immediately to the Senior Vice President of Human Resources or the Executive Vice President for investigation and appropriate action. AMA Human Resources Policy 205 designates an external vendor to confidentially receive concerns regarding failure to comply with law, regulation or policy. The vendor will notify AMA of any concern received so that AMA may investigate. HR Policy 205 does not by its terms extend to the House of Delegates, councils, sections, or all other AMA entities, such as the RUC and CPT Editorial Panel.

The Board believes it is preferable to address allegations of harassment at the time they occur, whenever possible. In some cases, individuals who are the recipients of or who witness what they perceive to be harassing conduct may elect to address the conduct with the accused as a first step, giving the individual an opportunity to apologize and to correct behavior. When the recipient or witness is uncomfortable addressing harassing behavior directly, or is dissatisfied with the accused’s response to a direct address, the Board recommends that harassing conduct be reported in keeping with the policy set out below.

The Board further believes it is the responsibility of those who chair activities associated with the AMA to assist in enforcing Policy H-140.837, “Anti-Harassment.” For meetings of the AMA House of Delegates, the Board deems the Speaker and Vice Speaker of the House to be appropriate authorities to receive complaints of harassment involving AMA House of Delegates. For other activities associated with the AMA, such as meetings of AMA councils, sections, the RVS Update Committee (RUC), or CPT Editorial Panel, the Board deems the presiding officer(s) of such activities to be appropriate authorities to receive complaints. Alternatively, complaints may be lodged with the Chair of the Board or the AMA Office of General Counsel. Absent an emergent situation, the recipient of the complaint must maintain the report in confidence, aside from the further reporting called for by policy. Additionally, and consistent with AMA Human Resources Policy 205, the Board believes that individuals who are not comfortable with in-person reporting to the above-designated authorities should have the option of reporting to an outside vendor.

RECOMMENDATION

Consistent with approaches taken in the professional community and in keeping with existing AMA policy regarding harassment, the Board of Trustees recommends that Policy H-140.837, “Anti-Harassment Policy,” be amended by deleting Section 2 thereof, in its entirety, that the following be adopted, and that the remainder of this report be filed:

1. Reporting a complaint of harassment

Any persons who believe they have experienced or witnessed conduct in the AMA House of Delegates in violation of Anti-Harassment Policy H-140.837 should promptly notify the Speaker or Vice Speaker of the House or the AMA Office of General Counsel.

Any persons who believe they have experienced or witnessed conduct in other activities associated with the AMA (such as meetings of AMA councils, sections, the RVS Update Committee (RUC), or CPT Editorial Panel) in violation of Anti-Harassment Policy H-140.837 should promptly notify the presiding officer(s) of such AMA-associated meeting or activity or either the Chair of the Board or the AMA Office of General Counsel.

Anyone who prefers to register a complaint to an external vendor may do so using an AMA compliance hotline (telephone and online) maintained on behalf of the AMA. The name of the
reporting party will be kept confidential by the vendor and not be released to the AMA. The vendor will advise the AMA of any complaint it receives so that the AMA may investigate.

2. Investigations

Investigations of harassment complaints will be conducted by AMA Human Resources. Each complaint of harassment or retaliation shall be promptly and thoroughly investigated. Generally, AMA Human Resources will (a) use reasonable efforts to minimize contact between the accuser and the accused during the pendency of an investigation and (b) provide the accused an opportunity to respond to allegations. Based on its investigation, AMA Human Resources will make a determination as to whether a violation of Anti-Harassment Policy H-140.837 has occurred.

3. Disciplinary Action

If AMA Human Resources determines that a violation of Anti-Harassment Policy H-140.837 has occurred, AMA Human Resources shall (i) notify the Speaker and Vice Speaker of the House or the presiding officer(s) of such other AMA-associated meeting or activity in which such violation occurred, as applicable, of such determination, and (ii) refer the matter to a three-member disciplinary committee comprised of the Chair of the Board of Trustees, the Immediate Past President of the AMA and the President-Elect of the AMA, for disciplinary and/or corrective action, which may include but is not limited to expulsion from the relevant AMA-associated meetings or activities and/or referral to the Council on Ethical and Judicial Affairs (CEJA) for further review and action.

If a Delegate or Alternate Delegate is determined to have violated Anti-Harassment Policy H-140.837, the disciplinary committee shall determine disciplinary and/or corrective action in consultation with the Speaker and Vice Speaker of the House.

If a member of an AMA council, section, the RVS Update Committee (RUC), or CPT Editorial Panel is determined to have violated Anti-Harassment Policy H-140.837, the disciplinary committee shall determine disciplinary and/or corrective action in consultation with the presiding officer(s) of such activities.

If a nonmember or non-AMA party is the accused, AMA Human Resources shall refer the matter to appropriate AMA management, and when appropriate, may suggest that the complainant contact legal authorities.

4. Confidentiality

To the fullest extent possible, the AMA will keep complaints, investigations and resolutions confidential, consistent with usual business practice. (New HOD Policy)

Fiscal note: Less than $1,000
REFERENCES


APPENDIX

AMA Policy H-140.837, “Anti-Harassment Policy”

1. Our AMA adopts the following policy:

**Anti-Harassment Policy Applicable to AMA Entities**
It is the policy of the American Medical Association that any type of harassment of AMA staff, fellow delegates or others by members of the House of Delegates or other attendees at or in connection with HOD meetings, or otherwise, including but not limited to dinners, receptions and social gatherings held in conjunction with HOD meetings, is prohibited conduct and is not tolerated. The AMA is committed to a zero tolerance for harassing conduct at all locations where AMA delegates and staff are conducting AMA business. This zero tolerance policy also applies to meetings of all AMA sections, councils, committees, task forces, and other leadership entities (each, an “AMA Entity”), as well as other AMA-sponsored events.

**Definition**
Harassment consists of unwelcome conduct whether verbal, physical or visual that denigrates or shows hostility or aversion toward an individual because of his/her race, color, religion, sex, sexual orientation, gender identity, national origin, age, disability, marital status, citizenship or other protected group status, and that: (1) has the purpose or effect of creating an intimidating, hostile or offensive environment; (2) has the purpose or effect of unreasonably interfering with an individual’s participation in meetings or proceedings of the HOD or any AMA Entity; or (3) otherwise adversely affects an individual’s participation in such meetings or proceedings or, in the case of AMA staff, such individual’s employment opportunities or tangible job benefits.

Harassing conduct includes, but is not limited to: epithets, slurs or negative stereotyping; threatening, intimidating or hostile acts; denigrating jokes; and written, electronic, or graphic material that denigrates or shows hostility or aversion toward an individual or group and that is placed on walls or elsewhere on the AMA’s premises or at the site of any AMA meeting or circulated in connection with any AMA meeting.
Sexual Harassment
Sexual harassment also constitutes discrimination, and is unlawful and is absolutely prohibited. For the purposes of this policy, sexual harassment includes:

- making unwelcome sexual advances or requests for sexual favors or other verbal, physical, or visual conduct of a sexual nature; and
- creating an intimidating, hostile or offensive environment or otherwise unreasonably interfering with an individual’s participation in meetings or proceedings of the HOD or any AMA Entity or, in the case of AMA staff, such individual’s work performance, by instances of such conduct.

Sexual harassment may include such conduct as explicit sexual propositions, sexual innuendo, suggestive comments or gestures, descriptive comments about an individual’s physical appearance, electronic stalking or lewd messages, displays of foul or obscene printed or visual material, and any unwelcome physical contact.

Retaliation against anyone who has reported harassment, submits a complaint, reports an incident witnessed, or participates in any way in the investigation of a harassment claim is forbidden. Each complaint of harassment or retaliation will be promptly and thoroughly investigated. To the fullest extent possible, the AMA will keep complaints and the terms of their resolution confidential.

2. Our AMA's Board of Trustees will establish a formal process by which any delegate, AMA Entity member or AMA staff member who feels he/she has experienced or witnessed conduct in violation of this policy may report such incident; and consider and prepare for future consideration by the House of Delegates, potential corrective action and/or discipline for conduct in violation of this policy, with report back at the 2017 Interim Meeting.
Resolution 601-A-17, “Reinstate the AMA Commission to End Health Care Disparities,” which was introduced by New York, asks “that the American Medical Association reinstate the Commission to Eliminate Health Care Disparities, including goals and objectives that are Specific, Measurable, Agreed Upon, Realistic and Time Related (SMART) metrics.” The AMA Board of Trustees requested, Reference Committee F recommended, and the House of Delegates approved referral of Resolution 601 for “a report back to the House of Delegates with a more comprehensive and sustainable plan for continued progress toward health equity.”

BACKGROUND

In September, the Board Chair, acting on behalf the Board of Trustees, appointed a time-limited Health Equity Task Force with ten members drawn from a number of the AMA constituencies with special interest and expertise in health and health care disparities, diversity and inclusion, and health equity to advise the Board on an action plan.

The members of the Task Force are as follows:

- Willard V. Edwards, MD, MBA; Board of Trustees; Task Force Chair
- Frank A. Clark, MD; Minority Affairs Section Chair
- Erick A. Eiting, MD, MPH; Advisory Committee on LGBTQ Issues
- Ved V. Gossain, MD; International Medical Graduates Section Governing Council
- Patrice A. Harris, MD, MA; Board of Trustees
- Diana E. Ramos, MD, MPH; Former member, Minority Affairs Section Governing Council
- Malcolm D. Reid, MD, MPP; New York Delegation
- Katrina L. Rhodes, MD, MS; YPS Assembly Delegate, American Association of Public Health Physicians
- Patricia L. Turner, MD; Immediate Past Chair, Council on Medical Education
- Siobhan M. Wescott, MD, MPH; Minority Affairs Section Governing Council

The Task Force was asked to adopt a definition of health equity against which proposed actions can be tested; learn from the contributions of the Commission to End Health Care Disparities; build on AMA’s leadership, capabilities, and its advocacy and strategic efforts; and recommend actions and efforts that can be undertaken by AMA to positively contribute to health equity and to communicate its commitment to health equity.

The existence of gaps in health care across segments of the U.S. has been documented in previous AMA reports and in a legion of reports and articles from other credible sources. It is not the...
purpose of the Task Force or this report to summarize or replicate that information here. The AMA captures a selection of relevant information and data at https://www.ama-assn.org/delivering-care/reducing-disparities-health-care.

PROCESS

The Health Equity Task Force convened in person to hold facilitated discussions on December 19, 2017, and on February 11, 2018. Task Force members provided input before, between and following meetings, including reviewing interim drafts of this report. In addition, the Task Force had a large number of reports and articles at their disposal throughout the deliberations. Finally, related AMA policy was gathered and included in the Task Force resources.

At in-person meetings, the Task Force reviewed the history, actions, and achievements of the Commission to End Health Care Disparities. The Task Force was inspired by the Commission’s ground work, track record, and the powerful collaborations it established. The Task Force thought it critical to honor the Commission’s legacy and build upon it by taking AMA work on health equity to a new, more embedded and sustainable level and to do so with the expectation that working with other organizations will continue to be an essential component of the AMA’s commitment to health equity.

The Task Force heard a presentation on current AMA work related to health equity and contributed their first-hand knowledge. Task Force members proposed a robust list of past and current tactics the AMA might energize and new ones the AMA might take on. The Task Force then received written input about each of these from staff subject matter experts. This background was considered as the Task Force reviewed and used a priority screen to rate various actions. In addition to the input from staff, a survey of Federation organizations was fielded to gather information about their work on health equity, health disparities, and diversity and inclusion. This information will serve to provide a wider window on potential future tactics and collaborations as the Task Force recommendations are implemented.

RESULTS

Definition

The Task Force reviewed a number of definitions of health equity drawn from the literature and the public records of other organizations, identifying common themes. The Task Force wished to arrive at wording that clearly conveys a guiding perspective for its recommendations and the AMA’s actions going forward. A number of Task Force members penned potential definitions which were then discussed by all. Task Force members uniformly expressed a desire to keep the definition short and simple to facilitate communication to a variety of audiences. Lastly, the definition should be aspirational without caveats reflecting barriers or modifications based on possible differences in health potential.

The consensus definition is the following: “Health Equity is optimal health for all.” This phrase reflects what the AMA is working toward and what it stands for.

It is important to note that this definition refers to all aspects of health, including mental/behavioral health, when referring to health. The Task Force was intentional in that regard so as not to imply that mental/behavioral health is distinct from health in general.
The Task Force expects that often the definition will be followed by explanations of how health equity can be achieved, including discussion of social determinants as key factors influencing health equity.

The Task Force acknowledges that the AMA and physicians cannot control all factors that need to change in order to achieve health equity. For some the AMA’s role will be to identify their importance and to urge those who can have a direct role to act. Most, if not all, determinants of health must be addressed in collaboration with others. Further, individuals themselves must be engaged, but without implying that they bear full responsibility for their health outcomes.

**Populations**

When speaking of disparities in health, the Task Force uses the commonly understood meaning of differences in health outcomes among groups of people. Groups experiencing disparities often lack political, social, or economic power. The Commission to End Health Care Disparities focused on disparities experienced by racial and ethnic minorities. While acknowledging that those disparities have not been sufficiently addressed and should remain a high priority in the AMA work, the Task Force proposes broadening the list of populations of interest to include the many others for which disparities have been documented. The Task Force points out that these identities may have a multiplier effect when they are co-occurring, i.e., when an individual belongs to more than one disadvantaged group.

The composition of the Task Force itself represents the Board’s expectation that the Task Force recommendations will be applied broadly, and is in close alignment with Healthy People 2020 ([https://www.healthypeople.gov/](https://www.healthypeople.gov/)) which points to “many dimensions of disparity,” and lists “race or ethnicity, sex, sexual identity, age, disability, socioeconomic status, and geographic location” as contributing “to an individual’s ability to achieve good health.”

In considering the list of populations to which the AMA’s work might be applied, the Task Force makes the following points:

1. Populations once thought of as “minority” may soon no longer be the minority in regard to population percentages, but disparities and inequities have endured and will continue.
2. Wording preferences around the labels “sex and sexual identity” have continued to evolve.
3. Though the Task Force is taking an inclusive view of health equity and populations, priorities will have to be set and target populations specified for specific change initiatives. That tension will be ongoing at the programmatic level, and making choices will be difficult. The AMA will not be able to address all needs immediately. AMA will always have finite resources and will need to make decisions about how best to leverage them.

With those caveats, the Task Force settled on the following list of population descriptors by which populations that experience health disparities may be identified: Race, ethnicity, gender, gender identity, sexual orientation, age, disability, socioeconomic status, geographic location, and educational level. The Task Force points out that the list is not intended to be exhaustive, that is, it does not preclude adding populations for which inequities in health outcomes are documented.

**Strategic Framework**

Having defined the health equity goal for the AMA, the Task Force identified key strategies that constitute how the AMA can work toward realizing the goal of achieving health equity. These are the big themes of work that together make up the AMA’s contribution to achieving the health
equity goal. This strategic framework is intended to provide enduring guideposts for a sustained effort, while appreciating that individual actions or tactics necessarily will change through time. The Task Force proposed the following strategic framework that outlines key AMA roles, and for which tactics can be grouped:

- Advocate for health care access for all;
- Promote equity in care;
- Increase health workforce diversity and cultural awareness/competency;
- Influence determinants of health; and
- Voice and model commitment to health equity.

Several approaches cross these five framework elements. First, the AMA should partner with others. Many organizations and individuals have been working on health equity for a long time. The AMA should not re-invent efforts where they exist and are successful, but should find opportunities for respectful collaboration so that an even greater impact can be achieved. Second, metrics should be specified to describe the outcomes expected from any activity and progress should be tracked and reported. These metrics will establish accountability for results and serve as a guide in adjusting tactics to enhance impact. Third, respect for the patient-physician relationship should be central to the AMA efforts. Engaging with patients and increasing health literacy will be necessary.

Organizational Home for Health Equity

The Task Force concluded overwhelmingly that the AMA must establish a structural or organizational component charged with looking through the health equity lens to facilitate, coordinate, and enhance current streams of work and to stimulate additional work to increase the AMA health equity footprint and impact. This recommendation is offered as the top priority of the Task Force. The characteristics of an organizational home, e.g., a “Center,” should be designed to elevate the importance of and to sustain the AMA’s health equity efforts.

The Task Force suggests such a home for health equity would be expected to have the following features:

- Dedicated resources, including staff and budget; an advisory body; accountability for creating a multi-year roadmap and related programmatic actions such as developing effective partnerships with a variety of stakeholders, creating and curating tools and resources for physicians, and seeking external funding sources, e.g., grants, as appropriate;
- Responsibility for facilitating and coordinating health equity work across focus areas and other organizational units and thereby stimulating and advancing health equity work;
- Authority to propose through the AMA planning process specific additional initiatives and implement those approved; and
- Accountability for developing a dashboard of metrics by which results are tracked, and responsibility for reporting on health equity efforts to the Board and, through the Board, to the HOD.

Communication

The Task Force was charged with advising on how the AMA should communicate its commitment to health equity. The creation of an organizational presence is part of doing so. An ongoing communication plan and additional definitional and explanatory materials should be developed by the health equity staff working with communications staff. It should leverage all AMA
communication vehicles, including special events and AMA leadership speeches, to enable the AMA to “speak with one voice” about the importance of health equity and the AMA’s commitment to action. In the end, achievements will be the foundation for demonstrating true commitment.

Tactics for Consideration

In the course of its work, the Task Force discussed a number of possible activities that might be undertaken as part of an AMA health equity roadmap and screened them by ease of implementation and potential impact.

The Task Force suggests that further vetting of specific tactics to be pursued become the responsibility of the new organizational unit as part of the AMA’s planning process.

Further, the Task Force submits the following as deserving of further consideration by the dedicated health equity entity as it organizes, sets its priorities, and develops a multi-year roadmap:

- Advocate for a variety of incentives for treating currently underserved patients;
- Build upon current Improving Health Outcomes (IHO) and Accelerating Change in Medical Education (ACE) Consortium work on chronic disease prevention and treatment;
- Encourage health equity-promoting solutions through the AMA’s innovation ecosystem;
- Provide grants to support specific kinds of health equity work by others; and
- Review and address as indicated lack of diversity within AMA.

RECOMMENDATIONS

The Board of Trustees recommends the following be adopted in lieu of Resolution 601-A-17 and the remainder of the report be filed:

1. That Health Equity, defined as optimal health for all, is a goal toward which our AMA will work by advocating for health care access, promoting equity in care, increasing health workforce diversity, influencing determinants of health, and voicing and modeling commitment to health equity. (New HOD Policy)

2. That our AMA develop an organizational unit, e.g., a Center or its equivalent, to facilitate, coordinate, initiate, and track AMA health equity activities. (Directive to Take Action)

3. That the Board provide an annual report to the House of Delegates regarding AMA’s health equity activities and achievements. (Directive to Take Action)

Fiscal note: $1,000,000 annually.
REFERENCE

Subject: AMA to Protect Human Health from the Effects of Climate Change by Ending its Investments in Fossil Fuel Companies (Resolution 607-A-17)

Presented by: Gerald E. Harmon, MD, Chair

Referred to: Reference Committee F (Julia V. Johnson, MD, Chair)

At the 2017 Annual Meeting, Resolution 607-A-17 was introduced by the American Association of Public Health Physicians and referred. Resolution 607-A-17 asked that: (1) the American Medical Association (AMA), AMA Foundation (Foundation), and any affiliated corporations, work in a timely and fiscally responsible manner to end all financial investments or relationships (divestment) with companies that generate the majority of their income from the exploration for, production of, transportation of, or sale of fossil fuels; (2) the AMA, when fiscally responsible, choose for its commercial relationships vendors, suppliers, and corporations that have demonstrated environmental sustainability practices that seek to minimize their fossil fuels consumption; and (3) the AMA support efforts of physicians and of other health professional associations to proceed with divestment, including to create policy analyses, support continuing medical education, and to inform our patients, the public, legislators and government policymakers.

BACKGROUND

The AMA, as a science-based organization, has long supported environmental issues and spoken out on climate change, including policy H-135.973, “Stewardship of the Environment,” and H-135-969, “Environmental Health Programs,” that encourage physicians to be spokespersons for environment stewardship among other things; H-135.938, “Global Climate Change and Human Health,” that concurs with the scientific consensus that Earth is undergoing adverse climate change and that anthropogenic contributions are significant and will create conditions affecting public health with disproportionate impacts on vulnerable populations; and finally H-135.923, “AMA Advocacy for Environmental Sustainability and Climate,” outlining AMA’s support of initiatives to promote environmental sustainability and other efforts to halt global climate change. (See Appendix)

The AMA also has policy prohibiting investments in the tobacco industry as part of our broad strategy to oppose tobacco use (H-500.975[5], “AMA Corporate Policies on Tobacco”).

DISCUSSION

Over the past decade, groups concerned about climate change have pressured academic institutions and endowments to divest fossil fuel-related securities. While some have divested, most have decided not to do so. AMA engaged an independent advisor, Mercer Investments, to review the status of fossil fuel divestment for major investment portfolios and to perform a study evaluating the potential impact of implementing Resolution 607-A-17 and making a recommendation from an investment advisor viewpoint.
Mercer is a subsidiary of March & McLennan Companies ($13.2 Billion in revenue), and is a global leader in providing institutional investment services. It is an independent advisor that has not been involved with the AMA investment portfolios.

The AMA also received an outside legal opinion from Sidley Austin LLP, AMA’s outside counsel. Sidley reviewed Resolution 607-A-17 in the context of the governing standard, the Uniform Prudent Management of Institutional Funds Act (“the Act”) that is incorporated into Illinois law, the state law that governs the AMA and the Foundation.

Mercer’s analysis included: (1) an overview of fossil fuel divestment among large institutional investors; (2) back tests over the last 20 years, evaluating the impact of fossil fuel divestment on both the actual AMA portfolio and market index portfolios with respect to return and risk; and (3) future return and risk projections utilizing Mercer’s capital market assumptions, comparing a portfolio with no constraints and a portfolio implementing fossil fuel divestment.

The overwhelming majority of institutions have made a decision not to divest from fossil fuels. Of the largest 1,000 retirement plans, only 11 have committed to divest fossil fuels in some form. Of the 100 largest endowment and foundations, six have committed to divest in some form. The most common focus of those institutions implementing divestment has been limited to divestment of investments in coal mining companies. Divestment has not gained traction among US pension funds, due primarily to the fiduciary standard of best interest of plan participants under ERISA.

The US Department of Labor (DOL) has issued an interpretive bulletin stating “fiduciaries may never subordinate the economic interests of the plan to unrelated objectives, and may not select investments on the basis of any factor outside the economic interest of the plan except in very limited circumstances.” The DOL subsequently opined that fiduciaries may pursue such options but “may not accept lower expected returns or take on greater risks.” While the market has seen some divestment activity, most institutions have researched divestment and decided not to proceed at this time.

As noted above, Mercer performed back tests on both the specific AMA portfolios reflecting holdings as of December 31, 2017, and index data utilizing the MSCI All Country Index, to quantify the historic impact of a divestment strategy on return, risk, and return for unit of risk. Due to data limitations, the Mercer analysis covered only market activity over the last twenty years, for the period ending December 2017. This period was dominated by low interest rates, low inflation and generally low market volatility. Over this same period, there was a general decline in energy prices. As such, this period may not be representative of future periods. Mercer’s analysis of this period suggests that a divestment of fossil fuels from the AMA Reserve Portfolios is unlikely to result in a material change to return/risk expectations of the current portfolio. In particular, the analysis suggests that divestment would result in an increase in total risk (roughly 15 basis points), as would be expected by a more constrained portfolio, and this increase in risk would be partially offset by an increase of 7 basis points in expected return. While a divested portfolio in the back test period would have delivered a slightly higher return on a prospective basis, it would do so with higher risk or volatility resulting in the same return for risk measurement as the current portfolio.

Independent of the Mercer analysis, scenarios in which higher inflation, higher interest rates and greater market volatility are more prevalent must be considered in evaluating fossil fuel divestment. Specific to inflationary risk, energy holdings are likely to prove beneficial to the current portfolio relative to the divested portfolio, as historically rising inflation results in higher commodity prices, such as energy. Other academic studies, covering longer time frames and more market cycles, conclude that the estimated cost of fossil fuel divestment is significant. One such study, by Professor Daniel Fuschel of the University of Chicago, estimates a diversification cost
from divesting energy stocks of approximately .5 percent per year. Another study, by Dr. Bradford 
Cornel of Caltech, estimates the mean risk-adjusted shortfall due to divestment at .23 percent per 
year. Based on the current size of the AMA’s portfolio and these studies, an investment shortfall of 
$1.3 million to $2.9 million per year could be expected. This investment shortfall does not include 
other costs of divestment, such as transaction costs associated with selling and buying securities 
and the cost of compliance with fossil fuel divestiture goals, both of which are often material but 
not estimable at this point. From a judgment perspective, consideration needs to be given to the 
tradeoffs of a less diversified portfolio and how relationships may change over time. From an 
investment perspective, not implementing a divestment process is consistent with current market 
practice and provides investment flexibility, particularly if the markets return to a higher growth, 
higher inflation environment.

In response to those who may question whether investments in fossil fuels may result in wasted 
capital/stranded assets, professional asset managers uniformly integrate environmental issues into 
their investment due diligence and decision-making process. These professional asset managers 
weigh valuation against risk and opportunities, including environmental issues. Markets are 
efficient and expectations of future states and events are factored into security prices.

Sidley Austin noted that one of the duties imposed by the Act is “An institution shall diversify the 
investments of an institutional fund unless the institution reasonably determines that, because of 
special circumstances, the purposes of the fund are better served without diversification”. Since 
Resolution 607-A-17, if adopted, would potentially rule out a large sector of the economy 
(dissimilar to the AMA’s policy restriction on investment in tobacco, which is a much smaller 
sector), Sidley opined that such a resolution “would unduly interfere with the fiduciary obligations 
of the AMA Board of Trustees and the Board of Directors of the Foundation to manage the assets 
of these organizations in a fiscally prudent manner.” Sidley stated that its belief is that “the related 
objectives of (1) managing assets so as to produce a reasonable return without undue risk and (2) 
diversification of investments to achieve this result would require managers of the assets of the 
AMA and the Foundation at least to have the option of investing in the fossil fuel sector of the 
economy. If these managers concluded that investment in fossil fuel companies and related 
enterprises was not necessary to achieve a reasonable return with reasonable risk, they would not 
have to make such investments. But absolutely to preclude such investments would be to tie the 
hands of these managers in a way that would prevent them from carrying out their responsibilities 
under the Act.”

The Sidley Austin legal opinion also noted that there is a critical distinction between the current 
AMA policy on investments in tobacco companies and the proposed resolution on investment in 
fossil fuel companies. Importantly, the tobacco industry is a far less substantial portion of the 
economy than the fossil fuel industry and the companies that depend on or serve that industry. The 
tobacco sector represents only 1% of the MSCI All World Index, while fossil fuels represent 6% of 
the MSCI All World Index. Sidley Austin concluded that with regard to investments in tobacco 
stocks, the current AMA policy does not materially prevent AMA asset managers from exercising 
the care that an ordinarily prudent person in a like position would exercise. By contrast, ruling out 
any investment in fossil fuel companies and in enterprises which depend on or serve those 
companies would place a very major constraint on AMA asset managers.

CONCLUSION

Given the results above, with a bias towards maintaining diversification and flexibility, Mercer 
recommends against implementing a divestment requirement. Rather, Mercer recommends the 
decision concerning exposure to energy sector investments remain with the AMA’s selected
investment managers. As noted above, a broad number of companies across industries are involved
in fossil fuels, resulting in divestment from them having a much more significant impact on the
diversification of the portfolio. In addition, not implementing a full divestment process is consistent
with the approach taken by most major endowments and pension funds in the United States.

Sidley’s opinion concludes that the proposed resolution, if adopted, “would unduly interfere with
the fiduciary obligation of the AMA Board of Trustees and the Board of the AMA Foundation to
manage the assets of these organizations in a fiscally prudent manner.” The Board believes it
should not be handicapped in fulfilling its fiduciary duty.

The Board shares a strong belief in the scientific consensus on global climate change and its threats
to public health, especially for vulnerable populations. However, given the number of companies
involved in fossil fuels and the Board’s fiduciary obligations outlined in this report, the Board
believes it should focus on legislative, regulatory, and other policy efforts as called for in existing
House policy to address the threats of climate change.

RECOMMENDATION

Based on the above analysis, the Board of Trustees recommends that Resolution 607-A-17 not be
adopted, and the remainder of this report be filed.
Appendix - AMA Policy

Stewardship of the Environment H-135.973
The AMA: (1) encourages physicians to be spokespersons for environmental stewardship, including the discussion of these issues when appropriate with patients; (2) encourages the medical community to cooperate in reducing or recycling waste; (3) encourages physicians and the rest of the medical community to dispose of its medical waste in a safe and properly prescribed manner; (4) supports enhancing the role of physicians and other scientists in environmental education; (5) endorses legislation such as the National Environmental Education Act to increase public understanding of environmental degradation and its prevention; (6) encourages research efforts at ascertaining the physiological and psychological effects of abrupt as well as chronic environmental changes; (7) encourages international exchange of information relating to environmental degradation and the adverse human health effects resulting from environmental degradation; (8) encourages and helps support physicians who participate actively in international planning and development conventions associated with improving the environment; (9) encourages educational programs for worldwide family planning and control of population growth; (10) encourages research and development programs for safer, more effective, and less expensive means of preventing unwanted pregnancy; (11) encourages programs to prevent or reduce the human and environmental health impact from global climate change and environmental degradation. (12) encourages economic development programs for all nations that will be sustainable and yet nondestructive to the environment; (13) encourages physicians and environmental scientists in the United States to continue to incorporate concerns for human health into current environmental research and public policy initiatives; (14) encourages physician educators in medical schools, residency programs, and continuing medical education sessions to devote more attention to environmental health issues; (15) will strengthen its liaison with appropriate environmental health agencies, including the National Institute of Environmental Health Sciences (NIEHS); (16) encourages expanded funding for environmental research by the federal government; and (17) encourages family planning through national and international support.

Environmental Health Programs H-135.969
Our AMA (1) urges the physicians of the United States to respond to the challenge for a clean environment individually and through professional groups by becoming the spokespersons for environmental stewardship; and (2) encourages state and county medical societies to establish active environmental health committees.

Global Climate Change and Human Health H-135.938
Our AMA: 1. Supports the findings of the Intergovernmental Panel on Climate Change's fourth assessment report and concurs with the scientific consensus that the Earth is undergoing adverse global climate change and that anthropogenic contributions are significant. These climate changes will create conditions that affect public health, with disproportionate impacts on vulnerable populations, including children, the elderly, and the poor.

2. Supports educating the medical community on the potential adverse public health effects of global climate change and incorporating the health implications of climate change into the spectrum of medical education, including topics such as population displacement, heat waves and drought, flooding, infectious and vector-borne diseases, and potable water supplies.

3. (a) Recognizes the importance of physician involvement in policymaking at the state, national, and global level and supports efforts to search for novel, comprehensive, and economically sensitive approaches to mitigating climate change to protect the health of the public; and (b) recognizes that whatever the etiology of global climate change, policymakers should work to reduce human contributions to such changes.
4. Encourages physicians to assist in educating patients and the public on environmentally sustainable practices, and to serve as role models for promoting environmental sustainability.

5. Encourages physicians to work with local and state health departments to strengthen the public health infrastructure to ensure that the global health effects of climate change can be anticipated and responded to more efficiently, and that the AMA's Center for Public Health Preparedness and Disaster Response assist in this effort.


**AMA Advocacy for Environmental Sustainability and Climate H-135.923**

Our AMA (1) supports initiatives to promote environmental sustainability and other efforts to halt global climate change; (2) will incorporate principles of environmental sustainability within its business operations; and (3) supports physicians in adopting programs for environmental sustainability in their practices and help physicians to share these concepts with their patients and with their communities.
At the 2017 Annual Meeting, the House of Delegates referred Resolution 609, “Model Hospital Medical Staff Bylaws.” Resolution 609-A-17, which was introduced by the Organized Medical Staff Section, asks the AMA to:

1. develop model hospital medical staff bylaws that incorporate currently believed to be best practices, meet the requirements of the Medicare Conditions of Participation, hospital accreditation organizations with deeming authority, and state laws and regulations, including annotations to show the source of all legal, regulatory, and accreditation requirements;

2. post this resource on the AMA website, continuously updated and available on demand to medical staffs, medical staff offices, and medical society staff, and widely distributed as an adjunct to the next edition of the AMA Physician’s Guide to Medical Staff Bylaws; and

3. ask the legal counsels of State Medical Societies to outline state specific restrictions of medical staff self-governance so that these may be posted on the AMA-OMSS website for use by all AMA members.

BACKGROUND

The Physician’s Guide to Medical Staff Organization Bylaws (the “Bylaws Guide”) is the AMA’s primary repository of information for physicians on medical staff governance, and one of the only available resources in the country addressing these matters from the physician’s perspective.¹ Weighing in at more than 250 pages, the Bylaws Guide comprehensively addresses all major elements of medical staff bylaws with substantial discussion of each topic, including links to and citations of selected laws and regulations, accreditation standards, case law, and relevant AMA policy. See the Appendix for a complete list of topics covered in the Bylaws Guide.

For each topic covered, the Bylaws Guide also presents sample bylaws language that has been broadly structured to fulfill Joint Commission and other accreditation requirements and to support AMA policy on self-governance and other relevant medical staff topics. Nevertheless, the Bylaws Guide is not intended to be used as a “model bylaws” document. Rather, medical staff bylaws must be tailored to suit the needs of particular medical staffs, which differ along multiple dimensions, including nuances of state law, varying hospital accreditation organization requirements, and widely diverging hospital and medical staff characteristics. These differences substantially affect not only how individual bylaws provisions must be constructed but also which provisions should be included in the first place.
DISCUSSION

Model medical staff bylaws

Resolution 609-A-17 asks the AMA to create a set of model medical staff bylaws that can account for all of these differences. Unfortunately, there are simply too many permutations to produce a single, coherent set of model bylaws that would be any more useful than the illustrative content already included in the Bylaws Guide. One alternative, which is hinted at by the resolution, might be to develop a comprehensive database of sample bylaws language covering each major conceivable situation. A user might query this database, for example, to obtain appropriate bylaws language on procedures for voting to amend the bylaws for a medical staff that: (a) exists within a multi-hospital system; (b) is not formally unified with the other medical staffs in the system; (c) includes a telemedicine membership category; and (d) is in a hospital accredited by The Joint Commission. Changing any one of these baseline conditions could affect how this voting provision must be written for this particular medical staff; accordingly, the database would have to include many distinct provisions to address all relevant combinations. Multiply this case by the many other similarly complex medical staff governance situations and the massive scope of this project becomes clear. While the task is not impossible, it would be costly to implement (as much as $100,000 upfront) and to maintain ($20,000 or more per year). Furthermore, whatever value a medical staff might find in the existence of such a database would be diminished in part by the fact that the staff would still have to retain legal counsel to ensure that any provisions pulled from the database were appropriately tailored for that hospital’s and medical staff’s unique conditions.

Other ways to augment the AMA’s medical staff resources

Although the creation of a set of model medical staff bylaws may be impractical, there are steps the AMA can take immediately to enhance the value of its medical staff resources. For example, as highlighted by testimony on Resolution 609-A-17, there exists a need for additional information on key state-by-state differences in medical staff bylaws requirements and best practices, especially on emerging issues such as the intersection of employment law and medical staff bylaws. While the Bylaws Guide includes detailed discussion on some state-by-state issues (e.g., the contractual status of medical staff bylaws), the AMA would be well-served to review this resource to ensure that it covers all of the most relevant bylaws topics on which there are significant state-by-state differences.

Additionally, recognizing that the medical societies of many states (including California, Massachusetts, and North Carolina, among others) already maintain excellent state-specific guidance for medical staffs, the AMA should work with the Federation to catalog and make physicians aware of the availability of these valuable state-level resources.

Finally, the AMA should continue its efforts to improve the usability and accessibility of its current and future medical staff-related content, another objective hinted at by Resolution 609-A-17. As presently constituted, the Bylaws Guide is a densely written document presented in a static format. While the core content must by its nature remain somewhat legalistic in order to retain its value, there are a variety of ways to reimagine this content in a more interactive and engaging way—for example, by layering more readily accessible resources atop the underlying content. Such efforts are already underway; specifically, in response to a resolution adopted at the 2017 Annual Meeting, the AMA has developed a 30-minute interactive education module instructing medical staff leaders and other physicians on how to address disruptive physician behavior." The module, which offers CME credit, takes as its starting point the “AMA Model Medical Staff Code of Conduct” and ultimately directs learners to that and other resources included in the Bylaws Guide. The AMA
should continue to identify and pursue such opportunities to more effectively engage physicians using its medical staff content.

CONCLUSION

The Physician’s Guide to Medical Staff Organization Bylaws is a valuable reference manual for physicians seeking to draft or amend medical staff bylaws and to better understand emerging issues in health care that impact the medical staff. Although comprehensive in scope and including hundreds of sample bylaws provisions, the Bylaws Guide was not developed to serve as a set of model medical staff bylaws. This direction is intentional, owing to the fact that bylaws must be carefully tailored to each medical staff, and that there are simply too many permutations of meaningful differences in state law, accreditation requirements, and hospital and medical staff characteristics to create truly useable model bylaws.

We therefore recommend that our AMA preserve the largely educational and illustrative nature of its medical staff-related content, including the Bylaws Guide, and not pursue the development of a separate set of model medical staff bylaws. Instead, we recommend that the Bylaws Guide be augmented to more fully discuss key bylaws matters that may differ from state to state, and that our AMA work with the Federation to catalog the many valuable state-specific medical staff resources available to physicians. Additionally, we recommend that our AMA continue to pursue opportunities to improve the user experience with our AMA’s medical staff resources.

RECOMMENDATION

The Board of Trustees recommends that the following be adopted in lieu of Resolution 609-A-17, and that the remainder of the report be filed:

1. That our AMA continue to update the Physician’s Guide to Medical Staff Organization Bylaws to address emerging issues in medical staff affairs, including relevant changes to medical staff regulatory and accreditation requirements, such as those outlined in the Medicare Hospital Conditions of Participation and in the accreditation standards of The Joint Commission and other hospital accrediting organizations. (Directive to Take Action)

2. That our AMA develop guidance for physicians on key state-by-state differences in medical staff bylaws requirements and best practices, and work with state medical societies to catalog state-specific medical staff resources available to physicians. (Directive to Take Action)

3. That our AMA pursue opportunities to improve the accessibility and usability of the content contained in the Physician’s Guide to Medical Staff Organization Bylaws, including but not limited to development of supplemental materials such as education modules, checklists, and so forth. (Directive to Take Action)

Fiscal note: Moderate – between $5,000 and $10,000

Notes:

i The Bylaws Guide is available for free to AMA members and for $149 to non-members through the AMA Store: https://commerce.ama-assn.org/store/catalog/productDetail.jsp?product_id=prod2810007.

ii The module is now available through the AMA Education Center: https://cme.ama-assn.org/Activity/5976608/Detail.aspx.
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REPORT OF THE HOUSE OF DELEGATES COMMITTEE
ON THE COMPENSATION OF THE OFFICERS

Report A-18

Subject: Report of the House of Delegates Committee on Compensation of the Officers

Presented by: Brooks F. Bock, MD, Chair

Referred to: Reference Committee F
(Julia V. Johnson, MD, Chair)

This report by the Committee at the 2018 Annual Meeting presents one recommendation.

BACKGROUND

At the 1998 Interim Meeting, the House of Delegates (HOD) established a House Committee on Trustee Compensation, currently named the Committee on Compensation of the Officers, (the “Committee”). The Officers are defined in the American Medical Association’s (AMA) Constitution and Bylaws. (Note: under changes to the Constitution previously approved by the HOD, Article V refers simply to “Officer,” which includes all 21 members of the Board among whom are President, President-Elect, Immediate Past President, Secretary, Speaker of the HOD and Vice Speaker of the HOD, collectively referred to in this report as Officers). The composition, appointment, tenure, vacancy process and reporting requirements for the Committee are covered under the AMA Bylaws. Bylaws 2.13.4.5 provides:

The Committee shall present an annual report to the House of Delegates recommending the level of total compensation for the Officers for the following year. The recommendations of the report may be adopted, not adopted or referred back to the Committee, and may be amended for clarification only with the concurrence of the Committee.

At A-00, the Committee and the Board jointly adopted the American Compensation Association’s definition of total compensation which was added to the Glossary of the AMA Constitution and Bylaws. Total compensation is defined as the complete reward/recognition package awarded to an individual for work performance including: (a) all forms of money or cash compensation; (b) benefits; (c) perquisites; (d) services; and (e) in-kind payments.

Since the inception of this Committee, its reports document the process the Committee follows to ensure that current or recommended Officer compensation is based on sound, fair, cost-effective compensation practices as derived from research and use of independent external consultants, expert in Board compensation. Reports beginning in December 2002 documented the principles the Committee followed in creating its recommendations for Officer compensation.

At A-08, the HOD approved changes that simplified compensation practices with increased transparency and consistency. At A-10, Reference Committee F requested that this Committee recommend that the HOD affirm a codification of the current compensation principle, which
occurred at I-10. At that time, the HOD affirmed that this Committee has and will continue to base
its recommendations for Officer compensation on the principle of the value of the work performed,
consistent with IRS guidance and best practices as recommended by the Committee’s external
independent consultant, who is expert in Board compensation.

At A-11, the HOD approved the alignment of Medical Student and Resident Officer Compensation
with that of all other Officers (excluding Presidents and Chair) because these positions perform
comparable work. At I-11, an updated compensation structure, based on research and counsel
provided by the committee’s external consultant Mr. Don Delves, founder of the Delves group, was
recommended to and approved by the HOD.

At I-13 the committee recommended and the HOD approved providing a travel allowance for each
President to be used for upgrades because of the significant volume of travel in representing our
AMA.

At I-16, based on results of a comprehensive compensation review conducted by Ms. Becky Glantz
Huddleston an expert in Board Compensation with Willis Towers Watson, the Committee
recommended and the HOD approved modest increases to the Governance Honorarium and Per
Diems for Officer Compensation, excluding the Presidents and Chair, effective July 1, 2017. A-
17’s report, approved by the HOD, modified the Governance Honorarium and Per Diem definition
so that Internal Representation, in excess of eleven days, receives a per diem.

METHODOLOGY

Early in 2018, the Committee asked its outside consultant to review and update the 2016 research
on compensation of the Officers, focusing on the compensation of the leadership positions:
President, President-elect, Immediate Past President, Chair and Chair-elect. The purpose of the
review was to ensure the leadership roles are compensated appropriately for the work performed on
behalf of the AMA.

The Committee’s review and subsequent recommendations for leadership compensation are based
on the principle of the value of the work performed, as affirmed by the HOD. In addition, the
following additional guidelines were followed:

- Compensation should be based on the value expected by the AMA from its Officers.
- Compensation should take into account that the AMA is a complex organization when
  comparing compensation provided to Board members by for-profit organizations and by
  complex not-for-profit organizations of similar size and activities.
- Compensation should be aligned with the long-term interests of AMA members and the
  fulfillment of the fiduciary responsibilities of the Officers.
- Officers should be adequately compensated for their value, time, and effort.
- Compensation should reinforce choices and behaviors that enhance effectiveness.
- Compensation should be approached on a comprehensive basis, rather than as an array of
  separate elements.

The process the Committee followed along with the aforementioned principles is consistent with
the guidelines recommended by the IRS for determining reasonable and competitive levels of
Officer compensation.
The Committee, with assistance from Ms. Huddleston developed their recommendations based on:

- The current compensation structure.
- Review and analysis of leadership compensation data for the past ten terms – the last increase in leadership compensation was in 2008.
- Pay practices for leadership positions at for-profit and not-for-profit organizations similar to the AMA who pay their Board members.
- A collaborative, deliberative and objective review process.

FINDINGS

The Committee notes that Board leadership roles; President, President-elect, Immediate Past President, Chair and Chair-elect continue to make significant time commitments in supporting our AMA in governance and representation functions and that representation work is unique to AMA leadership and officer roles.

AMA’s leadership roles have a significant level of responsibility, resulting in a time commitment well above that required by other not-for-profit boards. As a result, to assess the AMA compensation levels versus the not-for-profits compensation levels, a four-year average hourly rate was determined for each AMA leadership position aligned with the hourly rate for the Chair position at other not-for-profit organizations and associations. The three Presidents and the Chair-elect positions are unique to the AMA and as such, these roles were also aligned to the external data of the Chair position.

The report concluded that while the leadership compensation structure is generally aligned with the external market, modest increases are appropriate to better align AMA leadership compensation to the market median hourly rate. In considering an increase, the report also cited the fact that annual honoraria have not been changed since 2008. Additionally the external market data from other not-for-profit organizations and associations reflected a 1% annual increase in compensation for the Chair position for the past two years.

While one might apply the 1% annual market median increase to each of the past 10 years leadership did not receive an increase, the AMA’s Compensation Philosophy for Officers requires consideration of a volunteerism component in their compensation while fairly compensating leadership for the level of fiduciary responsibilities and the time commitment required of the roles. As such the Committee is recommending a modest increase of 4% to the leadership honoraria recognizing that this will be the first increase in ten years.

RECOMMENDATIONS

The Committee on Compensation of the Officers recommends the following recommendation be adopted and the remainder of this report be filed:

1. That the President, President-elect, Immediate Past-President, Chair, and Chair-elect Honoraria be increased by 4% effective July 1, 2018. The 4% increase results in the following Honoraria:
<table>
<thead>
<tr>
<th>POSITION</th>
<th>GOVERNANCE HONORARIUM</th>
</tr>
</thead>
<tbody>
<tr>
<td>President</td>
<td>$290,160</td>
</tr>
<tr>
<td>Immediate Past President</td>
<td>$284,960</td>
</tr>
<tr>
<td>President-Elect</td>
<td>$284,960</td>
</tr>
<tr>
<td>Chair</td>
<td>$280,280</td>
</tr>
<tr>
<td>Chair-Elect</td>
<td>$207,480</td>
</tr>
</tbody>
</table>

(Modify Current HOD Policy)

Fiscal Note: $51,840

APPENDIX

<table>
<thead>
<tr>
<th>POSITION</th>
<th>GOVERNANCE HONORARIUM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other Officers</td>
<td>$65,000</td>
</tr>
</tbody>
</table>

Definition of Governance Honorarium Effective July 1, 2017:

The purpose of this payment is to compensate Officers, excluding Board Chair, Chair-Elect and Presidents for all Chair-assigned internal AMA work and related travel. This payment is intended to cover all currently scheduled Board meetings, special Board or Board committee, subcommittee and task force meetings, Board orientation, Board development and media training, and Board conference calls, and any associated review or preparatory work, and all travel days related to such meetings. The Governance Honorarium also covers Internal Representation, such as section and council liaison meetings (and associated travel) or calls, up to eleven (11) Internal Representation days.

Definition of Per Diem for Representation effective July 1, 2017:

The purpose of this payment is to compensate for Board Chair-assigned representation day(s) and related travel. Representation is either external to the AMA, or for participation in a group or organization with which the AMA has a key role in creating/partnering/facilitating achievement of the respective organization goals such as the AMA Foundation, PCPI, etc. or for Internal Representation days above eleven (11). The Board Chair may also approve a per diem for special circumstances that cannot be anticipated such as weather related travel delays. Per Diem for Chair-assigned representation and related travel is $1,300 per day.

Definition of Telephonic Per Diem for External Representation effective July 1, 2017:

Officers, excluding the Board Chair and the Presidents, who are assigned as the AMA representative to outside groups as one of their specific Board assignments or assigned Internal Representation day above eleven (11), receive a per diem rate for teleconference meetings when the total of all teleconference meetings of 30 minutes or longer during a calendar day equal 2 or more hours. Payment for these meetings would require approval of the Chair of the Board. The amount of the Telephonic Per Diem will be ½ of the full Per Diem or $650.
Whereas, The AMA House of Delegates (HOD) allows for the creation of Specialty Section Councils composed of member organizations with common medical interests or specialty training (B-9.1); and

Whereas, The AMA HOD currently recognizes thirty-one (31) Specialty Section Councils within the House of Delegates (B-14.0.1); and,

Whereas, LGBTQ Health has become a fully acknowledged subspecialty of medical practice, spanning a range of medical specialties including, but not limited to, internal medicine, pediatrics, geriatrics, obstetrics and gynecology, endocrinology, plastic surgery; and

Whereas, The study and practice of LGBTQ Health as a recognized subspecialty is vital due to the presence of well-established medical disparities that affect this population; and

Whereas, The AMA Foundation, recognizing the importance of LGBTQ specific medical training, has chosen to utilize the LGBT Honor Fund to establish the creation of subspecialty fellowship training programs in LGBTQ Health; therefore be it

RESOLVED, That our American Medical Association House of Delegates establish a Specialty Section Council on LGBTQ Health. (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000.

Received: 03/08/18
RELEVANT AMA POLICY

B-9.1 Purpose.
9.1.1 Specialty Section Councils shall be established by the House of Delegates. Specialty Section Councils shall provide for deliberation and study of scientific educational and other appropriate interests and concerns of the specialty disciplines and the specialty societies representing these disciplines within the AMA.
9.1.2 The Section Council shall, on request, submit to the Board of Trustees nominations for AMA representatives to serve on approved Specialty Certifying Boards.

B-9.2 Composition.
9.2.1 National medical specialty societies represented in the House of Delegates may appoint representatives to the Specialty Section Councils for the medical specialty in which the specialty society participates. Such representatives must be members of the AMA.
9.2.2 Upon recommendation of the Specialty Section Council and approval of the Board of Trustees, national medical specialty societies that are not represented in the House of Delegates may appoint representatives to the Specialty Section Council for the medical specialty in which the specialty society participates. Such representatives must be members of the AMA.

B-9.3 Specialty Society Delegate.
The AMA delegate(s) and alternate delegate(s) from each national medical specialty society represented in the House of Delegates shall also serve in the Specialty Section Council of their respective specialty.

B-9.4 Chair and Vice Chair.
Each Specialty Section Council shall elect a Chair and Vice Chair from within its membership.

Glossary of Terms. B-14.0.1
Section Council - Specialty Section Councils have been recognized by the House of Delegates for the following specialties: Allergy; Anesthesiology; Cardiovascular Disease; Clinical Pharmacology and Therapeutics; Dermatology; Digestive Diseases; Disease of the Chest; Emergency Medicine; Endocrinology; Family and General Practice; Federal and Military Medicine; General Surgery; Genetics; Internal Medicine; Neurological Surgery; Neurology; Nuclear Medicine; Obstetrics and Gynecology; Ophthalmology; Orthopedic Surgery; Otolaryngology-Head and Neck Surgery; Pain and Palliative Medicine; Pathology; Pediatrics; Physical Medicine and Rehabilitation; Plastic, Reconstructive and Maxillofacial Surgery; Preventive Medicine; Psychiatry; Radiology; and Urology.
Whereas, The Resident and Fellow Section (RFS) passed policy 291.001R\(^1\) at the RFS 2015 Annual Meeting asking the RFS to “evaluate entering into arrangements with companies which promote health and fitness that are willing to provide discounts to AMA-RFS members”; and

Whereas, There are a variety of health and fitness companies, including fitness gyms, companies that encourage exercise, weight loss programs, and nutrition companies; and

Whereas, A discount to health and fitness companies would encourage residents and fellows to join the AMA, add additional benefits to our existing members, and would support the AMA’s overall goal of promoting health and wellness\(^2\) among resident and fellow members; and

Whereas, The AMA should be a part of wellness initiatives that impact physician health, including proper exercise, diet and mental health; and

Whereas, Many of the current member discounts (such as insurance companies, car rentals, etc.) do not appeal to most residents and fellows at this stage in their career; and

Whereas, A fitness discount has universal appeal among residents and fellows of different ages and stages of life; and

Whereas, The AMA should consider establishing relationships with health and fitness companies that are available nationwide so that all AMA members are able to benefit from the AMA member discount; and

Whereas, The discount negotiated on behalf of members should be equivalent to or better than the discounts the company offers via other advertisements; therefore be it

RESOLVED, That our American Medical Association promote health and wellness among AMA members (New HOD Policy); and be it further

RESOLVED, That our AMA further investigate and explore relationships with health and fitness companies to promote health and wellness among AMA members, including arrangements under which attractive discounts are offered to AMA members. (Directive to Take Action)

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\(^1\) 291.001R Improving Physician Well-Being by Exploring Partnerships with Companies that Promote Health and Fitness: That our AMA-RFS evaluate entering into arrangements with companies which promote health and fitness that are willing to provide discounts to AMA-RFS members. (Resolution 4, A-15)

Fiscal Note: Minimal - less than $1,000.

Received: 03/28/18

RELEVANT AMA POLICY

Physicians and Physicians-in-Training as Examples for Their Patients to Promote Wellness and Healthy Lifestyles H-405.959
Physicians and Physicians-in-Training as Examples for Their Patients to Promote Wellness and Healthy Lifestyles
Our AMA will: (1) establish a program that recognizes physicians and physicians-in-training who model wellness and healthy lifestyles in their practice and communities or establish programs that contribute to the wellness of their patients and/or community; and (2) will aid in the development of a health and wellness component in conjunction with the Doctors Back to School Program. Res. 8, A-13

Educating Physicians About Physician Health Programs D-405.990
1) Our AMA will work closely with the Federation of State Physician Health Programs (FSPHP) to educate our members as to the availability and services of state physician health programs to continue to create opportunities to help ensure physicians and medical students are fully knowledgeable about the purpose of physician health programs and the relationship that exists between the physician health program and the licensing authority in their state or territory; 2) Our AMA will continue to collaborate with relevant organizations on activities that address physician health and wellness; 3) Our AMA will, in conjunction with the FSPHP, develop state legislative guidelines addressing the design and implementation of physician health programs; and 4) Our AMA will work with FSPHP to develop messaging for all Federation members to consider regarding elimination of stigmatization of mental illness and illness in general in physicians and physicians in training. Res. 402, A-09 Modified: CSAPH Rep. 2, A-11 Reaffirmed in lieu of Res. 412, A-12, Appended: BOT action in response to referred for decision Res. 403, A-12

Physician Health Programs H-405.961
Our AMA affirms the importance of physician health and the need for ongoing education of all physicians and medical students regarding physician health and wellness. CSAPH Rep. 2, A-11 Reaffirmed in lieu of Res. 412, A-12 Reaffirmed: BOT action in response to referred for decision Res. 403, A-12
Whereas, Food rescue is described as the “practice of diverting edible food that would have been thrown out and redistributing this to those in need”;¹,² and

Whereas, Large corporations including Google© participate in programs that donate leftover food;³ and

Whereas, Achieving a 20% reduction in annual edible food waste translates into an additional 30 billion pounds of edible food per year available for human consumption;⁴ and

Whereas, AMA policies H-135.938 and H-135.939 demonstrate the AMA’s support for community programs aimed at furthering sustainable means of waste reduction and for healthcare professionals to partner with community members in realizing similar initiatives; and

Whereas, Achieving a 20% reduction in annual edible food waste translates into an additional 30 billion pounds of edible food per year available for human consumption;⁴ and

Whereas, A recent study estimated food waste annually accounts for more than 25% of total freshwater and 300 million barrels of oil consumed;⁵ and

Whereas, Food rescue is described as the “practice of diverting edible food that would have been thrown out and redistributing this to those in need or those who are food insecure”;⁶ and

Whereas, Charitable organizations often rely on partnerships with farmers, food enterprises, and other entities to rescue food, combat hunger, and alleviate food insecurity;⁷ and

³ (trying to find better source but not having too much luck) https://www.huffingtonpost.com/entry/google-airbnb-other-tech-giants-waste-tons-of-food-this-group-rescues-it_us_5773ecbbe4b0eb90355d0027
Whereas, While the EPA’s Food Recovery Hierarchy prioritizes utilizing food rescue to feed the hungry, the total amount of edible food currently rescued is still less than 2%;\(^7\) and

Whereas, AMA policies H-135.938 and H-135.939 showcase the AMA’s support for community programs aimed at furthering sustainable means of waste reduction and for healthcare professionals to partner with community members in realizing similar initiatives; therefore be it

RESOLVED, That our American Medical Association prioritize sustainability and mitigation of food waste in vendor and venue selection (New HOD Policy); and be it further

RESOLVED, That our AMA encourage vendors and relevant third parties to practice sustainability and mitigate food waste through donation. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000.

Date Received: 04/26/18

RELEVANT AMA POLICY

AMA Advocacy for Environmental Sustainability and Climate H-135.923
Our AMA (1) supports initiatives to promote environmental sustainability and other efforts to halt global climate change; (2) will incorporate principles of environmental sustainability within its business operations; and (3) supports physicians in adopting programs for environmental sustainability in their practices and help physicians to share these concepts with their patients and with their communities. (Res. 924, I-16)

Global Climate Change and Human Health H-135.938
Our AMA:
1. Supports the findings of the Intergovernmental Panel on Climate Change’s fourth assessment report and concurs with the scientific consensus that the Earth is undergoing adverse global climate change and that anthropogenic contributions are significant. These climate changes will create conditions that affect public health, with disproportionate impacts on vulnerable populations, including children, the elderly, and the poor.
2. Supports educating the medical community on the potential adverse public health effects of global climate change and incorporating the health implications of climate change into the spectrum of medical education, including topics such as population displacement, heat waves and drought, flooding, infectious and vector-borne diseases, and potable water supplies.
3. (a) Recognizes the importance of physician involvement in policy making at the state, national, and global level and supports efforts to search for novel, comprehensive, and economically sensitive approaches to mitigating climate change to protect the health of the public; and (b) recognizes that whatever the etiology of global climate change, policymakers should work to reduce human contributions to such changes.
4. Encourages physicians to assist in educating patients and the public on environmentally sustainable practices, and to serve as role models for promoting environmental sustainability.
5. Encourages physicians to work with local and state health departments to strengthen the public health infrastructure to ensure that the global health effects of climate change can be anticipated and responded to more efficiently, and that the AMA’s Center for Public Health Preparedness and Disaster Response assist in this effort.
(CSAPH Rep. 3, I-08), (Reaffirmation A-14)

See also:
Green Initiatives and the Health Care Community H-135.939
Update on the Food and Drug Administration’s Efforts to Improve Food Safety H-150.940
Sustainable Food D-150.978

Whereas, One of the duties of AMA Delegates is to advocate for increased AMA membership for physicians across the federation; and

Whereas, Our AMA House of Delegates is comprised of delegates representing state and national medical specialty societies, as well as special sections; and

Whereas, The apportionment of state medical society delegates during the current year is based on an annual census of the number of AMA members who reside in the state as determined by a count on December 31 of the previous year; and

Whereas, In the current system of accounting, physicians who join the AMA during the latter part of a year are incentivized to claim their membership beginning January 1 of the following year, instead of the latter part of year in which they actually joined (which would cost more money); and

Whereas, When new members are counted as AMA members for the matter of AMA delegation apportionments at the beginning of a new year, they are not counted for delegation entitlements until the following year even though they are AMA members all year long; and

Whereas, Many state medical and national medical specialty societies convene their annual and other sessions during the latter part of the year; and

Whereas, Updating the methodology for increasing AMA representation at the HOD might result in more vigorous AMA membership campaigns during the latter part of the year at state medical and national specialty society events; and

Whereas, The AMA Membership Department has indicated it would not be an undue burden to produce a second census of the number, specialty and location of AMA members during the first two weeks of a new year; and

Whereas, To add a second period of time to determine AMA delegation entitlements will require an amendment to the AMA Bylaws; therefore be it

RESOLVED, That our American Medical Association continue to provide a count of AMA members for AMA delegation entitlements to the House of Delegates as of December 31 and also provide a second count of AMA members within the first two weeks of the new year and that the higher of the two counts will be used for state and national specialty society delegation entitlements during the current year (Directive to Take Action); and be it further
1 RESOLVED, That the Council on Constitution and Bylaws prepare appropriate language to add
2 a second period of time to determine AMA delegation entitlements to be considered by the AMA
3 House at its earliest opportunity. (Modify Bylaws)

Fiscal Note: Not yet determined

Received: 04/25/18
Whereas, The AMA's membership for physicians 40 years and older (Life Stage categories "Mature" and "Senior," based on the AMA Physician Masterfile) declined from 118,504 in December 2010 to 109,186 in June 2017; and

Whereas, Physician membership to the AMA decreased from 16.0% of all physicians to 15.6% of all physicians from December 2010 to July 2017; and

Whereas, A clear discrepancy exists between declines in AMA membership for the majority of practicing physicians and the AMA's intent to be the voice of physicians; and

Whereas, Reasons for this discrepancy need to be understood and acted upon so that membership declines in practicing physicians can be reversed for the strength and financial health of the organization as well as the larger voice of physicians in the country; and

Whereas, It is in the interest of any membership organization to represent a substantial portion of the individuals it claims to represent; therefore be it

RESOLVED, That our American Medical Association release to its membership annually in its Annual Report any and all aggregate data for that year it has pertaining to reasons physicians are either leaving or not joining the AMA ("Data"), including but not limited to, survey data, focus group data, and exit interview data, giving specific attention to those physicians in the "Young," "Mature," and "Senior" membership categories. (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000.

Received: 05/10/18

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Whereas, Our country’s health care system belongs to the public, our patients; and
Whereas, The success of our country’s health care system depends on a well-informed public; therefore be it

RESOLVED, That our American Medical Association establish a program for training physicians in the art and science of conducting public forums in order to ensure that the public is well informed on the health care system of our country. (Directive to Take Action)

Fiscal Note: Estimated cost to implement this resolution is $25,000.

Received: 05/10/18
Whereas, The assignment of Current Procedural Terminology (CPT) codes for a patient’s medical conditions is required for each doctor-patient encounter; and

Whereas, Our American Medical Association has exclusive rights to CPT coding; and

Whereas, Our AMA receives licensing revenue related to CPT coding, including CPT code usage within electronic medical billing systems; and

Whereas, These costs are often passed on to physicians; and

Whereas, Discounted or waived CPT fees would be a valuable AMA member benefit and would probably drive an increase in AMA membership; therefore be it

RESOLVED, That our American Medical Association investigate mechanisms by which AMA members may receive a discount or waiver on CPT-related fees, including fees associated with using CPT codes within electronic medical billing systems. (Directive to Take Action)

Fiscal Note: Estimated cost of $14,000 to complete the requested study.

Received: 05/10/18