

October 28, 2019

Memo to: Delegates, Alternate Delegates
Executive Directors
State Medical Associations, National Medical Specialty Societies, Professional
Interest Medical Associations, Other Societies, Sections and Special Groups

Subject: 2019 Interim Meeting Handbook Addendum

We are pleased to provide the following items received in addition to those included in the advance Delegate's Handbook.

Reports

- Report of the HOD Committee on Compensation of the Officers
- Report of the Speakers: Task Force on Election Reform

Resolutions Recommended for Consideration

- 215 Board Certification of Physician Assistants
- 216 Legislation to Facilitate Corrections-to-Community Healthcare Continuity via Medicaid
- 217 Promoting Salary Transparency Among Veterans Health Administration Employed Physicians
- 218 Private Payers and Office Visit Policies
- 219 QPP and the Immediate Availability of Results in CEHRTs
- 812 Autopsy Standards as Condition of Participation
- 813 Public Reporting of PBM Rebates
- 814 PBM Value-Based Framework for Formulary Design
- 815 Step Therapy
- 925 Suspending Sales of Vaping Products/Electronic Cigarettes Until FDA Review
- 927 Climate Change
- 928 CBD Oil and Supplement Use in Treatment
- 929 Regulating Marketing and Distribution of Tobacco Products and Vaping-Related Products

Resolutions Not for Consideration

- 012 Study of Forced Organ Harvesting by China
- 926 School Resource Officer Qualifications and Training

Finally, your Speakers wish to inform you that the charts listing actions taken in follow-up to resolutions and report recommendations from the 2018 Interim and 2019 Annual Meetings will be posted on the Interim Meeting website (www.ama-assn.org/interim-meeting).

Sincerely,



Bruce A. Scott, MD
Speaker, House of Delegates



Lisa Bohman Egbert, MD
Vice Speaker, House of Delegates

REPORT OF THE HOUSE OF DELEGATES COMMITTEE
ON COMPENSATION OF THE OFFICERS

Report I-19

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

Presented by: Richard A. Evans, MD, Chair

Referred to: Reference Committee F

1 This report by the committee at the 2019 Interim Meeting presents several recommendations. It
2 also documents the compensation paid to Officers for the period July 1, 2018 thru June 30, 2019
3 and includes the 2018 calendar year IRS reported taxable value of benefits, perquisites, services,
4 and in-kind payments for all Officers.

5
6 **BACKGROUND**

7
8 At the 1998 Interim Meeting, the House of Delegates (HOD) established a House Committee on
9 Trustee Compensation, currently named the Committee on Compensation of the Officers, (the
10 “Committee”). The Officers are defined in the American Medical Association’s (AMA)
11 Constitution and Bylaws. (Note: under changes to the Constitution previously approved by the
12 HOD, Article V refers simply to “Officer,” which includes all 21 members of the Board among
13 whom are the President, President-Elect, Immediate Past President, Secretary, Speaker of the HOD
14 and Vice Speaker of the HOD, collectively referred to in this report as Officers.) The composition,
15 appointment, tenure, vacancy process and reporting requirements for the Committee are covered
16 under the AMA Bylaws. Bylaws 2.13.4.5 provides:

17
18 The Committee shall present an annual report to the House of Delegates recommending the
19 level of total compensation for the Officers for the following year. The recommendations of the
20 report may be adopted, not adopted, or referred back to the Committee, and may be amended
21 for clarification only with the concurrence of the Committee.

22
23 At A-00, the Committee and the Board jointly adopted the American Compensation Association’s
24 definition of total compensation which was added to the Glossary of the AMA Constitution and
25 Bylaws. Total compensation is defined as the complete reward/recognition package awarded to an
26 individual for work performance including: (a) all forms of money or cash compensation; (b)
27 benefits; (c) perquisites; (d) services; and (e) in-kind payments.

28
29 Since the inception of this Committee, its reports document the process the Committee follows to
30 ensure that current or recommended Officers compensation is based on sound, fair, cost-effective
31 compensation practices as derived from research and use of independent external consultants,
32 expert in Board compensation. Reports beginning in December 2002 documented the principles the
33 Committee followed in creating its recommendations for Officer compensation.

34
35 At A-08, the HOD approved changes that simplified compensation practices with increased
36 transparency and consistency. At A-10, Reference Committee F requested that this Committee
37 recommend that the HOD affirm a codification of the current compensation principle, which

1 occurred at I-10. At that time, the HOD affirmed that this Committee has and will continue to base
2 its recommendations for Officer compensation on the principle of the value of the work performed,
3 consistent with IRS guidelines and best practices as recommended by the Committee's external
4 independent consultant, who is expert in Board compensation.

5
6 At A-11, the HOD approved the alignment of Medical Student and Resident Officer compensation
7 with that of all other Officers (excluding Presidents and Chair) because these positions perform
8 comparable work.

9
10 Immediately following A-11, the Committee retained Mr. Don Delves, founder of the Delves
11 Group, to update his 2007 research by providing the Committee with comprehensive advice and
12 counsel on Officer compensation. The updated compensation structure was presented and approved
13 by the HOD at I-11 with an effective date of July 1, 2012.

14
15 The Committee's I-13 report recommended and the HOD approved the Committee's
16 recommendation to provide a travel allowance for each President to be used for upgrades because
17 of the significant volume of travel in representing our AMA.

18
19 At I-16, based on results of a comprehensive compensation review conducted by Ms. Becky Glantz
20 Huddleston, an expert in Board Compensation with Willis Towers Watson, the HOD approved the
21 Committee's recommendation of modest increases to the Governance Honorarium and Per Diems
22 for Officer Compensation, excluding the Presidents and Chair, effective July 1, 2017. At A-17 the
23 HOD approved modifying the Governance Honorarium and Per Diem definition so that Internal
24 Representation, greater than eleven days, receives a per diem.

25
26 At A-18, based on comprehensive review of Board leadership compensation, the HOD approved
27 the Committee's recommendation to increase the President, President-elect, Immediate Past-
28 President, Chair and Chair-elect honoraria by 4% effective July 1, 2018.

29
30 At I-18 and A-19, the House approved the Committee's recommendation to provide a Health
31 Insurance Stipend to President(s) who are under Medicare eligible age when the President(s) and
32 his/her covered dependents, not Medicare eligible, lose the President's employer provided health
33 insurance during his/her term as President. Should the President(s) become Medicare eligible while
34 in office, he/she will receive an adjusted Stipend to provide insurance coverage to his/her
35 dependents not Medicare eligible.

36 37 CASH COMPENSATION SUMMARY

38
39 The cash compensation of the Officers shown in the following table will not be the same as
40 compensation reported annually on the AMA's IRS Form 990 because Form 990s are based on a
41 calendar year. The total cash compensation in the summary is compensation for the days these
42 officers spent away from home on AMA business approved by the Board Chair. The total cash
43 compensation in the summary includes work as defined by the Governance Honorarium and Per
44 Diem for Representation including conference calls with groups outside of the AMA, totaling 2
45 hours or more per calendar day as approved by the Board Chair. Detailed definitions are in the
46 Appendix.

1 The summary covers July 2018 to June 30, 2019.

2

| AMA Officers | Position | Total Compensation | Total Days |
|-------------------------------------|---------------------------------------|---------------------------|-------------------|
| Grayson W Armstrong, MD, MPH | Resident Officer | \$ - | 2.5 |
| Susan R Bailey, MD | Speaker, House of Delegates | \$ 89,700 | 69 |
| David O Barbe, MD, MHA | Immediate Past President | \$ 284,960 | 96.5 |
| Willarda V Edwards, MD, MBA | Officer | \$ 65,650 | 45 |
| Lisa Bohman Egbert, MD | Vice Speaker, House of Delegates | \$ - | 2 |
| Jesse M Ehrenfeld, MD, MPH | Chair-Elect & Young Physician Officer | \$ 207,480 | 104.5 |
| Scott Ferguson, MD | Officer | \$ 71,500 | 54.5 |
| Sandra Adamson Fryhofer, MD | Officer | \$ 83,200 | 68 |
| Gerald E Harmon, MD | Immediate Past Chair | \$ 86,450 | 67 |
| Patrice A Harris, MD, MA | President-Elect | \$ 288,210 | 185 |
| William E Kobler, MD | Officer | \$ 86,450 | 62 |
| Russell WH Kridel, MD | Secretary | \$ 78,000 | 66 |
| Barbara L McAneny, MD | President | \$ 290,160 | 189 |
| William A McDade, MD, PhD | Officer | \$ 78,000 | 59.5 |
| Mario E Motta, MD | Officer | \$ 66,950 | 39 |
| Bobby Mukkamala, MD | Officer | \$ 74,100 | 56 |
| Albert J Osbahr, III, MD | Officer | \$ 78,000 | 52.5 |
| Jack Resneck, Jr, MD | Chair | \$ 280,280 | 97.5 |
| Ryan J Ribeira, MD, MPH | Resident Officer | \$ 65,000 | 49 |
| Karthik V Sarma, MS | Medical Student Officer | \$ 113,750 | 91 |
| Bruce A Scott, MD | Vice Speaker, House of Delegates | \$ 71,500 | 64 |
| Sarah Mae Smith | Medical Student Officer | \$ - | 6.5 |
| Michael Suk, MD, JD, MPH, MBA | Officer | \$ - | 2.5 |
| Georgia A Tuttle, MD | Officer | \$ 84,500 | 58 |
| Willie Underwood, III, MD, MSc, MPH | Officer | \$ - | 2 |
| Kevin A Williams, MSA | Public Board Member | \$ 66,950 | 50 |

3

4 President, President-Elect, Immediate Past President, and Chair

5 In 2018 – 2019, each of these positions received an annual Governance Honorarium which was
6 paid in monthly increments. These four positions spent a total of 568.5 days on approved
7 Assignment and Travel, or 142 days each on average.

8

9 Chair-Elect

10 This position received a Governance Honorarium of approximately 75% of the Governance
11 Honorarium provided to the Chair.

12

13 All other Officers

14 All other Officers received cash compensation, which included a Governance Honorarium of
15 \$65,000 paid in monthly installments. The remaining cash compensation is for Assignment and
16 Travel Days that are approved by the Board Chair to externally represent the AMA. These days
17 were compensated at a per diem rate of \$1,300.

1 Assignment and Travel Days

2 The total Assignment and Travel Days for all Officers (excluding the President, President-Elect
3 Immediate Past President and Chair) were 1070.5; this includes reimbursement for telephonic
4 representation meetings for external organizations that are 30 minutes or longer during a calendar
5 day and total 2 or more hours. These are reimbursed at ½ of the current per diem rate. During this
6 reporting period, there were 16 reimbursed calls, representing 8 per diem days.

7
8 EXPENSES

9
10 Total expenses paid for the period, July 1, 2018 – June 30, 2019, \$882,074 compared to \$798,212
11 for the previous period, representing a 10.5% increase. This includes \$3,644 in upgrades for
12 Presidents' travel per the approved Presidential Upgrade Allowance of \$2,500 per position per
13 term.

14
15 BENEFITS, PERQUISITES, SERVICES, AND IN-KIND PAYMENTS

16
17 Officers are able to request benefits, perquisites, services, and in-kind payments, as defined in the
18 "AMA Board of Trustees Standing Rules on Travel Expenses." These non-taxable business
19 expense items are provided to assist the Officers in performing their duties:

- 20
21
 - AMA Standard laptop computer or iPad
 - 22 • iPhone
 - 23 • American Express card (for AMA business use)
 - 24 • Combination fax/printer/scanner
 - 25 • An annual membership to the airline club of choice offered each year during the Board
 - 26 member's tenure
 - 27 • Personalized AMA stationary, business cards and biographical data for official use

28

29 Additionally, all Officers are eligible for \$305,000 term life insurance and are covered under the
30 AMA's \$500,000 travel accident policy and \$10,000 individual policy for medical costs arising out
31 of any accident while traveling on official business for the AMA. Life insurance premiums paid by
32 the AMA are reported as taxable income. Also, travel assistance is available to all Officers when
33 traveling more than 100 miles from home or internationally.

34
35 Secretarial support, other than that provided by the AMA's Board office, is available up to defined
36 annual limits as follows: President, during the Presidential year, \$15,000, \$5,000 each for the
37 President-Elect, Chair, Chair-Elect and Immediate Past President per year. Secretarial expenses
38 incurred by other Officers in connection with their official duties are paid up to \$750 per year per
39 Officer. This is reported as taxable income.

40
41 Travel expenses incurred by family members are not reimbursable, except for the family of the
42 incoming President at the Annual Meeting of the HOD.

43
44 Calendar year taxable life insurance and taxable secretarial fees reported to the IRS totaled \$41,292
45 and \$26,250 respectively for 2018. An additional \$12,125 was paid to third parties for secretarial
46 services during 2018.

1 METHODOLOGY

2
3 The Committee commissioned a comprehensive review of Officer compensation, excluding
4 leadership, since it has been three years since the last compensation review. The purpose of this
5 review was to refresh the Committee's knowledge of market conditions related to Board
6 compensation, to ensure the Officers are compensated appropriately for the work performed on
7 behalf of the AMA and that the structure of Officer compensation aligned with current trends in
8 for-profit Board compensation. The Committee also continues to be interested in reviewing and
9 refining its compensation practices for increased simplification and transparency.

10
11 To complete the compensation review, the Committee retained Becky Glantz Huddleston, of Willis
12 Towers Watson. Ms. Huddleston is an expert in Board compensation and works with both for-
13 profit and not-for-profit organizations. The firm she works for, Willis Towers Watson, is one of the
14 largest, most prestigious and well-respected compensation consulting firms.

15
16 The Committee's review and subsequent recommendations for Officer compensation are based on
17 the principle of the value of the work performed, as affirmed by the HOD and the following
18 additional guidelines:

- 19
20 • Compensation should be based on the value expected by the AMA from its Officers.
21 • Compensation should take into account that the AMA is a complex organization when
22 comparing compensation provided to Board members at for-profit organizations and at
23 complex not-for-profit organizations of similar size and activities.
24 • Compensation should reflect a balance of volunteerism while also compensating Officers for
25 level of fiduciary responsibilities and time commitment of the role.
26 • Compensation should be aligned with the long-term interests of AMA members.
27 • Compensation should reinforce choices and behaviors that enhance effectiveness.
28 • Compensation should be approached on a comprehensive basis, rather than as an array of
29 separate elements.

30
31 The process the Committee followed along with the aforementioned principles is consistent with
32 the guidelines recommended by the IRS for determining reasonable and competitive levels of
33 Officer compensation.

34
35 Ms. Huddleston and the Committee developed their recommendations based on:

- 36
37 • The current compensation structure.
38 • Review and analysis of Officer compensation data for the past three terms.
39 • Pay practices for Boards of Directors at for-profit and not-for-profit organizations similar to the
40 AMA who pay their Board members.
41 • A collaborative, deliberative and objective review process.

42
43 FINDINGS

44
45 The Committee notes that Officers continue to make significant time commitments in supporting
46 our AMA in governance and representation functions. Given the amount of time required of Board
47 members, it is important that individuals seeking a position on the Board be aware of the scope of
48 the commitment and the related compensation.

49
50 In reviewing the Officer Compensation data for the past three terms, the Committee and its
51 consultant first reviewed the time commitment of the non-leadership Officers. This review showed

1 that the time commitment for Board-related work was generally consistent among the non-
2 leadership Officers with the variability in the honorarium days due to travel, committee meetings
3 which vary by Board committee and committee orientation. Internal representation had more
4 variability than Board-related work and External Representation was the most variable.

5
6 The Committee and its consultant also reviewed the current structure of Officer compensation to
7 ensure that the structure appropriately compensates the Officers for the number of days worked and
8 the varied time commitment of each Officer. The analysis compared the Officer compensation for
9 the 2018/2019 term under the current definition which compensates Officers via a Per Diem for
10 Internal Representation days above eleven with a hypothetical scenario where all internal
11 representation days were included in the Governance Honorarium. The conclusion of this analysis
12 is that the current structure appropriately compensates the Officers for the varied time
13 commitments in Internal Representation. The analysis further demonstrated that the current
14 structure addresses the variable time commitment of the Immediate Past Chair role.

15
16 External compensation data from both for-profit and not-for-profit organizations was reviewed.
17 For-profit Board compensation data was sourced from the National Association of Corporate
18 Directors (NACD) 2018-2019 survey of organizations with revenue between \$50M - \$500M. This
19 data indicated for-profit Board compensation consisted of both a pay and stock component. The
20 Committee's external consultant noted that not-for-profit organizations do not have the ability to
21 grant stock awards and therefore do not necessarily intend to be competitive with the for-profit
22 sector from the perspective of total compensation. While AMA's Governance Honorarium was
23 close to the median cash compensation, it was well below the total Board compensation due to
24 absence of stock awards.

25
26 The consultant collected and analyzed data from not-for-profit organizations determined to be of
27 similar size and complexity as the AMA, AMA's not-for-profit peer group. This information was
28 collected from Form 990 filings, generally for 2017. This data showed that AMA non-leadership
29 Officers spend significantly more time on internal Board and representation when compared to the
30 peer group. Further analysis to adjust for the variance in time commitments showed that AMA's
31 Governance Honorarium was significantly lower than the peer group. Since the 2016 assessment,
32 the compensation data of for-profit and not-for-profit organizations showed an average increase of
33 slightly over 7%.

34
35 There is no good external comparison for Per Diem pay for External Representation for non-
36 leadership Officers given the unique nature of this function at the AMA. However, the Per Diem
37 amount has not changed since 2016 and the Committee used the data from the not-for-profit peer
38 group Governance Honorarium comparison to directionally inform them.

39
40 The Committee balanced simplicity, transparency and comparability with internal and external
41 compensation data and the total cost of governance to the AMA when recommending the modest
42 increases to the Governance Honorarium and Per Diems. This Committee is recommending an
43 increase of approximately 3%, or approximately 1% per year, to both the Honorarium and Per
44 Diem, effective July 1, 2020.

45 RECOMMENDATIONS

46
47
48 The Committee on Compensation of the Officers recommends the following recommendations be
49 adopted and the remainder of this report be filed:

- 1 1. That there be no change to the current Definitions effective July 1, 2018 as they appear in the
2 Travel and Expenses Standing Rules for AMA Officers for the Governance Honorarium, Per
3 Diem for Representation and Telephonic Per Diem except for the Governance Honorarium and
4 Per Diem amounts as recommended in 2, 3 and 4 below.
5
6 • Definition of Governance Honorarium effective July 1, 2017:
7 The purpose of this payment is to compensate Officers, excluding Board Chair, Chair-Elect
8 and Presidents, for all Chair-assigned internal AMA work and related travel. This payment is
9 intended to cover all currently scheduled Board meetings, special Board or Board committee,
10 subcommittee and task force meetings, Board orientation, Board development and media
11 training, and Board conference calls, and any associated review or preparatory work, and all
12 travel days related to all such meetings. The Governance Honorarium also covers Internal
13 Representation, such as section and council liaison meetings (and associated travel) or calls, up
14 to eleven (11) Internal Representation days.
15
16 • Definition of Per Diem for Representation effective July 1, 2017:
17 The purpose of this payment is to compensate for Board Chair-assigned representation day(s)
18 and related travel for Officers, excluding Board Chair, Chair-Elect and Presidents.
19 Representation is either external to the AMA, or for participation in a group or organization
20 with which the AMA has a key role in creating/partnering/facilitating achievement of the
21 respective organization goals such as the AMA Foundation, PCPI, etc., or for Internal
22 Representation days above eleven (11). The Board Chair may also approve a per diem for
23 special circumstances that cannot be anticipated such as weather-related travel delays.
24
25 • Definition of Telephonic Per Diem for Representation effective July 1, 2017:
26 Officers, excluding the Board Chair, Chair-Elect and Presidents, who are assigned as the AMA
27 representative to outside groups as one of their specific Board assignments or assigned Internal
28 Representation days above eleven (11), receive a per diem rate for teleconference meetings
29 when the total of all teleconference meetings of 30 minutes or longer during a calendar day
30 equal 2 or more hours. Payment for these meetings would require approval of the Chair of the
31 Board.
32
33 2. That the Governance Honorarium for all Board members excluding, Board Chair, Board
34 Chair-elect, President, President-elect, and Immediate Past President be increased effective
35 July 1, 2020 to \$67,000. (Directive to Take Action)
36
37 3. That the Per Diem for Chair-assigned representation for all Board members excluding the
38 Board Chair, Chair-Elect and Presidents and related travel be increased effective July 1, 2020
39 to \$1,400 per day. (Directive to Take Action)
40
41 4. That the Per Diem for Chair-assigned Telephonic Per Diem for Representation be increased
42 effective July 1, 2020 to \$700 as defined. (Directive to Take Action)

Fiscal Note: Estimated annual cost of Recommendations 2, 3 and 4 is \$49,950 based on data reported for July 1, 2018 through June 30, 2019. This cost represents the impact of the Governance Honorarium increase (\$2,000 for each of the 16 non-leadership Officers), the Per Diem increase (\$100 per day) and the Telephonic Per Diem increase (\$50 per teleconference meeting as defined).

APPENDIX

| POSITION | GOVERNANCE HONORARIUM |
|--|-----------------------|
| President | \$ 290,160 |
| Immediate Past President & President-Elect | \$ 284,960 |
| Chair | \$ 280,280 |
| Chair-Elect | \$ 207,480 |

REPORT OF THE SPEAKERS

Speakers' Report 1-I-19

Subject: Speakers' Report: Task Force on Election Reform

Presented by: Bruce A. Scott, MD, and Lisa Bohman Egbert, MD

At this past June's meeting the House of Delegates adopted [policy](#) calling for the Speaker to appoint a task force that would recommend improvements to our AMA's election processes. The following members were appointed to the task force:

- Jenni Barlotti-Telesz, MD, American Society of Anesthesiologists
- Richard Evans, MD, Maine
- James Hay, MD, California
- Dan Heinemann, MD, American Academy of Family Physicians
- David Henkes, MD, Texas
- Jessica Krant, MD, American Society for Dermatologic Surgery
- Josh Lesko, MD, Resident Physician, Virginia
- John Poole, MD, New Jersey
- Karthik Sarma, immediate past medical student trustee
- Stephen Tharp, MD, Indiana
- Jordan Warchol, MD, MPH, Nebraska
- Bruce Scott, MD, Speaker, Kentucky
- Lisa Bohman Egbert, MD, Vice Speaker, Ohio

Interest in the task force was high, with more than 60 requests to serve. Selection was based primarily on experience with AMA elections, either as a candidate or part of a campaign committee, and most members had been involved multiple times and in multiple ways. Consideration was also given to ensuring a broad cross section of the House of Delegates.

BACKGROUND

The task force is not yet prepared to propose specific changes to the election rules, but rather is seeking broad input from the HOD. This report describes activities undertaken since the task force was launched and outlines topics that have been discussed among members. Your speakers have arranged for an open forum to be held during the Interim Meeting to solicit thoughts across topics outlined below. A report with recommendations should be expected at the 2020 Annual Meeting.

Current election rules are found in both AMA bylaws and policy (see [Appendix A](#)) but are also dependent on Speaker rulings and discretion (eg, the cap on expenditures for giveaways). Chief among expressed concerns were the expense and time invested in campaigns, but also mentioned were associated effects such as decisions by otherwise qualified candidates to not seek office and the limiting effect of election-related activities on the ability to fully address policy matters. In the view of the task force, costs are real, measured not only in dollars but in time, distractions and stress. Moreover, these costs are shared by both candidates and the larger House.

1 The task force is assessing the entirety of our election process, and while recommendations are
2 forthcoming next June, the task force would note that its primary goal is to ensure that the best
3 candidates are selected as AMA's leaders in free and fair elections and in furtherance of AMA's
4 "Guiding [principles](#) for House Elections." For candidates, the task force hopes to make campaigns
5 less expensive and more equitable, while removing obstacles that discourage qualified members
6 from seeking election. At the same time, the task force seeks to ensure that electors constitute an
7 informed electorate. While the task force believes the election process should not be unduly
8 distracting from our policy discussions, we also recognize the importance of our elected leadership
9 and believe it is appropriate for the House to spend time and focus on selecting these individuals.

10
11 Additionally, the task force holds that addressing our AMA's election rules should be an
12 evolutionary process, with the task force's eventual recommendations only a step along a path that
13 is sensitive to changes in technology, the needs of the profession, the diversity of AMA
14 membership and the makeup of the House of Delegates. That said, the task force does not mean to
15 suggest that it should be an ongoing entity. Rather changes should henceforth be organic.

16
17 For example, in some of the task force discussions questions arose about the value of certain
18 actions or activities that more often than not are part of most candidates' election efforts. The
19 consensus within the task force is that many of these actions add little, if any, value to a candidate's
20 likelihood of election, but candidates or their supporters are hesitant to not continue the activity
21 because "everyone does it." From the perspective of the task force, one would hope that both rules
22 and practice would be modified over time when new norms become the standard.

23 24 ***Task Force Activity***

25
26 After it was formed, the task force engaged in a series of email exchanges on multiple election-
27 related topics; those have continued even with the approach of the Interim Meeting. Typically, the
28 Speaker, Dr. Scott, proposed a relatively narrow item for discussion, with his initial question
29 directed to all members of the task force and responses shared across the group. As an example,
30 one of the early discussions dealt with the giveaways that are included in the not for official
31 business bag at the opening session of the Annual Meeting. Each discussion thread was conducted
32 independently and allowed to conclude naturally.

33
34 The task force also met face to face and will be meeting again during the Interim Meeting. The in-
35 person meetings afford an opportunity for the members to interact and discuss ideas and concerns
36 about more conceptual ideas, not easily handled by email because nuance and slight alterations can
37 affect the ensuing dialog.

38 39 **ITEMS FOR CONSIDERATION**

40
41 The task force has discussed and would like input on multiple items, but it should be noted that
42 inclusion on this list does not imply that the task force has concluded its discussion of the matter or
43 that they have adopted a position.

44
45 Note in each area of consideration you will find highlighted questions to be discussed
46 at the open forum. These should not be considered as all-inclusive or in any way
47 exclusive of other comments. Open discussion of each topic is welcome.

48
49 Additionally, [Appendix B](#) includes a list of topics that will be discussed in the open
50 forum.

Interviews

It is common for candidates to be interviewed by literally dozens of caucuses and delegations. This process stretches over several days and has been described as “grueling.” Delegations and interview committees spend considerable time listening and evaluating candidates. Some complain that these presentations interrupt their policy discussions and delegates report hearing redundant presentations (others report hearing conflicting comments from some candidates in different venues). While there is no question that this process is time consuming for both the candidates and those interviewing them, others defend this as “the most important way candidates are vetted.”

The Office of House of Delegates Affairs currently schedules 10-minute interviews for officer candidates in contested elections. Those interviews are scheduled only with geographic caucuses, because scheduling interviews with every interested group would be prohibitively complex and time consuming. Nonetheless, other groups can and do schedule interviews with officer candidates, and candidates in council elections are scheduled either by the interviewing group or the candidates themselves (or their campaign team). Some delegations employ committees to conduct candidate interviews, with the committee’s recommendation then provided to members of that delegation (or caucus). Other groups and caucuses allow candidates to present to the entire delegation. Still other delegations handle officer and council candidates differently.

Open Forum Topic #1

The election task force wants to hear what changes, if any, would improve the interview process. Should there be formalized interview forums (like currently held for president elect candidates) before the entire HOD or large assembly, perhaps just for officers or for all candidates? Would delegations support being grouped together to reduce the number of interviews or do delegations want to continue their individual or small group interviews? What measures should be taken to ensure interviews are equally available to all candidates for a given position? Should council and officer candidates be handled differently? (this same question could be asked about subsequent topics as well)

Campaign expenses

One of the major areas of expressed concern regarding campaigns is the real or anticipated expense. While there is wide variability in the costs of campaigns and some would argue that big budgets don’t necessarily lead to election, it has been said that there are individuals that do not seek election because of the anticipated cost. Some delegations have more resources available than others, but most all associations are facing increasing budgetary concerns. In fact, financial concerns have been stated as a reason for some societies to not fill their entire delegation. Budgetary considerations should not be a deciding factor in the election of candidates.

Strict limits on campaign expense or required transparency of expenditures have been recommended to the task force. It is difficult to measure actual expenditures particularly for larger delegations that routinely have receptions, suites, dinners and giveaways. Some delegations are willing and able to spend more on campaigns. Some candidates have more available resources whether financial or otherwise (eg, web design expertise, video studio,) from their family, friends or medical association.

Open Forum Topic #2

Should there be a limit on campaign expense or required reporting? How would actual expenditures be accurately measured and reported? Is there a true correlation between expenditure and election? The possibility of “public funding” of elections has been raised – how would the funds be raised and distributed? Should AMA be expected to

1 finance the election process? Would delegations be willing to share expense per capita
2 or otherwise?

3 4 ***Campaign receptions***

5 Campaign receptions are likely the largest single expenditure for most campaigns, with estimates
6 ranging upward from \$20,000 and the overall cost dependent on decorations and refreshments, and
7 some costs are shared across a caucus. Providing alcohol is already prohibited by the rules, which
8 serves to some extent to limit the cost. While candidates have been elected without a reception (and
9 others with well attended, elaborate receptions have not been elected) some may be deterred from
10 running because of the perceived need for a reception and the anticipated expense. These continue
11 to be well attended and candidates seem to have no hesitation (and feel welcome) attending other
12 receptions, even that of their opponents, so there seems to be little exclusivity. While there is no
13 question that most, if not all, open receptions have a campaign component, conversations typically
14 include policy discussions and valued social interaction. Some have complained about long
15 receiving lines that delay mingling and constructive discussion.

16 17 **Open Forum Topic #3**

18 Is there an option that would provide the opportunity for candidates to interact with a
19 broad range of delegates outside the formal interviews and at the same time provide
20 social interaction for others to encourage their attendance? Could individual receptions
21 be replaced by a joint reception or perhaps separate receptions for different categories
22 of candidates (eg, officers versus council candidates)? Some states and regional
23 delegations have parties every year, with or without a candidate (eg, ice cream social,
24 chili, chowder or wine tasting). If a general reception were offered, should separate
25 receptions be allowed? If receptions are continued should receiving lines be
26 discouraged or should this decision be left to the host?

27 28 ***Campaign memorabilia***

29 Giveaways or gifts: Our current rules allow the Speaker to set an expenditure limit for the
30 giveaways that are distributed via the not for official business bag or at a party. The limit is
31 calculated on a per capita basis given the number of delegates and alternate delegates. This past
32 June the aggregate limit was \$3200. Although not one of the larger campaign expenses, every
33 dollar counts particularly for candidates with limited budgets. Many would say that while they
34 enjoy the treats that this is not a factor in their vote; others argue these allow candidates to display
35 their individuality and draw attention to literature that is often attached.

36 37 **Open Forum Topic #4**

38 Should gifts be "discouraged" or even disallowed altogether? What if a state wants to
39 provide a gift that is not "tied to" a candidate? Some states put something in the bag
40 or distribute a gift that they believe represents their state even when they don't have a
41 candidate (eg, Virginia peanuts, New England lobsters).

42
43 Pins, buttons and stickers: The rules separate pins, buttons and stickers from campaign giveaways,
44 noting that they do not count against spending limits, but the rules also say they should be simple.
45 Although not a major expenditure, concerns have arisen around their distribution and
46 appropriateness for a professional association. Some individuals feel pressured to wear stickers and
47 object to "forced stickering;" while others say that the stickers are used as a conversation starter
48 and allow one to display their support for a candidate.

1 Open Forum Topic #5

2 Should pins / buttons / stickers be disallowed? Several specialty societies and some
3 states have pins or stickers that may not necessarily include a candidate's name but
4 may still be perceived as campaign material. Where do we draw the line?

5
6 ***Campaign literature***

7 Campaign mailings preceding the Annual Meeting are common, and the not for official business
8 bag is generally filled with campaign material. Some of the materials attest to the qualifications of
9 a candidate, while others include little more than a photo and endorsement. Under current rules
10 electronic (email) communications to members of the House "must allow recipients to opt out" of
11 future messages. Considerable effort and funds are spent on creating and distributing this material.
12 Some delegates read the material considering it an important source of information and have
13 commented that it gives them a sense of the candidate's personality and background. Others
14 believe this is a waste of resources, particularly the printed material, and should be banned or at
15 least switched to electronic only.

16
17 An AMA election manual has been prepared for the last 33 years and starting in 2016 has appeared
18 exclusively in electronic form on our AMA's [website](#). Candidates are responsible for the content of
19 their submissions, but our AMA does minimal copy editing to ensure a consistent style. The
20 manual is intended in part to reduce the need for other forms of communication as well as provide
21 a level playing field.

22
23 Open Forum Topic #6

24 Does the election manual alone provide sufficient information? If technically feasible,
25 should individuals be allowed to select electronic communications only or opt out of
26 receiving campaign literature altogether? Do materials in the not for official business
27 bag provide meaningful information or are they a waste of resources and should be
28 discouraged or even disallowed?

29
30 ***Election process***

31 Elections are scheduled on [Tuesday](#) morning at the Annual Meeting, and the initial round of voting
32 is conducted before the House opens its business session that morning. Runoffs, if they are needed,
33 are held in the House by paper ballot once ballots are prepared. Comments have been heard
34 regarding the timing of the vote, including the day it should occur, along with suggestions to
35 employ electronic voting for runoffs and concerns about the disruptions caused by runoffs and
36 victory and concession speeches. Electronic voting will expedite runoffs (and potentially initial
37 voting as well) and reduce disruption. Victory and concession speeches could be time limited. Any
38 change to the day or time of the elections would likely require other adjustments to our typical
39 schedule.

40
41 Open Forum Topic #7

42 The task force is interested in members' comments about any aspect of the processes
43 associated with the actual voting. Assuming technology can provide secure voting
44 from delegate seats within the House, does the HOD support a move to electronic
45 voting? What are the advantages and disadvantages of moving the day or time of the
46 election? Should post-election speeches be time limited or even not allowed?

47
48 ***Other issues***

49 The task force has received comments regarding "pop up" candidates – previously unannounced
50 candidates that are nominated from the floor when a new opening is created by the election of a
51 sitting council member or trustee to a higher office. These candidates do not receive the scrutiny of

1 the normal election process yet are elected to a full term. Further concern was expressed that the
2 potential of opening a new seat has become a strategy for election. It has been suggested that sitting
3 council or board members with unexpired terms that are nominated for higher office be required to
4 resign their current position thus opening their seat regardless of the outcome of their new election.
5 This would provide for nominations for the opened seat to follow the normal election process but
6 would truncate the service of experienced leaders and possibly lead to more individuals remaining
7 in their seats for full terms reducing opportunity for new leadership. Others have suggested that the
8 vacated seat remain open until the next annual election. Still others have noted that pop-up
9 candidates choose to "pop-up" because of the opportunity to run for a desired office without the
10 burden of the campaign expense.

11
12 **Open Forum Topic #8**

13 Do pop-up candidates distort the election process? Should our process of electing
14 individuals for newly opened positions after regular nominations are closed be
15 changed? If so, how?

16
17 Concerns have been expressed about suites, dinners and other gatherings that are in effect
18 campaign events occurring at our annual meeting and before "official campaigning" is allowed
19 (National Advocacy Conference, State Legislative Conference and Interim Meeting). These add
20 considerable expense. It is difficult to determine when a gathering in a suite or a dinner is simply a
21 social event for individuals to interact socially, which your task force believes is important, or a
22 campaign event.

23
24 **Open Forum Topic #9**

25 Would a restriction that dinners be "Dutch treat" if an announced candidate was
26 present be effective? How can we tell delegations they can't entertain their friends or
27 colleagues? Would restrictions on campaign receptions considered above actually
28 drive more resources to these less regulated events?

29
30 ***Final discussion***

31 The election task force believes that while the current election process certainly can and should be
32 improved that the current elected AMA leadership retains our fullest confidence. Your speakers
33 have noted that while there have been general comments about behavior that might be considered a
34 violation of the rules, formal reports of violations have been remarkably few.

35
36 Finally, in reviewing the history of our election process the task force wondered how familiar
37 candidates, delegates and alternate delegates are with our current election rules. Many of the
38 expressed concerns including those regarding vote trading, block voting, caucuses attempting to
39 direct individual delegate votes and negative campaigning are contrary to our current "Guiding
40 Principles." Perhaps adherence to the policies and rules previously adopted by the HOD should be
41 given greater emphasis. While one would hope that professionalism alone would demand
42 compliance, the challenge for many of the concerns is surveillance and enforcement. We encourage
43 everyone to review the current rules and principles listed in the appendix of this report.

44
45 **Open Forum Topic #10**

46 The question arises should election reforms simply discourage undesirable behavior
47 or attempt to prohibit such behavior. The task force welcomes comments regarding
48 monitoring and enforcement of what are often considered the most problematic
49 potential violations which are also those most difficult to track and prevent.

1 **CONCLUSION**

2
3 The election task force seeks the appropriate balance between an informed electorate who are
4 selecting the best candidates after adequate exposure and proper opportunity for due diligence
5 while eliminating obstacles, particularly those that do not add to the selection of the most qualified
6 candidates. We understand that any recommended changes to our election process must ensure that
7 the best candidates are selected as AMA's leaders in free and fair elections.
8

9 This report is meant as informational only. The task force has discussed all the issues detailed here
10 and more. We have planned an open forum at Interim 2019 and look forward to hearing from
11 members of the House. While the agenda of the open forum will include discussion of the topics
12 highlighted above, these are not meant to be totally inclusive and certainly not exclusive. Within
13 discussion of each of these topics we hope to hear what the HOD believes should be retained,
14 modified or eliminated. What do delegates value, what helps you make an informed decision on the
15 best candidates, how to balance distractions from policy discussion with appropriate attention on
16 election of leaders? For candidates what can be done to remove obstacles and create a fair,
17 equitable campaign? We will include time for additional comments on issues not detailed here and
18 we continue to welcome written comments from individuals and delegations.

APPENDIX A – AMA Election-related policies

Policy G-610.031, Creation of an AMA Election Reform Committee

Our AMA will create a Speaker-appointed task force for the purpose of recommending improvements to the current AMA House of Delegates election process with a broad purview to evaluate all aspects. The task force shall present an initial status report at the 2019 Interim Meeting.

Policy G-610.020, Rules for AMA Elections

- (1) The Speaker and Vice Speaker of the House of Delegates are responsible for overall administration of our AMA elections, although balloting is conducted under the supervision of the chief teller and the Committee on Rules and Credentials. The Speaker and Vice Speaker will advise candidates on allowable activities and when appropriate will ensure that clarification of these rules is provided to all known candidates. The Speaker, in consultation with the Vice Speaker, is responsible for declaring a violation of the rules;
- (2) Individuals intending to seek election at the next Annual Meeting should make their intentions known to the Speakers, generally by providing the Speaker's office with an electronic announcement "card" that includes any or all of the following elements and no more: the candidate's name, photograph, email address, URL, the office sought and a list of endorsing societies. The Speakers will ensure that the information is posted on our AMA website in a timely fashion, generally on the morning of the last day of a House of Delegates meeting or upon adjournment of the meeting. Announcements that include additional information (e.g., a brief resume) will not be posted to the website. Printed announcements may not be distributed in the venue where the House of Delegates meets. The Speakers may use additional means to make delegates aware of those members intending to seek election;
- (3) Active campaigning for AMA elective office may not begin until the Board of Trustees, after its April meeting, announces the nominees for council seats. Active campaigning includes mass outreach activities directed to all or a significant portion of the members of the House of Delegates and communicated by or on behalf of the candidate. If in the judgment of the Speaker of the House of Delegates circumstances warrant an earlier date by which campaigns may formally begin, the Speaker shall communicate the earlier date to all known candidates;
- (4) An Election Manual containing information on all candidates for election shall continue to be developed annually, with distribution limited to publication on our AMA website, typically on the Web pages associated with the meeting at which elections will occur. The Election Manual provides an equal opportunity for each candidate to present the material he or she considers important to bring before the members of the House of Delegates and should relieve the need for the additional expenditures incurred in making non-scheduled telephone calls and duplicative mailings. The Election Manual serves as a mechanism to reduce the number of telephone calls, mailings and other messages members of the House of Delegates receive from or on behalf of candidates;
- (5) A reduction in the volume of telephone calls from candidates, and literature and letters by or on behalf of candidates is encouraged. The use of electronic messages to contact electors should be minimized, and if used must allow recipients to opt out of receiving future messages;
- (6) At the Interim Meeting, campaign-related expenditures and activities shall be discouraged. Large campaign receptions, luncheons, other formal campaign activities and the distribution of campaign literature and gifts are prohibited at the Interim Meeting. It is permissible at the Interim Meeting for candidates seeking election to engage in individual outreach, such as small group meetings, including informal dinners, meant to familiarize others with a candidate's opinions and positions on issues;
- (7) Our AMA believes that: (a) specialty society candidates for AMA House of Delegates elected offices should be listed in the pre-election materials available to the House as the representative of that society and not by the state in which the candidate resides; (b) elected specialty society members should be identified in that capacity while serving their term of office; and (c) nothing in the above

recommendations should preclude formal co-endorsement by any state delegation of the national specialty society candidate, if that state delegation should so choose;

- (8) A state, specialty society, caucus, coalition, etc. may contribute to more than one party. However, a candidate may be featured at only one party, which includes: (a) being present in a receiving line, (b) appearing by name or in a picture on a poster or notice in or outside of the party venue, or (c) distributing stickers, buttons, etc. with the candidate's name on them. At these events, alcohol may be served only on a cash or no-host bar basis;
- (9) Displays of campaign posters, signs, and literature in public areas of the hotel in which Annual Meetings are held are prohibited because they detract from the dignity of the position being sought and are unsightly. Campaign posters may be displayed at campaign parties, and campaign literature may be distributed in the non-official business bag for members of the House of Delegates. No campaign literature shall be distributed and no mass outreach electronic messages shall be transmitted after the opening session of the House of Delegates;
- (10) Campaign expenditures and activities should be limited to reasonable levels necessary for adequate candidate exposure to the delegates. Campaign gifts can be distributed only at the Annual Meeting in the non-official business bag and at one campaign party. Campaign gifts should only be distributed during the Annual Meeting and not mailed to delegates and alternate delegates in advance of the meeting. The Speaker of the House of Delegates shall establish a limit on allowable expenditures for campaign-related gifts. In addition to these giveaway gifts, campaign memorabilia are allowed but are limited to a button, pin, or sticker. No other campaign memorabilia shall be distributed at any time;
- (11) The Speaker's Office will coordinate the scheduling of candidate interviews for general officer positions (Trustees, President-Elect, Speaker and Vice Speaker);
- (12) At the Opening Session of the Annual Meeting, officer candidates in a contested election will give a two-minute self-nominating speech, with the order of speeches determined by lot. No speeches for unopposed candidates will be given, except for president-elect. When there is no contest for president-elect, the candidate will ask a delegate to place his or her name in nomination, and the election will then be by acclamation. When there are two or more candidates for the office of president-elect, a two-minute nomination speech will be given by a delegate. In addition, the Speaker of the House of Delegates will schedule a debate in front of the AMA-HOD to be conducted by rules established by the Speaker or, in the event of a conflict, the Vice Speaker;
- (13) Candidates for AMA office should not attend meetings of state medical societies unless officially invited and could accept reimbursement of travel expenses by the state society in accordance with the policies of the society;
- (14) Every state and specialty society delegation is encouraged to participate in a regional caucus, for the purposes of candidate review activities; and
- (15) Our AMA (a) requires completion of conflict of interest forms by all candidates for election to our AMA Board of Trustees and councils prior to their election; and (b) will expand accessibility to completed conflict of interest information by posting such information on the "Members Only" section of our AMA website before election by the House of Delegates, with links to the disclosure statements from relevant electronic documents.

Policy G-610.021, Guiding Principles for House Elections

The following principles provide guidance on how House elections should be conducted and how the selection of AMA leaders should occur:

- (1) AMA delegates should: (a) avail themselves of all available background information about candidates for elected positions in the AMA; (b) determine which candidates are best qualified to help the AMA achieve its mission; and (c) make independent decisions about which candidates to vote for.
- (2) Any electioneering practices that distort the democratic processes of House elections, such as vote trading for the purpose of supporting candidates, are unacceptable.
- (3) Candidates for elected positions should comply with the requirements and the spirit of House of Delegates policy on campaigning and campaign spending.
- (4) Candidates and their sponsoring organizations should exercise restraint in campaign spending. Federation organizations should establish clear and detailed guidelines on the appropriate level of resources that should be allocated to the political campaigns of their members for AMA leadership positions.
- (5) Incumbency should not assure the re-election of an individual to an AMA leadership position.
- (6) Service in any AMA leadership position should not assure ascendancy to another leadership position.

Policy G-610.030, Election Process

AMA guidelines on the election process are as follows: (1) AMA elections will be held on Tuesday at each Annual Meeting; (2) Poll hours will not be extended beyond the times posted. All delegates eligible to vote must be in line to vote at the time appointed for the close of polls; and (3) The final vote count of all secret ballots of the House of Delegates shall be made public and part of the official proceedings of the House.

APPENDIX B – Topics for discussion during open forum.

This listing of topics and questions is not meant to be exhaustive. Rather it is illustrative, and other matters are welcome. An “open discussion” is included as the last topical section. Cutting across all topics, consider whether officer and council candidates should be treated differently.

See the text of the report for fuller discussion of each topic.

Topic 1 – Interviews

- Possibility of interview forums
- Reducing the number of interviews
- Equity of access to interviews across candidates in a race

Topic 2 – Campaign expenses

- Should expenses be limited / capped?
- Required reporting
- Public funding, i.e., AMA contributions and shared expenses among sponsors

Topic 3 – Campaign receptions

- Options to allow interaction with candidates
- Possibility of joint receptions
- Separate receptions for officers and council candidates
- Receiving lines
- Receptions with and without candidates

Topic 4 – Campaign memorabilia

- Giveaways – allowed or disallowed
- Gifts unrelated to campaigns

Topic 5 – Pins, buttons and stickers

- Allowed or disallowed
- Distribution and their role

Topic 6 – Campaign literature

- Mailings versus the election manual
- Option to choose electronic communications or to opt out of campaign literature
- Material in not-for-official-business bag

Topic 7 – Election process

- Day and time of election
- Secure voting from delegate seats using electronic devices
- Thank you and concession speeches

Topic 8 – Pop-up candidates

- A distortion of the process?
- Filling new vacancies

Topic 9 – Suites, dinners and gatherings

- “Dutch treat” dinners if a candidate is present
- Would rules changes for receptions lead to more campaign suites and dinners?

Topic 10 – Monitoring and enforcing rules

- Appropriate monitoring of rules
- Role of professionalism relative to active enforcement of rules

Topic 11 – Open discussion of any topic

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 012
(I-19)

Introduced by: District of Columbia

Subject: Study of Forced Organ Harvesting by China

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, Our AMA's "Declaration of Professional Responsibility: Medicine's Social Contract
2 With Humanity" (attached) adopted by this House of Delegates in December of 2001, outlines
3 and declares that "we, the members of the world community of physicians, solemnly commit
4 ourselves to:"; and
5

6 Whereas, The Independent Tribunal on Forced Organ Harvesting, after thorough study and
7 review, released its findings and conclusions on June 17th 2019 (<https://chinatribunal.com>); and
8

9 Whereas, The Tribunal's findings and conclusions clearly indicate beyond reasonable doubt that
10 China has killed and continues to kill prisoners of conscience for their organs--and that elements
11 of genocide against Falun Gong members are clearly established; and
12

13 Whereas, Both the Tribunal and Doctors Against Forced Organ Harvesting (DAFOH) have
14 issued calls (<http://t2m.io/ogJX931f>) for further investigation and reporting on this matter; and
15

16 Whereas, We have pledged to educate ourselves and the public "about present and future
17 threats to the health of humanity"; therefore be it
18

19 RESOLVED, That our American Medical Association gather and study all information available
20 and possible on the issue of forced organ harvesting by China and issue a report to our House
21 of Delegates at the 2020 Annual Meeting. (Directive to Take Action)

Fiscal Note: Modest - between \$1,000 - \$5,000

Received: 10/17/19

DECLARATION OF PROFESSIONAL RESPONSIBILITY: MEDICINE'S SOCIAL CONTRACT WITH HUMANITY

Preamble

Never in the history of human civilization has the well-being of each individual been so inextricably linked to that of every other. Plagues and pandemics respect no national borders in a world of global commerce and travel. Wars and acts of terrorism enlist innocents as combatants and mark civilians as targets. Advances in medical science and genetics, while promising great good, may also be harnessed as agents of evil. The unprecedented scope and immediacy of these universal challenges demand concerted action and response by all.

As physicians, we are bound in our response by a common heritage of caring for the sick and the suffering. Through the centuries, individual physicians have fulfilled this obligation by applying their skills and knowledge competently, selflessly and at times heroically. Today, our profession must reaffirm its historical commitment to combat natural and man-made assaults on the health and well-being of humankind. Only by acting together across geographic and ideological divides can we overcome such powerful threats. Humanity is our patient.

Declaration

We, the members of the world community of physicians, solemnly commit ourselves to:

1. Respect human life and the dignity of every individual.
2. Refrain from supporting or committing crimes against humanity and condemn all such acts.
3. Treat the sick and injured with competence and compassion and without prejudice.
4. Apply our knowledge and skills when needed, though doing so may put us at risk.
5. Protect the privacy and confidentiality of those for whom we care and breach that confidence only when keeping it would seriously threaten their health and safety or that of others.
6. Work freely with colleagues to discover, develop, and promote advances in medicine and public health that ameliorate suffering and contribute to human well-being.
7. Educate the public and polity about present and future threats to the health of humanity.
8. Advocate for social, economic, educational, and political changes that ameliorate suffering and contribute to human well-being.
9. Teach and mentor those who follow us for they are the future of our caring profession.

We make these promises solemnly, freely, and upon our personal and professional honor.

Adopted by the House of Delegates of the American Medical Association
in San Francisco, California on December 4, 2001

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 215
(I-19)

Introduced by: American Academy of Dermatology, American College of Mohs Surgery, American Society for Dermatologic Surgery Association, Society for Investigative Dermatology, American Society of Dermatopathology, American Association of Neurological Surgeons, Congress of Neurological Surgeons, American College of Emergency Physicians, Iowa, Maryland, Wisconsin, Virginia, Florida, International Society of Hair Restoration Surgery, Arizona

Subject: Board Certification of Physician Assistants

Referred to: Reference Committee B

1 Whereas, In 2019, state legislatures considered over 1,000 bills seeking to expand the scope of
2 practice of non-physicians; and
3

4 Whereas, Physician assistants sought legislation consistent with elements of the optimal team
5 practice act, which was adopted by the American Academy of Physician Assistants. While many
6 states attempted to remove direct physician supervision or allow PAs to perform certain
7 functions without physician supervision, most of the legislation was defeated or made minimal
8 change in practice; and
9

10 Whereas, Physician assistants are a valuable member of the physician-led team; and
11

12 Whereas, Physician assistants complete a 26-month physician assistant program followed by
13 2,000 hours of clinical rotations, which emphasize primary care in ambulatory clinics, physician
14 offices and acute or long-term care facilities; and
15

16 Whereas, After finishing a rigorous undergraduate academic curriculum, physicians receive an
17 additional four years of education in medical school, followed by 3-7 years of residency and
18 12,000-16,000 hours of patient care training; and
19

20 Whereas, There are substantial differences in the education of physician assistants and
21 physicians, both in depth of knowledge and length of training; and
22

23 Whereas, According to four nationwide surveys, 84% of respondents prefer a physician to have
24 primary responsibility for diagnosing and managing their health care, and 91% of respondents
25 said that a physician's years of medical education and training are vital to optimal patient care,
26 especially in the event of a complication or medical emergency; and
27

28 Whereas, A recent survey conducted by the American Medical Association's Scope of
29 Practice Partnership confirms increasing patient confusion regarding the many types of
30 health care providers - including physicians, nurses, physician assistants, technicians
31 and other varied providers. The survey revealed that 55 percent of patients believe it is
32 difficult to identify who is a licensed medical doctor and who is not by reading what
33 services they offer, their title and other licensing credentials in advertising or other
34 marketing materials; and

1 Whereas, An organization independent of the National Commission on Certification of
2 Physician Assistants is providing board certification exams for physician assistants
3 working within dermatology; and
4

5 Whereas, This certification can deceive the public and allow physician assistants to advertise
6 themselves as being "board certified;" and
7

8 Whereas, This can lead to significant patient safety issues; therefore be it
9

10 RESOLVED, That our American Medical Association amend Policy H-35.965, "Regulation of
11 Physician Assistants," by addition and deletion to read as follows:
12

13 Our AMA: (1) will advocate in support of maintaining the authority of medical licensing
14 and regulatory boards to regulate the practice of medicine through oversight of
15 physicians, physician assistants and related medical personnel; ~~and~~ (2) opposes
16 legislative efforts to establish autonomous regulatory boards meant to license, regulate,
17 and discipline physician assistants outside of the existing state medical licensing and
18 regulatory bodies' authority and purview; and (3) opposes efforts by independent
19 organizations to board certify physician assistants in a manner that misleads the public
20 to believe such certification is equivalent to medical specialty board certification. (Modify
21 Current HOD Policy); and be it further
22

23 RESOLVED, That our AMA amend Policy H-275.926, "Medical Specialty Board Certification
24 Standards," by addition to read as follows
25

26 Our AMA:

27 1. Opposes any action, regardless of intent, that appears likely to confuse the public
28 about the unique credentials of American Board of Medical Specialties (ABMS) or
29 American Osteopathic Association Bureau of Osteopathic Specialists (AOA-
30 BOS) board certified physicians in any medical specialty, or take advantage of the
31 prestige of any medical specialty for purposes contrary to the public good and safety.

32 2. Opposes any action, regardless of intent, by independent organizations providing
33 board certification for non-physicians that appears likely to confuse the public about the
34 unique credentials of medical specialty board certification or take advantage of the
35 prestige of medical specialty board certification for purposes contrary to the public good
36 and safety.

37 3. Continues to work with other medical organizations to educate the profession and the
38 public about the ABMS and AOA-BOS board certification process. It is AMA policy that
39 when the equivalency of board certification must be determined, accepted standards,
40 such as those adopted by state medical boards or the Essentials for Approval of
41 Examining Boards in Medical Specialties, be utilized for that determination. (Modify
42 Current HOD Policy)

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

Received: 10/16/19

RELEVANT AMA POLICY

Regulation of Physician Assistants H-35.965

Our AMA: (1) will advocate in support of maintaining the authority of medical licensing and regulatory boards to regulate the practice of medicine through oversight of physicians, physician assistants and related medical personnel; and (2) opposes legislative efforts to establish autonomous regulatory boards meant to license, regulate, and discipline physician assistants outside of the existing state medical licensing and regulatory bodies' authority and purview.

Citation: Res. 233, A-17

Physician Assistants H-35.989

1. Our AMA opposes legislation to increase public funding for programs to train physician assistants and supports a careful reevaluation of the need for public funding at the time that present legislative authorities expire.
2. A physician assistant should provide patient care services only in accord with the medical practice act and other applicable state law, and such law should provide that the physician assistant's utilization by a physician or group of physicians be approved by the medical licensing board. A licensed physician or group of physicians seeking to utilize a physician assistant should submit to the medical licensing board an application for utilization that identifies: the qualifications and experience of the physician assistant, the qualifications and experience of the supervising physician and a description of his or her practice, and a description of the manner and the health care settings in which the assistant will be utilized, and the arrangements for supervision by the responsible physician. Such an application should also specify the number of physician assistants that the physician or group of physicians plans to employ and supervise. A physician assistant should be authorized to provide patient care services only so long as the assistant is functioning under the direction and supervision of a physician or group of physicians whose application for utilization has been approved by the medical licensing board. State medical licensing boards, in their review of applications for utilization of a physician assistant, should take special care to insure that the proposed physician assistant functions not be of a type which: (a) would unreasonably expand the professional scope of practice of the supervising physician, (b) cannot be performed safely and effectively by the physician assistant, or (c) would authorize the unlicensed practice of medicine.
3. The physician assistant should function under the direction of and supervision by a duly qualified licensed physician. The physician must always maintain the ultimate responsibility to assure that high quality care is provided to every patient. In discharging that responsibility, the physician should exercise that amount of control or supervision over a physician assistant which is appropriate for the maintenance of quality medical care and in accord with existing state law and the rules and regulations of the medical licensing authority. Such supervision in most settings includes the personal presence or participation of the physician. In certain instances, such as remote practice settings, where the physician assistant may function apart from the supervising physician, such remote function (if permitted by state law) should be approved by the state medical licensing board on an individual basis. Such approval should include requirements for regular reporting to the supervising physician, frequent site visits by that physician, and arrangements for immediate communication with the supervising physician for consultation at all times. The physician assistant may serve the patients of the supervising physician in all types of health care settings, including but not limited to: physician's office, ambulatory or outpatient facility, clinic, hospital, patient's home, long-term care facility or nursing home. The state medical licensing board should determine on an individual basis the number of physician assistants that a particular physician may supervise or a group of physicians may employ.
4. While it is preferable and desirable that the physician assistant be employed by a physician or group of physicians so as to ensure appropriate physician supervision in the interests of the

patient, where a physician assistant is employed by a hospital, the physician assistant must provide patient care services in accordance with the rules and procedures established by the organized medical staff for utilization of physician-employed physician assistants functioning in that institution, and under the direction and supervision of a designated physician who has been approved by the state medical licensing board to supervise that physician assistant in accordance with a specific utilization plan and who shall be directly responsible as the attending physician for the patient care services delegated to his physician assistant.

5. The AMA opposes legislation or proposed regulations authorizing physician assistants to make independent medical judgments as to the drug of choice for an individual patient.

6. In view of an announced interest by HHS in considering national legislation which would override state regulatory systems for health manpower, the AMA recommends that present Association policy supporting state prerogatives in this area be strongly reaffirmed.

7. Our AMA opposes legislation or regulation that allows physician assistant independent practice.

Citation: BOT/CME/CMS Joint Rep., I-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmation A-99; Reaffirmed: CME Rep. 2, A-09; Reaffirmed: BOT Rep. 9, I-11; Appended: Res. 230, I-17

Medical Specialty Board Certification Standards H-275.926

Our AMA:

1. Opposes any action, regardless of intent, that appears likely to confuse the public about the unique credentials of American Board of Medical Specialties (ABMS) or American Osteopathic Association Bureau of Osteopathic Specialists (AOA-BOS) board certified physicians in any medical specialty, or take advantage of the prestige of any medical specialty for purposes contrary to the public good and safety.

2. Continues to work with other medical organizations to educate the profession and the public about the ABMS and AOA-BOS board certification process. It is AMA policy that when the equivalency of board certification must be determined, accepted standards, such as those adopted by state medical boards or the Essentials for Approval of Examining Boards in Medical Specialties, be utilized for that determination.

3. Opposes discrimination against physicians based solely on lack of ABMS or equivalent AOA-BOS board certification, or where board certification is one of the criteria considered for purposes of measuring quality of care, determining eligibility to contract with managed care entities, eligibility to receive hospital staff or other clinical privileges, ascertaining competence to practice medicine, or for other purposes. Our AMA also opposes discrimination that may occur against physicians involved in the board certification process, including those who are in a clinical practice period for the specified minimum period of time that must be completed prior to taking the board certifying examination.

4. Advocates for nomenclature to better distinguish those physicians who are in the board certification pathway from those who are not.

5. Encourages member boards of the ABMS to adopt measures aimed at mitigating the financial burden on residents related to specialty board fees and fee procedures, including shorter preregistration periods, lower fees and easier payment terms.

Citation: Res. 318, A-07; Reaffirmation A-11; Modified: CME Rep. 2, I-15

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 216
(I-19)

Introduced by: American Association of Public Health Physicians

Subject: Legislation to Facilitate Corrections-to-Community Healthcare Continuity via Medicaid

Referred to: Reference Committee B

1 Whereas, Our AMA has established policy in item 6 of Policy H-430.986, "Health Care While
2 Incarcerated," to "urge the Center for Medicare and Medicaid Services (CMS) and state
3 Medicaid agencies to provide Medicaid coverage for health care, care coordination activities
4 and linkages to care delivered to patients up to 30 days before the anticipated release from
5 correctional facilities"; and
6

7 Whereas, Medicare and Medicaid are legally prohibited by the inmate exclusion provision,
8 section 1905(a)(29) of the Social Security Act¹, from paying for expenses incurred while a
9 beneficiary is incarcerated, thus requiring Congressional action before CMS and states can
10 implement the policy that our AMA supports in H-430.986; and
11

12 Whereas, A bipartisan Congressional bill, H.R. 1329, introduced to the 116th Congress by Rep.
13 Paul Tonko (D-NY) & Rep. Michael Turner (R-OH)² and known as the Medicaid Reentry Act,
14 would amend the inmate exclusion provision to grant states flexibility to restart benefits for
15 Medicaid-eligible incarcerated individuals during the 30 day period preceding the date of
16 release; and
17

18 Whereas, The AMA has not yet announced support for the Medicaid Reentry Act as of
19 October 13, 2019; therefore be it
20

21 RESOLVED That our American Medical Association amend item #6 of HOD Policy H-430.986,
22 "Health Care While Incarcerated," by addition of the word "Congress" to read as follows:
23

24 6. Our AMA urges Congress, the Centers for Medicare & Medicaid Services (CMS),
25 and state Medicaid agencies to provide Medicaid coverage for health care, care
26 coordination activities and linkages to care delivered to patients up to 30 days before
27 the anticipated release from correctional facilities in order to help establish coverage
28 effective upon release, assist with transition to care in the community, and help reduce
29 recidivism. (Modify Current HOD Policy)

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

Received: 10/17/19

¹ https://www.ssa.gov/OP_Home/ssact/title19/1905.htm, accessed October 14, 2019.

² H.R. 1329, The Medicaid Reentry Act, <https://www.congress.gov/bills/116th-congress/house-bill/1329>, accessed October 14, 2019.

RELEVANT AMA POLICY**Health Care While Incarcerated H-430.986**

1. Our AMA advocates for adequate payment to health care providers, including primary care and mental health, and addiction treatment professionals, to encourage improved access to comprehensive physical and behavioral health care services to juveniles and adults throughout the incarceration process from intake to re-entry into the community.
2. Our AMA supports partnerships and information sharing between correctional systems, community health systems and state insurance programs to provide access to a continuum of health care services for juveniles and adults in the correctional system.
3. Our AMA encourages state Medicaid agencies to accept and process Medicaid applications from juveniles and adults who are incarcerated.
4. That our AMA encourage state Medicaid agencies to work with their local departments of corrections, prisons, and jails to assist incarcerated juveniles and adults who may not have been enrolled in Medicaid at the time of their incarceration to apply and receive an eligibility determination for Medicaid.
5. Our AMA encourages states to suspend rather than terminate Medicaid eligibility of juveniles and adults upon intake into the criminal justice system and throughout the incarceration process, and to reinstate coverage when the individual transitions back into the community.
6. Our AMA urges the Centers for Medicare & Medicaid Services (CMS) and state Medicaid agencies to provide Medicaid coverage for health care, care coordination activities and linkages to care delivered to patients up to 30 days before the anticipated release from correctional facilities in order to help establish coverage effective upon release, assist with transition to care in the community, and help reduce recidivism.
7. Our AMA advocates for necessary programs and staff training to address the distinctive health care needs of incarcerated women and adolescent females, including gynecological care and obstetrics care for pregnant and postpartum women.
8. Our AMA will collaborate with state medical societies and federal regulators to emphasize the importance of hygiene and health literacy information sessions for both inmates and staff in correctional facilities.
9. Our AMA supports: (a) linkage of those incarcerated to community clinics upon release in order to accelerate access to comprehensive health care, including mental health and substance abuse disorder services, and improve health outcomes among this vulnerable patient population, as well as adequate funding; and (b) the collaboration of correctional health workers and community health care providers for those transitioning from a correctional institution to the community.

Citation: CMS Rep. 02, I-16; Appended: Res. 417, A-19; Appended: Res. 420, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 217
(I-19)

Introduced by: Women Physicians Section

Subject: Promoting Salary Transparency Among Veterans Health Administration
Employed Physicians

Referred to: Reference Committee B

1 Whereas, Gender inequities among health care providers exist and are receiving increasing
2 scrutiny; and
3

4 Whereas, Inequities may be associated with a lack of mentors, discrimination, gender bias,
5 imposter syndrome, and difficulties with work-life balance; and
6

7 Whereas, Pay disparities exists as an example of gender inequity; and
8

9 Whereas, Pay disparity impacts women's morale and their ability to attain economic stability;
10 and
11

12 Whereas, Pay disparity also creates barriers to workforce participation for women, slowing the
13 growth of the U.S. economy, according to a Brookings Institute study;¹ and
14

15 Whereas, Following a steady increase between 1950-1999, female U.S. labor force participation
16 rates began to decline in the next decade;² and
17

18 Whereas, Most recent data demonstrate male physicians earn 9 to 40 percent more than female
19 physicians, controlling for age, experience, specialty, faculty rank, and clinical revenue;³ and
20

21 Whereas, This leads to an estimated \$36K-\$95K annual difference in earnings; and
22

23 Whereas, Pay scales should be easily quantifiable metrics and therefore ready targets for
24 intervention to improve equity; and
25

26 Whereas, There are no published data regarding Veterans Health Administration physician pay
27 differences; therefore be it
28

29 RESOLVED, That our American Medical Association encourage physician salary transparency
30 within the Veterans Health Administration. (Directive to Take Action)

Fiscal Note: Modest - between \$1,000 - \$5,000

Received: 10/08/19

References:

1. Dews, F. Charts of the Week: The gender wage gap. *Brookings Now*. March 22, 2019. Available at www.brookings.edu/blog/brookings-now/2019/03/22/charts-of-the-week-the-gender-wage-gap/.
2. Toossi M. and Morisi TL. Women in the Workforce Before, During, and After the Great Recession. Available at www.bls.gov/spotlight/2017/women-in-the-workforce-before-during-and-after-the-great-recession/pdf/women-in-the-workforce-before-during-and-after-the-great-recession.pdf.
3. Kacik, Alex. Large gap remains between male, female physician pay. *Modern Healthcare*. March 26, 2019. Available at www.modernhealthcare.com/finance/large-gap-remains-between-male-female-physician-pay.

RELEVANT AMA POLICY

Principles for Advancing Gender Equity in Medicine H-65.961

Our AMA:

1. declares it is opposed to any exploitation and discrimination in the workplace based on personal characteristics (i.e., gender);
2. affirms the concept of equal rights for all physicians and that the concept of equality of rights under the law shall not be denied or abridged by the U.S. Government or by any state on account of gender;
3. endorses the principle of equal opportunity of employment and practice in the medical field;
4. affirms its commitment to the full involvement of women in leadership roles throughout the federation, and encourages all components of the federation to vigorously continue their efforts to recruit women members into organized medicine;
5. acknowledges that mentorship and sponsorship are integral components of one's career advancement, and encourages physicians to engage in such activities;
6. declares that compensation should be equitable and based on demonstrated competencies/expertise and not based on personal characteristics;
7. recognizes the importance of part-time work options, job sharing, flexible scheduling, re-entry, and contract negotiations as options for physicians to support work-life balance;
8. affirms that transparency in pay scale and promotion criteria is necessary to promote gender equity, and as such academic medical centers, medical schools, hospitals, group practices and other physician employers should conduct periodic reviews of compensation and promotion rates by gender and evaluate protocols for advancement to determine whether the criteria are discriminatory; and
9. affirms that medical schools, institutions and professional associations should provide training on leadership development, contract and salary negotiations and career advancement strategies that include an analysis of the influence of gender in these skill areas.

Our AMA encourages: (1) state and specialty societies, academic medical centers, medical schools, hospitals, group practices and other physician employers to adopt the AMA Principles for Advancing Gender Equity in Medicine; and (2) academic medical centers, medical schools, hospitals, group practices and other physician employers to: (a) adopt policies that prohibit harassment, discrimination and retaliation; (b) provide anti-harassment training; and (c) prescribe disciplinary and/or corrective action should violation of such policies occur.

Citation: BOT Rep. 27, A-19;

Advancing Gender Equity in Medicine D-65.989

1. Our AMA will: (a) advocate for institutional, departmental and practice policies that promote transparency in defining the criteria for initial and subsequent physician compensation; (b) advocate for pay structures based on objective, gender-neutral criteria; (c) encourage a specified approach, sufficient to identify gender disparity, to oversight of compensation models, metrics, and actual total compensation for all employed physicians; and (d) advocate for training to identify and mitigate implicit bias in compensation determination for those in positions to determine salary and bonuses, with a focus on how subtle differences in the further evaluation of physicians of different genders may impede compensation and career advancement.

2. Our AMA will recommend as immediate actions to reduce gender bias: (a) elimination of the question of prior salary information from job applications for physician recruitment in academic and private practice; (b) create an awareness campaign to inform physicians about their rights under the Lilly Ledbetter Fair Pay Act and Equal Pay Act; (c) establish educational programs to help empower all genders to negotiate equitable compensation; (d) work with relevant stakeholders to host a workshop on the role of medical societies in advancing women in medicine, with co-development and broad dissemination of a report based on workshop findings; and (e) create guidance for medical schools and health care facilities for institutional transparency of compensation, and regular gender-based pay audits.

3. Our AMA will collect and analyze comprehensive demographic data and produce a study on the inclusion of women members including, but not limited to, membership, representation in the House of Delegates, reference committee makeup, and leadership positions within our AMA, including the Board of Trustees, Councils and Section governance, plenary speaker invitations, recognition awards, and grant funding, and disseminate such findings in regular reports to the House of Delegates and making recommendations to support gender equity.

4. Our AMA will commit to pay equity across the organization by asking our Board of Trustees to undertake routine assessments of salaries within and across the organization, while making the necessary adjustments to ensure equal pay for equal work.

Citation: Res. 010, A-18; Modified: BOT Rep. 27, A-19;

Inequity in Military Pay for Physicians D-40.993

Our AMA will work, as appropriate, with other interested organizations, to support immediate reintroduction of a bill based on H.R. 5353 (107th Congress) in this Congress.

Citation: (BOT Action in response to referred for decision Res. 901, I-03; Reaffirmed: BOT Rep. 28, A-13)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 218
(I-19)

Introduced by: American College of Rheumatology, American Academy of Neurology,
American Association of Clinical Endocrinologists, Endocrine Society,
North American Neuro-Ophthalmology Society

Subject: Private Payers and Office Visit Policies

Referred to: Reference Committee B

1 Whereas, Recently commercial payers have implemented policies for evaluation and
2 management (E/M) services that discontinue payments for consultations, in that they will deny
3 claims billed with CPT codes for consultation services as not valid; and
4

5 Whereas, Consultation is requested by primary care and other referring physicians to address
6 patients' most challenging and complex medical problems, and this work often includes
7 extensive review of prior records as well as communication and coordination with referring
8 providers. The expertise of the consulting physician is often cost-saving to the insurance carrier,
9 as these specialists can often diagnose and treat the condition without ordering unnecessary
10 tests or treatments; and
11

12 Whereas, Failing to acknowledge the difference in work between a consultation and the relative
13 simplicity of assuming the care of a patient with a known diagnosis is misguided and will
14 predictably limit the ability of providers to consult on complex cases; and
15

16 Whereas, When the Centers for Medicare and Medicaid Services discontinued payment for
17 consultation codes in 2010, the medical community raised significant concerns because in its
18 decision the agency failed to recognize the expertise and additional collaboration that is
19 reflected in the use of consultation codes; and
20

21 Whereas, In its CY 2020 Medicare physician fee schedule proposed rule the Centers for
22 Medicare and Medicaid services proposed adopting the American Medical Association RVS
23 Update Committee (RUC) recommended values for the office and outpatient evaluation and
24 management (E/M) visit codes for CY 2021, which would more appropriately value complex E/M
25 services; and
26

27 Whereas, Given that healthcare policy makers are moving toward a more appropriate valuation
28 of office visits and E/M services, it is alarming that commercial payers would move to stop
29 recognizing consultation services at this time; therefore be it
30

31 **RESOLVED**, That our American Medical Association with all haste directly engage and
32 advocate with commercial insurance companies that discontinue payment for consultation
33 codes or that are proposing to or considering eliminating payment for such codes, requesting
34 that the companies reverse or delay such policy changes while the Centers for Medicare and
35 Medicaid Services (CMS) updates its approach to valuation of office visits (Directive to Take
36 Action); and be it further

- 1 RESOLVED, That if in the CY 2020 Medicare physician fee schedule final rule CMS finalizes its
2 proposal to increase payments for evaluation and management services, then our American
3 Medical Association will advocate publicly and with all private payers that those private payers
4 mirror and follow CMS' lead in more appropriately valuing office visits, by increasing payments
5 for evaluation and management services in their reimbursement schedules. (Directive to Take
6 Action)

Fiscal Note: Modest - between \$1,000 - \$5,000

Received: 10/17/19

RELEVANT AMA POLICY

Consultation Codes and Private Payers D-385.955

1. Our AMA will proactively engage and advocate with any commercial insurance company that discontinues payment for consultation codes or that is proposing to or considering eliminating payment for such codes, requesting that the company reconsider the policy change.
2. Where a reason given by an insurance company for policy change to discontinue payment of consultation codes includes purported coding errors or abuses, our AMA will request the company carry out coding education and outreach to physicians on consultation codes rather than discontinue payment for the codes, and call for release of de-identified data from the company related to purported coding issues in order to help facilitate potential education by physician societies.

Citation: Res. 819, I-17

Medicare's Proposal to Eliminate Payments for Consultation Service Codes D-70.953

1. Our American Medical Association opposes all public and private payer efforts to eliminate payments for inpatient and outpatient consultation service codes, and supports legislation to overturn recent Center for Medicare & Medicaid Services (CMS) action to eliminate consultation codes.
2. Our AMA will work with CMS and interested physician groups through the CPT Editorial Panel to address all concerns with billing consultation services either through revision or replacement of the current code sets or by some other means.
3. Our AMA will, at the conclusion of the CPT Editorial Panel's work to address concerns with billing consultation services, work with CMS and interested physician groups to engage in an extensive education campaign regarding appropriate billing for consultation services.
4. Our AMA will: (a) work with the Centers for Medicare & Medicaid Services to consider a two-year moratorium on RAC audit claims based on three-year rule violations for E/M services previously paid for as consultations; and (b) pursue Congressional action through legislation to reinstate payment for consultation codes within the Medicare Program and all other governmental programs.
5. Our AMA will petition the CMS to limit RAC reviews to less than one year from payment of claims.

Citation: Res. 807, I-09; Appended: Sub. Res. 212, I-10; Reaffirmation A-12; Appended: Res. 216, A-12; Modified: CCB/CLRPD Rep. 2, A-14; Reaffirmation: A-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 219
(I-19)

Introduced by: American Society of Clinical Oncology

Subject: QPP and the Immediate Availability of Results in CEHRTs

Referred to: Reference Committee B

1 Whereas, The Centers for Medicare and Medicaid Services (CMS), through the Promoting
2 Interoperability Program for hospitals and MIPS eligible clinicians, currently requires health care
3 providers to share patient health data (including laboratory and pathology data) through an
4 application programming interface (API) within four days of its availability; and
5

6 Whereas, CMS recently issued an Advanced Notice of Proposed Rulemaking (ANPRM) that
7 seeks comment on whether Merit-based Incentive Payment System (MIPS) eligible clinicians
8 should be required to make patient health information available immediately through an API no
9 later than one day after it is available to the clinicians in the certified electronic health record
10 technology (CEHRT); and
11

12 Whereas, This, if implemented, would be part of the Quality Payment Program's (QPP)
13 Promoting Interoperability (PI) performance category and therefore directly impacts MIPS
14 participants and their reimbursement; and
15

16 Whereas, Generally, feasibility of information exchange is driven by improvements in technology
17 and the health information technology (HIT) infrastructure is led by vendors and developers, not
18 physicians; and
19

20 Whereas, EHR prompts do not give physicians the ability to publish notes into just the practice-
21 facing chart then separately into the patient-facing portal; and
22

23 Whereas, Patient access to their protected health information (PHI) should be supported, there
24 are concerns relating to immediate availability of certain laboratory and pathology test results
25 because patients would have access to pathology reports prior to a consultation with their
26 physician to aid in the understanding of the results; and
27

28 Whereas, This situation could cause significant patient and family distress so it is important to
29 equip patients with the necessary contextual information and clinical expertise provided by their
30 physicians when reviewing test results; therefore be it
31

32 RESOLVED, That our American Medical Association urge the Centers for Medicare & Medicaid
33 Services to create guardrails around the "immediate" availability of laboratory, pathology, and
34 radiology results, factoring in an allowance for physician judgement and discretion regarding the
35 timing of release of certain results (Directive to Take Action); and be it further

- 1 RESOLVED, That our AMA encourage vendors to implement prompts that give physicians the
- 2 ability to either approve notes to just the chart or approve and publish them in both the chart and
- 3 patient portal. (Directive to Take Action)

Fiscal Note: Modest - between \$1,000 - \$5,000

Received: 10/17/19

RELEVANT AMA POLICY

Information Technology Standards and Costs D-478.996

1. Our AMA will:(a) encourage the setting of standards for health care information technology whereby the different products will be interoperable and able to retrieve and share data for the identified important functions while allowing the software companies to develop competitive systems;(b) work with Congress and insurance companies to appropriately align incentives as part of the development of a National Health Information Infrastructure (NHII), so that the financial burden on physicians is not disproportionate when they implement these technologies in their offices;(c) review the following issues when participating in or commenting on initiatives to create a NHII: (i) cost to physicians at the office-based level; (ii) security of electronic records; and (iii) the standardization of electronic systems;(d) continue to advocate for and support initiatives that minimize the financial burden to physician practices of adopting and maintaining electronic medical records; and(e) continue its active involvement in efforts to define and promote standards that will facilitate the interoperability of health information technology systems.

2.Our AMA advocates that physicians: (a) are offered flexibility related to the adoption and use of new certified Electronic Health Records (EHRs) versions or editions when there is not a sufficient choice of EHR products that meet the specified certification standards; and (b) not be financially penalized for certified EHR technology not meeting current standards.

Citation: Res. 717, A-04; Reaffirmation, A-05; Appended: Sub. Res. 707, A-06; Reaffirmation A-07; Reaffirmed in lieu of Res. 818, I-07; Reaffirmed in lieu of Res. 726, A-08; Reaffirmation I-08; Reaffirmation I-09; Reaffirmation A-10; Reaffirmation I-10; Reaffirmed: Res. 205, A-11; Reaffirmed in lieu of Res. 714, A-12; Reaffirmed in lieu of Res. 715, A-12; Reaffirmed in lieu of Res. 724, A-13; Reaffirmation I-13; Reaffirmation A-14; Reaffirmed: BOT Rep. 03, I-16; Reaffirmed: BOT Rep. 05, I-16; Appended: Res. 204, I-17; Reaffirmation: I-17; Reaffirmed: BOT Rep. 45, A-18; Reaffirmed: BOT Rep. 19, A-18; Reaffirmation: A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 812
(I-19)

Introduced by: College of American Pathologists, National Association of Medical
Examiners, United States and Canadian Academy of Pathology, American
Society for Clinical Pathology, American Society of Cytopathology

Subject: Autopsy Standards as Condition of Participation

Referred to: Reference Committee J

1 Whereas, The Centers for Medicare & Medicaid Services (CMS) decision to remove the autopsy
2 standards §482.22 (d) for hospitals was released in the Omnibus Burden Reduction (Conditions
3 of Participation (COP)) Final Rule on September 26, 2019; and
4

5 Whereas, As a condition for Medicare reimbursement, hospitals have been previously required
6 to provide autopsies as part of COP; and
7

8 Whereas, The removal of this standard will contribute to the further decline in the national
9 autopsy rate, limiting the contributions to medical education and research that have the potential
10 to affect the quality of patient care; and
11

12 Whereas, The autopsy plays a unique and indispensable role in supporting the ability of health
13 care professionals to provide and improve high quality patient care; and
14

15 Whereas, Failure to provide autopsies in appropriate circumstances will have an adverse effect
16 on quality assurance and education; and
17

18 Whereas, Removal of this requirement, despite other mechanisms for encouraging hospitals to
19 retain their programs, will further erode the national clinical autopsy rates; therefore be it
20

21 RESOLVED, That our American Medical Association call upon the Centers for Medicare and
22 Medicaid Services to reinstate the Autopsy Standard as a Medicare Condition of Participation.
23 (Directive to Take Action)

Fiscal Note: Modest - between \$1,000 - \$5,000

Received: 10/17/19

RELEVANT AMA POLICY

Importance of Autopsies H-85.954

1. Our AMA supports seeking the cooperation of the National Advisory Council on Aging of the National Institutes of Health in recommending to physicians, hospitals, institutes of scientific learning, universities, and most importantly the American people the necessity of autopsy for pathological correlation of the results of the immeasurable scientific advancements which have occurred in recent years. Our AMA believes that the information garnered from such stringent scientific advancements and correlation, as well as coalitions, should be used in the most advantageous fashion; and that the conclusions obtained from such investigations should be widely shared with the medical and research community and should be interpreted by these groups with the utmost scrutiny and objectivity.
 2. Our AMA: (a) supports the efforts of the Institute of Medicine and other national organizations in formulating national policies to modernize and promote the use of autopsy to meet present and future needs of society; (b) promotes the use of updated autopsy protocols for medical research, particularly in the areas of cancer, cardiovascular, occupational, and infectious diseases; (c) promotes the revision of standards of accreditation for medical undergraduate and graduate education programs to more fully integrate autopsy into the curriculum and require postmortems as part of medical educational programs; (d) encourages the use of a national computerized autopsy data bank to validate technological methods of diagnosis for medical research and to validate death certificates for public health and the benefit of the nation; (e) requests The Joint Commission to consider amending the Accreditation Manual for Hospitals to require that the complete autopsy report be made part of the medical record within 30 days after the postmortem; (f) supports the formalization of methods of reimbursement for autopsy in order to identify postmortem examinations as medical prerogatives and necessary medical procedures; (g) promotes programs of education for physicians to inform them of the value of autopsy for medical legal purposes and claims processing, to learn the likelihood of effects of disease on other family members, to establish the cause of death when death is unexplained or poorly understood, to establish the protective action of necropsy in litigation, and to inform the bereaved families of the benefits of autopsy; and (h) promotes the incorporation of updated postmortem examinations into risk management and quality assurance programs in hospitals.
 3. Our AMA reaffirms the fundamental importance of the autopsy in any effective hospital quality assurance program, and urges physicians and hospitals to increase the utilization of the autopsy so as to further advance the cause of medical education, research and quality assurance.
 4. Our AMA representatives to the Liaison Committee on Medical Education ask that autopsy rates and student participation in autopsies continue to be monitored periodically and that the reasons that schools do or do not require attendance be collected. Our AMA will continue to work with other interested groups to increase the rate of autopsy attendance.
 5. Our AMA requests that the National Committee on Quality Assurance (NCQA) and other accrediting bodies encourage the performance of autopsies to yield benchmark information for all managed care entities seeking accreditation.
 6. Our AMA calls upon all third party payers, including CMS, to provide adequate payment directly for autopsies, and encourages adequate reimbursement by all third party payers for autopsies.
 7. It is the policy of our AMA: (a) that the performance of autopsies constitutes the practice of medicine; and (b) in conjunction with the pathology associations represented in the AMA House, to continue to implement all the recommendations regarding the effects of decreased utilization of autopsy on medical education and research, quality assurance programs, insurance claims processing, and cost containment.
 8. Our AMA affirms the importance of autopsies and opposes the use of any financial incentives for physicians who acquire autopsy clearance.
- Citation: (CCB/CLRPD Rep. 3, A-14)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 813
(I-19)

Introduced by: American College of Rheumatology
American Society of Clinical Oncology

Subject: Public Reporting of PBM Rebates

Referred to: Reference Committee J

1 Whereas, Pharmacy Benefit Managers (PBMs) are third-parties that create drug formularies for
2 insurers; and

3
4 Whereas, PBMs negotiate rebates and discounts with pharmaceutical manufacturers under the
5 pretense of lowering drug costs and insurance costs for consumers and insurers; and

6
7 Whereas, The amount of rebates and discounts made available to PBMs can create a perverse
8 incentive to raise prices for preferred formulary placement or otherwise serve as a mechanism
9 to influence a drug's placement on a formulary; and

10
11 Whereas, There is no legal requirement that PBMs pass these savings back to plans or
12 consumers; and

13
14 Whereas, Under the prevailing regulatory regimes PBMs may reclassify rebates and discounts
15 to retain the benefit of the bargain for themselves; and

16
17 Whereas, The details of these rebates and discounts are not currently made available to the
18 public; and

19
20 Whereas, In states where the details of the rebates and discounts are disclosed to state
21 regulatory bodies, as required in Arkansas, Minnesota, and Utah, they should be made
22 available to the public; therefore be it

23
24 RESOLVED, That our American Medical Association advocate for Pharmacy Benefit Managers
25 (PBMs) and state regulatory bodies to make rebate and discount reports and disclosures
26 available to the public (Directive to Take Action); and be it further

27
28 RESOLVED, That our AMA advocate for the inclusion of required public reporting of rebates
29 and discounts by PBMs in federal and state PBM legislation. (Directive to Take Action)

Fiscal Note: Modest - between \$1,000 - \$5,000

Received: 10/17/19

RELEVANT AMA POLICY

The Impact of Pharmacy Benefit Managers on Patients and Physicians D-110.987

1. Our AMA supports the active regulation of pharmacy benefit managers (PBMs) under state departments of insurance.
2. Our AMA will develop model state legislation addressing the state regulation of PBMs, which shall include provisions to maximize the number of PBMs under state regulatory oversight.
3. Our AMA supports requiring the application of manufacturer rebates and pharmacy price concessions, including direct and indirect remuneration (DIR) fees, to drug prices at the point-of-sale.
4. Our AMA supports efforts to ensure that PBMs are subject to state and federal laws that prevent discrimination against patients, including those related to discriminatory benefit design and mental health and substance use disorder parity.
5. Our AMA supports improved transparency of PBM operations, including disclosing:
 - Utilization information;
 - Rebate and discount information;
 - Financial incentive information;
 - Pharmacy and therapeutics (P&T) committee information, including records describing why a medication is chosen for or removed in the P&T committee's formulary, whether P&T committee members have a financial or other conflict of interest, and decisions related to tiering, prior authorization and step therapy;
 - Formulary information, specifically information as to whether certain drugs are preferred over others and patient cost-sharing responsibilities, made available to patients and to prescribers at the point-of-care in electronic health records;
 - Methodology and sources utilized to determine drug classification and multiple source generic pricing; and
 - Percentage of sole source contracts awarded annually.
6. Our AMA encourages increased transparency in how DIR fees are determined and calculated.

Citation: CMS Rep. 05, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 814
(I-19)

Introduced by: American Society of Clinical Oncology

Subject: PBM Value-Based Framework for Formulary Design

Referred to: Reference Committee J

Whereas, The Centers for Medicare and Medicaid Services recently updated the Minimum Specialty Tier Eligibility criteria for drugs covered by in-network specialty pharmacies through Medicare Part D to be drugs that cost more than \$670 a month¹; and

Whereas, In a typical Medicare Part D plan, medications classified as “specialty drugs” are set at the highest specialty benefit tier which is subject to the highest cost-sharing²; and

Whereas, According to the 2018 Express Scripts Drug Trend Report, specialty medications now account for 44.7 percent of total drug spending in the United States³; and

Whereas, In 2017 the median monthly out of pocket drug expenditure for insured cancer patients was roughly \$703--equating to roughly 11% of household income for the average cancer patient⁴; and

Whereas, Many employers and other plan sponsors use pharmacy benefit managers (PBMs) to outsource the complicated work of designing and maintaining formularies in order to generate potential cost savings for payers and plan sponsors--however it is not clear those savings necessarily accrue to patients⁵; and

Whereas, Most PBM companies follow a definition similar to the Magellan Rx definition of “specialty drugs” -- drugs that are high cost (for Magellan Rx this means \$1000+ per 30-day supply), high complexity, and/or high touch oral or injectable medications used to treat complex or chronic conditions⁶; and

Whereas, PBMs obtain revenue from pharmaceutical manufacturers in the form of rebate payments for “preferred” formulary status, which results in increased market-share by encouraging utilization of the drugs chosen⁷; and

Whereas, Despite PBMs negotiating lower drug prices through rebates, this lower price may not translate to patient savings if the price reduction is not enough to trigger the plan to place the drug on a lower cost-sharing tier; and

¹ Centers for Medicare and Medicaid Services. Announcement of Calendar Year (CY) 2019 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter. April 2, 2018. (Accessed: September 26, 2019). URL: <https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2019.pdf>

² Silverscript, MedicareRX. Medicare Part D Formulary Tiers. October 10, 2018. (Accessed: September 30, 2019). URL: <https://www.silverscript.com/learn/formulary-tiers>

³ Express Scripts. 2018 Express Scripts Drug Trend Report. 2019. (Accessed September 30, 2019). URL: <https://my.express-scripts.com/rs/809-VGG-836/images/Express%20Scripts%202018%20Drug%20Trend%20Report.pdf>

⁴ Forbes. Even Insured Patients are Overwhelmed by the Cost of Cancer Care. August 10, 2017. (Accessed: September 26, 2019). URL: <https://www.forbes.com/sites/arieneweintraub/2017/08/10/even-insured-patients-are-overwhelmed-by-the-cost-of-cancer-care/#6b80188b51c4>

⁵ American Society of Clinical Oncology. ASCO Policy Statement on Pharmacy Benefit Managers and Their Impact on Cancer Care. August 2018. (Accessed: October 3, 2019). URL: <https://www.asco.org/sites/new-www.asco.org/files/content-files/advocacy-and-policy/documents/2018%20ASCO%20PBM%20Statement.pdf>

⁶ Magellan Rx Management. Specialty Pharmacy Drug List (Accessed: September 24, 2019). URL: https://magellanrx.com/member/external/commercial/common/doc/en-us/MRx_Formulary_Specialty.pdf

⁷ American Society of Clinical Oncology. ASCO Policy Statement on Pharmacy Benefit Managers and Their Impact on Cancer Care.

1 Whereas, The relatively lower price of a drug compared to other treatments does not
2 necessarily equate to value--value ultimately comes down to the relationship between price and
3 meaningful improvements in health outcomes at the level of individual patients; and
4

5 Whereas, The trend toward tiered formularies burdens vulnerable patients with high levels of
6 coinsurance, does not guarantee that they are receiving the most effective possible treatment,
7 and places them in the cross hairs of a drug pricing problem that they did not create⁸; therefore
8 be it
9

10 RESOLVED, That our American Medical Association emphasize the importance of physicians'
11 choice of the most appropriate pharmaceutical treatment for their patients in its advocacy;
12 (Directive to Take Action) and be it further
13

14 RESOLVED, That our AMA advocate for pharmacy benefit managers (PBMs) and health plans
15 to use a value-based decision-making framework that is transparent and includes applicable
16 specialty clinical oversight when determining which specialty drugs to give preference on their
17 formularies. (Directive to Take Action)

Fiscal Note: Modest - between \$1,000 - \$5,000

Received: 10/17/19

RELEVANT AMA POLICY

Incorporating Value into Pharmaceutical Pricing H-110.986

1. Our AMA supports value-based pricing programs, initiatives and mechanisms for pharmaceuticals that are guided by the following principles: (a) value-based prices of pharmaceuticals should be determined by objective, independent entities; (b) value-based prices of pharmaceuticals should be evidence-based and be the result of valid and reliable inputs and data that incorporate rigorous scientific methods, including clinical trials, clinical data registries, comparative effectiveness research, and robust outcome measures that capture short- and long-term clinical outcomes; (c) processes to determine value-based prices of pharmaceuticals must be transparent, easily accessible to physicians and patients, and provide practicing physicians and researchers a central and significant role; (d) processes to determine value-based prices of pharmaceuticals should limit administrative burdens on physicians and patients; (e) processes to determine value-based prices of pharmaceuticals should incorporate affordability criteria to help assure patient affordability as well as limit system-wide budgetary impact; and (f) value-based pricing of pharmaceuticals should allow for patient variation and physician discretion.

2. Our AMA supports the inclusion of the cost of alternatives and cost-effectiveness analysis in comparative effectiveness research.

3. Our AMA supports direct purchasing of pharmaceuticals used to treat or cure diseases that pose unique public health threats, including hepatitis C, in which lower drug prices are assured in exchange for a guaranteed market size.

Citation: CMS Rep. 05, I-16; Reaffirmed in lieu of: Res. 207, A-17; Reaffirmed: CMS-CSAPH Rep. 01, A-17; Reaffirmed: CMS Rep. 07, A-18

Value-Based Insurance Design H-185.939

Our AMA supports flexibility in the design and implementation of value-based insurance design (VBID) programs, consistent with the following principles:

a. Value reflects the clinical benefit gained relative to the money spent. VBID explicitly considers the clinical benefit of a given service or treatment when determining cost-sharing structures or other benefit design elements.

b. Practicing physicians must be actively involved in the development of VBID programs. VBID program design related to specific medical/surgical conditions must involve appropriate specialists.

⁸ American Society of Clinical Oncology. ASCO Position Statement on the Affordability of Cancer Drugs.

- c. High-quality, evidence-based data must be used to support the development of any targeted benefit design. Treatments or services for which there is insufficient or inconclusive evidence about their clinical value should not be included in any targeted benefit design elements of a health plan.
 - d. The methodology and criteria used to determine high- or low-value services or treatments must be transparent and easily accessible to physicians and patients.
 - e. Coverage and cost-sharing policies must be transparent and easily accessible to physicians and patients. Educational materials should be made available to help patients and physicians understand the incentives and disincentives built into the plan design.
 - f. VBID should not restrict access to patient care. Designs can use incentives and disincentives to target specific services or treatments, but should not otherwise limit patient care choices.
 - g. Physicians retain the ultimate responsibility for directing the care of their patients. Plan designs that include higher cost-sharing or other disincentives to obtaining services designated as low-value must include an appeals process to enable patients to secure care recommended by their physicians, without incurring cost-sharing penalties.
 - h. Plan sponsors should ensure adequate resource capabilities to ensure effective implementation and ongoing evaluation of the plan designs they choose. Procedures must be in place to ensure VBID coverage rules are updated in accordance with evolving evidence.
 - i. VBID programs must be consistent with AMA Pay for Performance Principles and Guidelines (Policy H-450.947), and AMA policy on physician economic profiling and tiered, narrow or restricted networks (Policies H-450.941 and D-285.972).
- Citation: CMS Rep. 2, A-13; Reaffirmed in lieu of Res. 122, A-15; Reaffirmed in lieu of: Res. 121, A-16; Reaffirmed: CMS Rep. 05, I-16; Reaffirmation I-16; Reaffirmed: Joint CMS/CSAPH Rep. 01, I-17; Reaffirmed: CMS Rep. 07, A-18; Reaffirmed: Joint CMS CSAPH Rep. 01, I-18; Reaffirmed: CMS Rep. 06, A-19

The Impact of Pharmacy Benefit Managers on Patients and Physicians D-110.987

1. Our AMA supports the active regulation of pharmacy benefit managers (PBMs) under state departments of insurance.
 2. Our AMA will develop model state legislation addressing the state regulation of PBMs, which shall include provisions to maximize the number of PBMs under state regulatory oversight.
 3. Our AMA supports requiring the application of manufacturer rebates and pharmacy price concessions, including direct and indirect remuneration (DIR) fees, to drug prices at the point-of-sale.
 4. Our AMA supports efforts to ensure that PBMs are subject to state and federal laws that prevent discrimination against patients, including those related to discriminatory benefit design and mental health and substance use disorder parity.
 5. Our AMA supports improved transparency of PBM operations, including disclosing:
 - Utilization information;
 - Rebate and discount information;
 - Financial incentive information;
 - Pharmacy and therapeutics (P&T) committee information, including records describing why a medication is chosen for or removed in the P&T committee's formulary, whether P&T committee members have a financial or other conflict of interest, and decisions related to tiering, prior authorization and step therapy;
 - Formulary information, specifically information as to whether certain drugs are preferred over others and patient cost-sharing responsibilities, made available to patients and to prescribers at the point-of-care in electronic health records;
 - Methodology and sources utilized to determine drug classification and multiple source generic pricing;
 - and
 - Percentage of sole source contracts awarded annually.
 6. Our AMA encourages increased transparency in how DIR fees are determined and calculated.
- Citation: CMS Rep. 05, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 815
(I-19)

Introduced by: American Society of Clinical Oncology, American College of Rheumatology, American College of Gastroenterology, American Association of Clinical Endocrinologists, American Gastroenterological Association, American Academy of Ophthalmology

Subject: Step Therapy

Referred to: Reference Committee J

Whereas, In 2017 our AMA along with 17 other medical specialty and healthcare organizations established the Prior Authorization and Utilization Management Reform Principles urging health plans, pharmacy benefit managers and third-party administrators to reform utilization management protocols including step therapy;¹ and

Whereas, Our AMA, at its June 2019 House of Delegates Annual Meeting, resolved to continue to advocate against the use of step therapy protocols in Medicare Advantage plans with the additional patient protections laid out in Policy D-320.981, “Medicare Advantage Step Therapy”; and

Whereas, On April 16, 2019 Representative Raul Ruiz (D-CA) and Representative Brad Wenstrup (R-OH) filed H.R. 2279 “The Safe Step Act”, bipartisan legislation that mirrors patient protections against step therapy protocols that have been enacted legislatively in more than 20 states across the country²; and on September 25, 2019 Senator Lisa Murkowski (R-AK), Senator Doug Jones (D-AL), and Senator Bill Cassidy (R-LA) introduced S. 2546, the Senate version of this legislation; and

Whereas, Legislators in Colorado (2018 HB 1148), Connecticut (2017 HB 7023), Georgia (2016 HB 975), and Maryland (2017 HB74/SB919) have all gone above and beyond the general protections against step therapy protocols by enacting “Jimmy Carter” legislation- allowing more cancer patients to receive the same lifesaving treatment that the former president received by preventing health plans from limiting coverage of drugs for stage IV cancer patients; and

Whereas, Health plans’ use of step therapy frequently reduces access to innovative and complex drugs including biologics and chemotherapy, which have been a lifeline for patients with chronic and life-threatening conditions including but not limited to cancer, rheumatoid arthritis, Crohn’s disease, ulcerative colitis, macular degeneration, multiple sclerosis, osteoporosis, primary immunodeficiency diseases, and others; and

Whereas, Health plans also apply often step therapy to antiemetics in cancer care, negatively impacting patient quality of life, adherence to treatments, and in some cases leading to increased emergency room visits or hospitalizations; therefore be it

¹American Medical Association. Prior Authorization Reform Principles. 2017. Date Accessed: September 26, 2019. URL: <https://www.ama-assn.org/system/files/2019-06/principles-with-signatory-page-for-slsc.pdf>

² National Psoriasis Foundation. Press Release: Patient Advocates Applaud Filing of the Safe Step Act’ in the US House of Representatives. April 16, 2019. Date Accessed: September 30, 2019. URL: <https://www.prnewswire.com/news-releases/patient-advocates-applaud-filing-of-the-safe-step-act-in-us-house-of-representatives-300832818.html>

1 RESOLVED, That our American Medical Association extend its advocacy for the patient
2 protections against step therapy protocols outlined in D-320.981, "Medicare Advantage Step
3 Therapy," to all health plans (Directive to Take Action); and be it further
4

5 RESOLVED, That our AMA actively support state and federal legislation that would allow timely
6 clinician-initiated exceptions to, and place reasonable limits on, step therapy protocols imposed
7 by health care plans. (Directive to Take Action)

Fiscal Note: Modest - between \$1,000 - \$5,000

Received: 10/17/19

RELEVANT AMA POLICY

Medicare Advantage Step Therapy D-320.981

1. Our AMA believes that step therapy programs create barriers to patient care and encourage health plans to instead focus utilization management protocol on review of statistical outliers.
2. Our AMA will advocate that the Medicare Advantage step therapy protocol, if not repealed, should feature the following patient protections:
 - a. Enable the treating physician, rather than another entity such as the insurance company, to determine if a patient "fails" a treatment;
 - b. Exempt patients from the step therapy protocol when the physician believes the required step therapy treatments would be ineffective, harmful, or otherwise against the patients' best interests;
 - c. Permit a physician to override the step therapy process when patients are stable on a prescribed medication;
 - d. Permit a physician to override the step therapy if the physician expects the treatment to be ineffective based on the known relevant medical characteristics of the patient and the known characteristics of the drug regimen; if patient comorbidities will cause, or will likely cause, an adverse reaction or physical harm to the patient; or is not in the best interest of the patient, based on medical necessity;
 - e. Include an exemption from step therapy for emergency care;
 - f. Require health insurance plans to process step therapy approval and override request processes electronically;
 - g. Not require a person changing health insurance plans to repeat step therapy that was completed under a prior plan; and
 - h. Consider a patient with recurrence of the same systematic disease or condition to be considered an established patient and therefore not subject to duplicative step therapy policies for that disease or condition.

Citation: Res. 714, A-19

Medicare Advantage Step Therapy D-320.984

Our AMA will continue strong advocacy for the rejection of step therapy in Medicare Advantage plans and impede the implementation of the practice before it takes effect on January 1, 2019.

Citation: Res. 810, I-18

Medicare Part B Competitive Acquisition Program (CAP) H-110.983

Our AMA will advocate that any revised Medicare Part B Competitive Acquisition Program meet the following standards to improve the value of the program by lowering the cost of drugs without undermining quality of care:

- (1) it must be genuinely voluntary and not penalize practices that choose not to participate;
- (2) it should provide supplemental payments to reimburse for costs associated with special

handling and storage for Part B drugs;

(3) it must not reduce reimbursement for services related to provision/administration of Part B drugs, and reimbursement should be indexed to an appropriate healthcare inflation rate;

(4) it should permit flexibility such as allowing for variation in orders that may occur on the day of treatment, and allow for the use of CAP-acquired drugs at multiple office locations;

(5) it should allow practices to choose from multiple vendors to ensure competition, and should also ensure that vendors meet appropriate safety and quality standards;

(6) it should include robust and comprehensive patient protections which include preventing delays in treatment, helping patients find assistance or alternative payment arrangements if they cannot meet the cost-sharing responsibility, and vendors should bear the risk of non-payment of patient copayments in a way that does not penalize the physician;

(7) it should not allow vendors to restrict patient access using utilization management policies such as step therapy; and

(8) it should not force disruption of current systems which have evolved to ensure patient access to necessary medications.

Citation: Res. 216, I-18

Eliminate Fail First Policy in Addiction Treatment H-320.941

Our AMA will advocate for the elimination of the "fail first" policy implemented at times by some insurance companies and managed care organizations for addiction treatment.

Citation: Res. 802, I-16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 925
(I-19)

Introduced by: California

Subject: Suspending Sales of Vaping Products / Electronic Cigarettes Until FDA
Review

Referred to: Reference Committee K

1 Whereas, Nationwide, the number of cases of confirmed and probable vaping-associated lung
2 illnesses has risen to 1,080 across 48 states, with 19 reported deaths, according to the Centers
3 for Disease Control and Prevention (CDC) and therefore, the CDC has warned people to avoid
4 vaping altogether; and

5
6 Whereas, Vaping and electronic cigarettes are also increasingly being shown to have negative
7 health impacts including harm to cardiovascular function, addiction to nicotine, secondhand
8 exposure to harmful chemicals, progression to use of tobacco products, and more, with
9 adolescent use skyrocketing in recent years, even erasing more than a decade of progress in
10 reducing youth tobacco consumption; and

11
12 Whereas, The U.S. Food and Drug Administration (FDA) recently strengthened its warning to
13 consumers to stop using vaping products containing THC amid more than 1,000 reports of lung
14 injuries--including some resulting in deaths--following the use of vaping products; and

15
16 Whereas, The mass marketing of vaping products has been shown in some ways to resemble
17 long time tobacco marketing practices, including downplaying risks and targeting young people,
18 despite restrictions on sale to youth; and

19
20 Whereas The explosion of the vaping products industry and marketing has somewhat caught
21 health officials and researchers off-guard, with a "catch-up" scenario playing out as regulation
22 and education lag behind the explosion in use; and

23
24 Whereas, The FDA did not gain regulatory power over e-cigarettes until 2016, so many popular
25 brands that launched before that date, including market leader Juul, are currently available for
26 sale despite lacking explicit FDA authorization. The agency has given manufacturers until May
27 2020 to retroactively apply for authorization; if at that point they cannot prove their products are
28 "appropriate for the protection of public health," they could be removed from the market; and

29
30 Whereas, The "precautionary principle," an increasingly accepted guideline for public health and
31 environmental policy, states that "When an activity raises threats of harm to human health or the
32 environment, precautionary measures should be taken even if some cause and effect
33 relationships are not fully established scientifically; In this context the proponent of an activity,
34 rather than the public, should bear the burden of proof"; and

1 Whereas, An increasing number of states (Michigan, New York, Massachusetts, Rhode Island)
2 and municipalities (Los Angeles and San Francisco), among others, are filling a regulatory void
3 caused by federal inaction and are banning sales of flavored tobacco and vaping products as
4 research shows these are harmful, to health, addictive, and marketed towards youth; and
5

6 Whereas, Officials in San Francisco and other municipalities have proposed new regulations
7 that would prohibit the sale of any e-cigarette that has not undergone FDA review; any e-
8 cigarette that is required to have, but has not received, FDA pre-market review could not be sold
9 at a store or bought online and shipped to a San Francisco address until the FDA completes its
10 review and allows the products to be sold;" and
11

12 Whereas, This proposal is in line with both the precautionary principle and Hippocratic dictum,
13 and is increasingly supported by research on the impacts and risks of vaping and electronic
14 cigarettes; therefore be it
15

16 RESOLVED, That our American Medical Association support regulations that would prohibit the
17 sale of any e-cigarette or other vaping product that has not undergone U.S. Food and Drug
18 Administration (FDA) pre-market review until the FDA completes its review and allows the
19 products to be sold. (New HOD Policy)

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

Received: 10/11/19

RELEVANT AMA POLICY

Legal Action to Compel FDA to Regulate E-Cigarettes D-495.992

Our AMA will consider joining other medical organizations in an amicus brief supporting the American Academy of Pediatrics legal action to compel the U.S. Food and Drug Administration to take timely action to establish effective regulation of e-cigarettes, cigars and other nicotine tobacco products.

Citation: Res. 432, A-18

Sales and Distribution of Tobacco Products and Electronic Nicotine Delivery Systems (ENDS) and E-cigarettes H-495.986

H-495.986 Tobacco Product Sales and Distribution

Our AMA:

- (1) recognizes the use of e-cigarettes and vaping as an urgent public health epidemic and will actively work with the Food and Drug Administration and other relevant stakeholders to counteract the marketing and use of addictive e-cigarette and vaping devices, including but not limited to bans and strict restrictions on marketing to minors under the age of 21;
- (2) encourages the passage of laws, ordinances and regulations that would set the minimum age for purchasing tobacco products, including electronic nicotine delivery systems (ENDS) and e-cigarettes, at 21 years, and urges strict enforcement of laws prohibiting the sale of tobacco products to minors;
- (3) supports the development of model legislation regarding enforcement of laws restricting children's access to tobacco, including but not limited to attention to the following issues: (a) provision for licensure to sell tobacco and for the revocation thereof; (b) appropriate civil or criminal penalties (e.g., fines, prison terms, license revocation) to deter violation of laws restricting children's access to and possession of tobacco; (c) requirements for merchants to post notices warning minors against attempting to purchase tobacco and to obtain proof of age for would-be purchasers; (d) measures to facilitate enforcement; (e) banning out-of-package cigarette sales ("loosies"); and (f) requiring tobacco purchasers and vendors to be of legal smoking age;
- (4) requests that states adequately fund the enforcement of the laws related to tobacco sales to

minors;

(5) opposes the use of vending machines to distribute tobacco products and supports ordinances and legislation to ban the use of vending machines for distribution of tobacco products;

(6) seeks a ban on the production, distribution, and sale of candy products that depict or resemble tobacco products;

(7) opposes the distribution of free tobacco products by any means and supports the enactment of legislation prohibiting the disbursement of samples of tobacco and tobacco products by mail;

(8) (a) publicly commends (and so urges local medical societies) pharmacies and pharmacy owners who have chosen not to sell tobacco products, and asks its members to encourage patients to seek out and patronize pharmacies that do not sell tobacco products; (b) encourages other pharmacists and pharmacy owners individually and through their professional associations to remove such products from their stores; (c) urges the American Pharmacists Association, the National Association of Retail Druggists, and other pharmaceutical associations to adopt a position calling for their members to remove tobacco products from their stores; and (d) encourages state medical associations to develop lists of pharmacies that have voluntarily banned the sale of tobacco for distribution to their members; and

(9) opposes the sale of tobacco at any facility where health services are provided; and

(10) supports that the sale of tobacco products be restricted to tobacco specialty stores.

Citation: CSA Rep. 3, A-04; Appended: Res. 413, A-04; Reaffirmation A-07; Amended: Res. 817, I-07; Reaffirmation A-08; Reaffirmation I-08; Reaffirmation A-09; Reaffirmation I-13; Reaffirmation A-14; Reaffirmation I-14; Reaffirmation A-15; Modified in lieu of Res. 421, A-15; Modified in lieu of Res. 424, A-15; Reaffirmation I-16; Appended: Res. 926, I-18

Electronic Cigarettes, Vaping, and Health H-495.972

1. Our AMA urges physicians to: (a) educate themselves about electronic nicotine delivery systems (ENDS), including e-cigarettes, be prepared to counsel patients about the use of these products and the potential for nicotine addiction and the potential hazards of dual use with conventional cigarettes, and be sensitive to the possibility that when patients ask about e-cigarettes, they may be asking for help to quit smoking; (b) consider expanding clinical interviews to inquire about "vaping" or the use of e-cigarettes; (c) promote the use of FDA-approved smoking cessation tools and resources for their patients and caregivers; and (d) advise patients who use e-cigarettes to take measures to assure the safety of children in the home who could be exposed to risks of nicotine overdose via ingestion of replacement e-cigarette liquid that is capped or stored improperly.

2. Our AMA: (a) encourages further clinical and epidemiological research on e-cigarettes; (b) supports education of the public on the health effects, including toxins and carcinogens of electronic nicotine delivery systems (ENDS) including e-cigarettes; and (c) recognizes that the use of products containing nicotine in any form among youth, including e-cigarettes, is unsafe and can cause addiction.

3. Our AMA supports legislation and associated initiatives and will work in coordination with the Surgeon General to prevent e-cigarettes from reaching youth and young adults through various means, including, but not limited to, CDC research, education and a campaign for preventing and reducing use by youth, young adults and others of e-cigarettes, and combustible and emerging tobacco products.

Citation: CSAPH Rep. 2, I-14; Modified in lieu of Res. 412, A-15; Modified in lieu of Res. 419, A-15; Reaffirmed: Res. 421, A-15; Modified: CSAPH Rep. 05, A-18; Reaffirmed: CSAPH Rep. 03, A-19; Appended: Res. 428, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 926
(I-19)

Introduced by: Women Physicians Section

Subject: School Resource Officer Qualifications and Training

Referred to: Reference Committee K

Whereas, There has been a rash of shootings and violence in Colorado, Connecticut, Texas, Florida and other less well publicized school settings; and

Whereas, Many schools throughout this country have hired school resource officers (SROs) who are paid employees; and

Whereas, Some schools have chosen to arm these individuals without adequate training in child psychology, restorative justice, and conflict de-escalation and resolution, for example;¹ therefore be it

RESOLVED, That our American Medical Association encourage an evaluation of existing national standards (and legislation, if necessary) to have qualifications by virtue of training and certification that includes child psychology and development, restorative justice, conflict resolution, crime awareness, implicit/explicit biases, diversity inclusion, cultural humility, and individual and institutional safety and others deemed necessary for school resource officers (Directive to Take Action); and be it further

RESOLVED, That our AMA encourage the development of policies that foster the best environment for learning through protecting the health and safety of those in school, including students, teachers, staff and visitors (New HOD Policy); and be it further

RESOLVED, That our AMA encourage mandatory reporting of de-escalation procedures by school resource officers and tracking of student demographics of those reprimanded to identify areas of implicit bias. (Directive to Take Action)

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

Received: 10/08/19

Reference:

¹ "Training Courses." National Association of School Resource Officers. Available at <https://nasro.org/>. Accessed September 2019.

RELEVANT AMA POLICY**Providing Medical Services through School-Based Health Programs H-60.991**

(1) The AMA supports further objective research into the potential benefits and problems associated with school-based health services by credible organizations in the public and private sectors. (2) Where school-based services exist, the AMA recommends that they meet the following minimum standards: (a) Health services in schools must be supervised by a physician, preferably one who is experienced in the care of children and adolescents. Additionally, a physician should be accessible to administer care on a regular basis. (b) On-site services should be provided by a professionally prepared school nurse or similarly qualified health professional. Expertise in child and adolescent development, psychosocial and behavioral problems, and emergency care is desirable. Responsibilities of this professional would include coordinating the health care of students with the student, the parents, the school and the student's personal physician and assisting with the development and presentation of health education programs in the classroom. (c) There should be a written policy to govern provision of health services in the school. Such a policy should be developed by a school health council consisting of school and community-based physicians, nurses, school faculty and administrators, parents, and (as appropriate) students, community leaders and others. Health services and curricula should be carefully designed to reflect community standards and values, while emphasizing positive health practices in the school environment. (d) Before patient services begin, policies on confidentiality should be established with the advice of expert legal advisors and the school health council. (e) Policies for ongoing monitoring, quality assurance and evaluation should be established with the advice of expert legal advisors and the school health council. (f) Health care services should be available during school hours. During other hours, an appropriate referral system should be instituted. (g) School-based health programs should draw on outside resources for care, such as private practitioners, public health and mental health clinics, and mental health and neighborhood health programs. (h) Services should be coordinated to ensure comprehensive care. Parents should be encouraged to be intimately involved in the health supervision and education of their children.

Citation: (CSA Rep. D, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: Res. 412, A-05; Reaffirmed in lieu of Res. 908, I-12)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 927
(I-19)

Introduced by: Washington, Hawaii
Subject: Climate Change
Referred to: Reference Committee K

Whereas, Climate change could have a devastating effect on human and environmental health, including higher rates of respiratory and heat-related illness, increased prevalence of vector-borne and waterborne diseases, food and water insecurity, and malnutrition; and

Whereas, Persons who are elderly, sick, or poor are especially vulnerable to these potential consequences; and

Whereas, Addressing climate change could have substantial benefits to human health and avert dire environmental outcomes; and

Whereas, Our AMA and its physicians can play a role in achieving that goal; therefore be it

RESOLVED, That our American Medical Association acknowledge that:

1. Climate change is a critical public health issue.
2. Potential effects of climate change on human health include higher rates of respiratory and heat-related illness, increased prevalence of vector-borne and waterborne diseases, food and water insecurity, and malnutrition. Persons who are elderly, sick, or poor are especially vulnerable to these potential consequences.
3. We support 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.
4. We recognize the importance of physician involvement in policymaking at the state, national, and global level and support efforts to search for novel, comprehensive, and economically sensitive approaches to mitigating climate change to protect the health of the public; and recognize that whatever the etiology of global climate change, policymakers should work to reduce human contributions to such changes.
5. We encourage physicians to adopt programs for environmental sustainability in their practices, share these concepts with their patients and their communities. and to serve as role models for promoting environmental sustainability.
6. We encourage 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.
7. We support epidemiological, translational, clinical and basic science research necessary for evidence-based global climate change policy decisions related to health care and treatment. (New HOD Policy)

Fiscal Note: Minimal - less than \$1,000
Received: 10/16/19

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.

Citation: 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 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.
6. Supports epidemiological, translational, clinical and basic science research necessary for evidence-based global climate change policy decisions related to health care and treatment.

Citation: CSAPH Rep. 3, I-08; Reaffirmation A-14; Reaffirmed: CSAPH Rep. 04, A-19

AMA to Protect Human Health from the Effects of Climate Change by Ending its Investments in Fossil Fuel Companies D-135.969

Our AMA, AMA Foundation, and any affiliated corporations will work in a timely, incremental, and fiscally responsible manner, to the extent allowed by their legal and fiduciary duties, 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.

Citation: BOT Rep. 34, A-18

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.

Citation: CSA Rep. G, I-89; Amended: CLRPD Rep. D, I-92; Amended: CSA Rep. 8, A-03; Reaffirmed in lieu of Res. 417, A-04; Reaffirmed in lieu of Res. 402, A-10; Reaffirmation I-16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 928
(I-19)

Introduced by: American Society of Clinical Oncology

Subject: CBD Oil and Supplement Use in Treatment

Referred to: Reference Committee K

Whereas, Cannabidiol (CBD) oil has been rising in popularity around the country; and

Whereas, According to ASCO's 2018 National Cancer Opinion Survey, which tracks the U.S public's views on cancer research and care, nearly four in ten Americans believe cancer can be cured through alternative therapies¹; and

Whereas, This news comes despite evidence that patients who use alternative therapies instead of standard cancer treatments have much higher mortality rates; and

Whereas, The studies around CBD oil and other supplements relieving cancer symptoms or cancer treatment side effects have been mixed and unstandardized³; and

Whereas, To date the Food and Drug Administration has not approved any CBD products to treat cancer or symptoms and side effects associated with care; and

Whereas, The FDA has issued a warning letter to at least one company for illegally selling unapproved products containing CBD with unsubstantiated claims that the products treat cancer and other diseases or conditions⁴; and

Whereas, More research is needed to evaluate not only the effectiveness of CBD oil and other supplements for cancer patients, but also the side effects and interactions with other, prescribed medications^{5,6}; and

Whereas, According to a survey by the Arthritis Foundation, 79% of respondents are currently using CBD, have used it in the past, or are considering using it, with 87% of those who are currently using it saying it's to manage their arthritis symptoms²; and

Whereas, The Arthritis Foundation has issued recommendations warning users of the potential risks associated with CBD and advising them to consult with their physician⁷; therefore be it

RESOLVED, That our American Medical Association actively support and promote private and publicly funded research to support future evidence-based policymaking on Cannabidiol (CBD) products. (Directive to Take Action)

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

Received: 10/17/19

- 1 American Society of Clinical Oncology (ASCO). National Cancer Opinion Survey. 2018. <https://www.asco.org/sites/new-www.asco.org/files/content-files/research-and-progress/documents/2018-NCOS-Results.pdf> (Accessed September 24, 2019).
- 2 Arthritis Foundation. Patients Tell Us About CBD Use. 2019. <http://blog.arthritis.org/news/patients-tell-us-cbd-use/> (Accessed October 8, 2019).
- 3 The University of Texas MD Anderson Cancer Center. CBD oil and cancer: 9 things to know. 2019. <https://www.mdanderson.org/publications/cancerwise/cbd-oil-and-cancer--9-things-to-know.h00-159306201.html> (Accessed September 24, 2019).
- 4 The Food and Drug Administration. FDA warns company marketing unapproved cannabidiol products with unsubstantiated claims to treat cancer, Alzheimer's disease, opioid withdrawal, pain and pet anxiety. 2019. https://www.fda.gov/news-events/press-announcements/fda-warns-company-marketing-unapproved-cannabidiol-products-unsubstantiated-claims-treat-cancer?utm_campaign=072319_PR_FDA%20warns%20firm%20selling%20cannabidiol%20products%20with%20unproven%20claims&utm_medium=email&utm_source=Eloqua (Accessed September 24, 2019).
- 5 Stout, S. M., & Cimino, N. M. (2014). Exogenous cannabinoids as substrates, inhibitors, and inducers of human drug metabolizing enzymes: a systematic review. *Drug metabolism reviews*, 46(1), 86-95.
- 6 Qian, Y., Gurley, B. J., & Markowitz, J. S. (2019). The Potential for Pharmacokinetic Interactions Between Cannabis Products and Conventional Medications. *Journal of clinical psychopharmacology*, 39(5), 462-471.
- 7 Arthritis Foundation. Arthritis Foundation CBD Guidance for Adults with Arthritis. 2019. <https://www.arthritis.org/living-with-arthritis/pain-management/chronic-pain/arthritis-foundation-cbd-guidance-for-adults.php> (Accessed October 8, 2019).

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 929
(I-19)

Introduced by: American Association of Public Health Physicians

Subject: Regulating Marketing and Distribution of Tobacco Products and Vaping-Related Products

Referred to: Reference Committee K

1 Whereas, The 2019 outbreak of “E-cigarette and Vapor Associated Pulmonary Illness” (EVAPI)
2 has so far been almost entirely associated with the use of illicit, illegal, and/or user-modified
3 “electronic cigarette” products, especially those containing THC; and
4

5 Whereas, Nicotine is highly addictive; and
6

7 Whereas, It is important to decrease the rates of nicotine use and dependence in all age
8 groups, especially youth; and
9

10 Whereas, It is important to decrease the morbidity and mortality from nicotine products by all
11 appropriate means; and
12

13 Whereas, It is unclear whether prohibition of legal e-cigarette and “vaping” products would
14 increase or decrease the use of illicit, illegal, and/or user-modified products; and
15

16 Whereas, The net effect of e-cigarette flavoring bans on adult smokers is unclear; and
17

18 Whereas, There is an urgent need to decrease the addictiveness of electronic nicotine delivery
19 systems (ENDS); therefore be it

1 RESOLVED, That our American Medical Association support strict marketing standards to
2 prevent all nicotine-related products from being marketed to, or attractive to, children,
3 adolescents, and young adults, including but not limited to the following measures:

- 4
- 5 • Banning print advertising except in adult-only publications or media (adults are >85% of
- 6 audience).
- 7 • Banning advertising and/or sponsorship at stadiums, concerts, sporting or other public
- 8 events that are not primarily targeted to adults.
- 9 • Banning offers of any school or college scholarships by any company selling tobacco
- 10 products.
- 11 • Banning television advertising of any tobacco products, including any vapor products.
- 12 • Banning advertising, marketing and sale of tobacco products that:
 - 13 – Uses the terms "candy" or "candies" or variants in spelling, such as "kandy" or
 - 14 "kandeez," "bubble gum," "cotton candy," and "gummi bear", and "milkshake."
 - 15 – Uses the terms "cake" or "cakes" or variants such as "cupcake."
 - 16 – Uses packaging, trade dress or trademarks that imitate those of food or other products
 - 17 primarily targeted to minors such as candy, cookies, juice boxes or soft drinks.
 - 18 – Uses packaging that contains images of food products primarily targeted to minors such
 - 19 as juice boxes, soft drinks, soda pop, cereal, candy, or desserts.
 - 20 – Imitates a consumer product designed or intended primarily for minors
 - 21 – Uses cartoons or cartoon characters.
 - 22 – Uses images or references to superheroes.
 - 23 – Uses any likeness to images, characters, or phrases that are known to appeal primarily
 - 24 to minors, such as "unicorn".
 - 25 – Uses a video game, movie, video, or animated television show known to appeal
 - 26 primarily to minors.
- 27 • Banning advertising and marketing of tobacco products, including vapor products, that:
 - 28 – Does not accurately represent the ingredients contained in the products.
 - 29 – Uses contracted spokespeople or individuals that do not appear to be at least 25 years
 - 30 of age.
- 31 • Banning advertising on outdoor billboards near schools and playgrounds.
- 32 • Requiring labels to include warnings protecting youth such as "Sales to Minors Prohibited"
- 33 or "Underage Sales Prohibited" and/or "Keep Out of Reach of Children".
- 34 • Requiring all advertising to be accurate and not misleading (New HOD Policy); and be it
- 35 further
- 36

37 RESOLVED, That our AMA support the use of the most up-to-date and effective technology for
38 verifying the age of would-be purchasers of tobacco products and vaping-related products, both
39 online and in bricks-and-mortar retail outlets (New HOD Policy); and be it further

40
41 RESOLVED, That our AMA oppose sales of tobacco products or vaping-related products on any
42 third-party marketplace such as Alibaba, Amazon, eBay, et al, where the third-party marketplace
43 does not take full responsibility for verifying age; blocking unregulated cannabis and THC
44 products; identifying and prohibiting all counterfeit products; and forbidding packaging and other
45 materials that allow illicit sales of any tobacco product (New HOD Policy); and be it further

46
47 RESOLVED, That our AMA support licensing and frequent inspections of all retail outlets selling
48 any tobacco products or vaping-related products, with loss of license for repeated violations
49 (e.g., three violations in a three year period) (New HOD Policy); and be it further

1 RESOLVED, That our AMA support limitations on the concentration, chemical form, and vehicle
2 chemistry of all nicotine-related products, with special attention to the European product
3 standards which seem to lead to much lower addictiveness than many of the ENDS products
4 sold in the USA (New HOD Policy); and be it further
5

6 RESOLVED, That our AMA support a ban on all self-service displays of tobacco products,
7 which would require all tobacco products and vaping-related products to be behind a counter or
8 in a locked display and accessible only to a store employee (New HOD Policy); and be it further
9

10 RESOLVED, That our AMA support a ban on sales of all tobacco products and vaping-related
11 products except in stores that display signage indicating that (a) "Unaccompanied Minors Are
12 Not Allowed on Premises" or (b) "Products are Not for Sale to Minors" or (c) "Underage Sale
13 Prohibited", and that enforce these rules consistently (New HOD Policy); and be it further
14

15 RESOLVED, That our AMA support a ban on "straw man" sellers, which would make it illegal for
16 any person who is not a licensed tobacco product dealer or vaping-related product dealer to
17 sell, barter for, or exchange any tobacco product or vaping-related products (New HOD Policy);
18 and be it further
19

20 RESOLVED, That our AMA support legislation that would discourage "straw man" distribution by
21 prohibiting the retail sale of quantities likely intended for more than one consumer, such as the
22 retail sale to one customer of (a) more than two electronic-cigarette or vape devices; (b) more
23 than five standard packages of e-liquids; (c) more than 20 packs of cigarettes; or (d) similarly
24 determined quantities of other tobacco products and/or vaping-related products. (New HOD
25 Policy)

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

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