

Reference Committee B

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- 230* Advancing the Role of Outdoor Recreation in Public Health
- 231* Amending Policy H-155.955, "Increasing Accessibility to Incontinence Products to Include Diaper Tax Exemption"
- 232* Expansion of Epinephrine Entity Stocking Legislation
- 233* Support for Warning Labels on Firearm Ammunition Packaging
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Resolution(s)

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* *contained in the Handbook Addendum*

REPORT OF THE BOARD OF TRUSTEES

B of T Report 9-A-22

Subject: Council on Legislation Sunset Review of 2012 House Policies

Presented by: Bobby Mukkamala, MD, Chair

Referred to: Reference Committee B

- 1 Policy G-600.110, “Sunset Mechanism for AMA Policy,” calls for the decennial review of
2 American Medical Association (AMA) policies to ensure that our AMA’s policy database is
3 current, coherent, and relevant. Policy G-600.010 reads as follows, laying out the parameters for
4 review and specifying the procedures to follow:
5
- 6 1. As the House of Delegates (HOD) adopts policies, a maximum ten-year time horizon shall
7 exist. A policy will typically sunset after ten years unless action is taken by the HOD to retain
8 it. Any action of our AMA HOD that reaffirms or amends an existing policy position shall
9 reset the sunset “clock,” making the reaffirmed or amended policy viable for another 10 years.
10
 - 11 2. In the implementation and ongoing operation of our AMA policy sunset mechanism, the
12 following procedures shall be followed: (a) Each year, the Speakers shall provide a list of
13 policies that are subject to review under the policy sunset mechanism; (b) Such policies shall
14 be assigned to the appropriate AMA councils for review; (c) Each AMA council that has been
15 asked to review policies shall develop and submit a report to the HOD identifying policies that
16 are scheduled to sunset; (d) For each policy under review, the reviewing council can
17 recommend one of the following actions: (i) retain the policy; (ii) sunset the policy; (iii) retain
18 part of the policy; or (iv) reconcile the policy with more recent and like policy; (e) For each
19 recommendation that it makes to retain a policy in any fashion, the reviewing council shall
20 provide a succinct, but cogent justification; or (f) The Speakers shall determine the best way
21 for the HOD to handle the sunset reports.
22
 - 23 3. Nothing in this policy shall prohibit a report to the HOD or resolution to sunset a policy earlier
24 than its 10-year horizon if it is no longer relevant, has been superseded by a more current
25 policy, or has been accomplished.
26
 - 27 4. The AMA councils and the HOD should conform to the following guidelines for sunset:
28 (a) when a policy is no longer relevant or necessary; (b) when a policy or directive has been
29 accomplished; or (c) when the policy or directive is part of an established AMA practice that is
30 transparent to the House and codified elsewhere such as the AMA Bylaws or the AMA HOD
31 Reference Manual: Procedures, Policies and Practices.
32
 - 33 5. The most recent policy shall be deemed to supersede contradictory past AMA policies.
34
 - 35 6. Sunset policies will be retained in the AMA historical archives.

1 RECOMMENDATION

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3 The Board of Trustees recommends that the House of Delegates policies that are listed in the
 4 appendix to this report be acted upon in the manner indicated and the remainder of this report be
 5 filed.

APPENDIX – Recommended Actions

Policy Number	Title	Text	Recommendation
D-155.990	Responsibility for Transparency	Our AMA will actively oppose any legislation and/or regulation that deems the physician the responsible party to inform patients of their anticipated health care costs where the practitioner does not set reimbursement rates. (Res. 819, I-12)	Retain – this policy remains relevant.
D-160.999	Opposition to Criminalizing Health Care Decisions	Our AMA will educate physicians regarding the continuing threat posed by the criminalization of healthcare decision-making and the existence of our model legislation “An Act to Prohibit the Criminalization of Healthcare Decision-Making.” (Res. 228, I-98; Reaffirmed: BOT Rep. 5, A-08; Reaffirmation: I-12)	Retain – this policy remains relevant.
D-185.986	Third Party Payer Coverage Process Reform and Advocacy	1. Our AMA, working with interested state medical and national specialty societies, will develop model legislation and/or regulations to require that commercial insurance companies, state Medicaid agencies, or other third-party payers utilize transparent and accountable processes for developing and implementing coverage decisions and policies, and will actively seek the implementation of such model legislation and/or regulations at the national and state levels. 2. Our AMA will work with specialty and service organizations to advocate that private insurance plans and benefit management companies develop transparent clinical protocols as well as formal processes to write / revise them; that those processes should seek input from the relevant national physician	Retain – this policy remains relevant.

		<p>organizations; and that such clinical coverage protocols should be easily and publicly accessible on their websites, just as Medicare national and local coverage determinations are publicly available.</p> <p>3. Our AMA will advocate that when private insurance plans and benefit management companies make changes to or revise clinical coverage protocols, said companies must inform all insured individuals and participating providers in writing no less than 90 days prior to said change(s) going into effect.</p> <p>(Res. 820, I-11; Appended: Res. 807, I-12)</p>	
D-190.984	HIPAA	<p>Our AMA continue to identify and work toward the repeal of the onerous provisions in the Health Insurance Portability and Accountability Act legislation and regulations, including its criminal liability provisions, and that our AMA work to redress the breaches of patient confidentiality that the HIPAA regulations have allowed.</p> <p>(Res. 901, I-02; Reaffirmed: CCB/CLRPD Rep. 4, A-12)</p>	Retain – this policy remains relevant.
D-190.988	HIPAA interference with Peer Review Activities	<p>Our AMA shall seek immediate clarification from the Department of Health and Human Services of the impact of the Health Insurance Portability and Accountability Act Privacy Rule on the peer review process.</p> <p>(Res. 721, A-02; Reaffirmed: CCB/CLRPD Rep. 4, A-12)</p>	<p>Sunset this policy.</p> <p>HIPAA does not pose issues with the peer review process; presumably when the law first came out, physicians may have thought they would not be able to share protected health information for peer review, but HIPAA’s regulations allow that type of discussion.</p>
D-190.989	HIPAA Law And Regulations	<p>(1) Our AMA shall continue to aggressively pursue modification of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule to remove burdensome regulations that could interfere with efficient patient care.</p> <p>(2) If satisfactory modification to the</p>	<p>Retain and modify part of this policy.</p> <p>Rescind clause 2 and 3, and renumber and modify clause 4. Clause 2 is outdated and no longer applicable. Regarding clause 3, opposing unique patient</p>

		<p>HIPAA Privacy Rule is not obtained, our AMA shall aggressively pursue appropriate legislative and/or legal relief to prevent implementation of the HIPAA Privacy Rule.</p> <p>(3) Our AMA shall continue to oppose the creation or use of any unique patient identification number, including the Social Security number, as it might permit unfettered access by governmental agencies or other entities to confidential patient information.</p> <p>(4)(2) Our AMA shall immediately begin working <u>continue to work</u> with the appropriate parties and trade groups to explore ways to help offset the costs of implementing the changes required by the Health Insurance Portability and Accountability Act <u>associated with HIPAA compliance</u> so as to reduce the fiscal burden on physicians.</p> <p>(Sub. Res. 207, A-02; Reaffirmed: CCB/CLRPD Rep. 4, A-12)</p>	<p>identification number policies harms more than helps in certain stakeholder circles. Renumber clause 4 to be clause 2 and modify the clause by updating the language to be more in line with the wording of clause 1.</p>
<p>D-230.991</p>	<p>Inspector General to Rule on Exclusivity Restrictions for Medical Staff Membership</p>	<p>Our AMA will (1) continue its discussions with the Office of Inspector General of Health and Human Services and urge the OIG to issue a fraud alert on the practice of exclusive credentialing; and (2) take other appropriate action, which may include administrative action, litigation, and/or legislation, to protect our patients from being denied quality medical care through exclusive (including economic) credentialing by hospitals.</p> <p>(Res. 714, I-02; Reaffirmed: CCB/CLRPD Rep. 4, A-12)</p>	<p>Retain – this policy remains relevant.</p>
<p>D-235.987</p>	<p>Medical Staff Bylaws as Binding Contracts</p>	<p>Our AMA will actively pursue the enactment of federal legislation and/or regulation that will recognize medical staff bylaws as a binding contract, not subject to unilateral amendment, between the organized medical staff and the governing board of a hospital or health care delivery system.</p> <p>(Sub. Res. 818, I-12)</p>	<p>Sunset this policy.</p> <p>This resolution was based on a Minnesota trial court case that held that medical staff bylaws should not be deemed a contract between the medical staff and the hospital. Subsequent to the HOD’s adoption of this</p>

			<p>resolution, in December 2014, the Minnesota Supreme Court overruled the trial court’s decision and held that medical staff bylaws could be enforced as a contract. The AMA’s Litigation Center supported this case. Medical staff contract issues are primarily regulated at the state level. The AMA’s Advocacy Resource Center, through the Council on Legislation, has developed model state legislation entitled an “Act to Ensure the Autonomy of Hospital Medical Staffs.” In addition, AMA Policy H-235.976 recognizes that medical staff bylaws are a contract between the organized medical staff and the hospital.</p>
D-315.991	Medical Records with Bills	<p>Our AMA shall cause to be introduced legislation that would: (1) establish criteria defining when the request for medical records from a third party payer is appropriate, and (2) require insurance companies to pay for copied medical records requested by said insurance company at the rate established by law.</p> <p>(Res. 218, A-02; Reaffirmed: CCB/CLRPD Rep. 4, A-12)</p>	Retain – this policy remains relevant.
D-330.915	RAC Audits of E&M Codes	<ol style="list-style-type: none"> 1. Our AMA opposes Recovery Audit Contractor audits of E&M codes with the Centers for Medicare & Medicaid Services (CMS) and will explain to CMS and Congress why these audits as currently conducted are deleterious to the provision of care to patients with complex health needs. 2. If our AMA is unsuccessful in reversing the audits, our AMA will urge CMS and elected Washington officials to require physician reimbursement for time and expense of appeals. 3. Our AMA will urge CMS and elected 	Retain – this policy remains relevant.

		<p>Washington officials to provide statistical data regarding the audits, including the specialties most affected by these audits, and the percentage of denied claims for E&M codes which, when appealed, are reversed on appeal.</p> <p>(Res. 224, I-12)</p>	
D-330.966	Medicare Program Safeguard Contractors	<p>Our AMA, consistent with the principles set forth in its September 2001 letter to the Centers for Medicare & Medicaid Services, shall continue to press for legislative and/or administrative relief from the creation of Program Safeguard Contractors and other abusive contracting authority by CMS.</p> <p>(Res. 709, A-02; Reaffirmed: CCB/CLRPD Rep. 4, A-12)</p>	Retain – this policy remains relevant.
D-35.987	Evaluation of the Expanding Scope of Pharmacists’ Practice	<p>Our AMA: (1) will re-evaluate the expanding scope of practice of pharmacists in America and develop additional policy to address the proposed new services provided by pharmacists that may constitute the practice of Medicine; (2) will continue to collect and disseminate state specific information in collaboration with state medical societies regarding the current scope of practice for pharmacists in each state; studying if and how each state is addressing these expansions of practice; (3) will develop model state legislation to address the expansion of pharmacist scope of practice that is found to be inappropriate or constitutes the practice of medicine, including but not limited to the issue of interpretations or usage of independent practice arrangements without appropriate physician supervision and work with interested states and specialties to advance such legislation; (4) opposes federal and state legislation allowing pharmacists to independently prescribe or dispense prescription medication without a valid order by, or under the supervision of, a licensed doctor of medicine, osteopathy, dentistry or podiatry; (5) opposes federal and state legislation allowing</p>	Retain – this policy remains relevant.

		<p>pharmacists to dispense medication beyond the expiration of the original prescription; and (6) opposes the inclusion of Doctors of Pharmacy (PharmD) among those health professionals designated as a “Physician” by the Centers for Medicare & Medicaid Services.</p> <p>(Res. 219, A-11; Appended: Res. 218, A-12)</p>	
D-383.984	ERISA and Managed Care Oversight	<p>Our AMA will develop, propose, and actively support (1) federal legislation clarifying that ERISA preemption does not apply to physician/insurer contracting issues; (2) federal legislation that requires all third party payers serving as administrators for ERISA plans to accept assignment of benefits by patients to physicians; and (3) federal and state legislation prohibiting “all products” clauses or linking participation in one product to participation in other products (“tied”) administered or offered by third party payers or their affiliates.</p> <p>(Res. 915, I-06; Reaffirmed: Res. 223, I-10; Reaffirmed: CMS Rep. 6, A-12)</p>	<p>Retain – this policy remains relevant.</p> <p>This policy supports changes to the scope of ERISA preemption. ERISA preemption is a barrier to the AMA’s and the Federation’s advocacy in support of protecting physicians through state regulations from the adverse business practices of many of the payers with whom physicians contract.</p>
D-390.986	Medicare Balance Billing	<p>Our American Medical Association: (1) advocate that physicians be allowed to balance bill Medicare recipients to the full amount of their normal charge with the patient responsible for the difference between the Medicare payment and the physician charges; (2) seek introduction of national legislation to bring about implementation of balance billing of Medicare recipients; and (3) further advocate that such federal laws and regulations pre-empt state laws that prohibit balance billing.</p> <p>(Res. 713, I-02; Reaffirmation A-04; Reaffirmation A-06; Reaffirmed per BOT Action in response to referred for decision Res. 236, A-06; Reaffirmed: CMS Rep. 5, I-12)</p>	<p>Retain – this policy remains relevant.</p>
D-478.984	Clinical Data Repositories for Physicians, Patients	<p>Our American Medical Association will (1) collect and make available the best practices resulting from existing pilot Clinical Data Repository (CDR) projects</p>	<p>Retain – this policy remains relevant.</p>

	and Continuous Quality Improvement	to demonstrate the most appropriate measures and data aggregation methods for assessing physician performance, and to demonstrate how best to use clinical data to improve quality of patient care; and (2) identify and disseminate educational materials to be used by physician organizations and communities on how to best use data from CDRs in practice improvement, quality improvement, and contracting. (BOT Rep. 3, I-09; Reaffirmed in lieu of Res. 704, A-12)	
D-525.998	Mammography Screening for Breast Cancer	In order to assure timely access to breast cancer screening for all women, our AMA shall advocate for legislation that ensures adequate funding for mammography services. (Res. 120, A-02; Reaffirmed: CCB/CLRPD Rep. 4, A-12)	Retain – this policy remains relevant
D-85.994	Strengthening Medicolegal Death Investigations	Our AMA will work with interested states on legislation to facilitate the transition from coroner systems to medical examiner systems. (Res. 718, A-12)	Retain – this policy remains relevant.
H-100.954	Stimulate Antibiotic Research and Development	Our AMA supports legislation requiring the re-evaluation of FDA guidelines for clinical trials of antibiotics, including an increase in the period of market exclusivity. (Res. 210, A-12)	Sunset this policy. The Generating Antibiotic Incentives Now (GAIN) Act of 2012 was enacted after this resolution was adopted. The law increased exclusivity for antibiotics for 5 years and required FDA to evaluate ways to ensure continued research on antibiotics (which FDA subsequently did in updates to 3 different guidances).
H-100.957	Repeal of the Federal Restriction on the Use of Tax Exempt Funds to Buy Medications Without a Prescription in the PPACA (Health Reform Law)	Our AMA supports the repeal of the federal restriction on the use of tax-exempt funds to buy medications without a prescription and will formally notify the appropriate federal legislative bodies and regulatory agencies of this support for repeal. (Res. 211, A-11; Reaffirmation A-12)	Retain – this policy remains relevant.

<p>H-120.938</p>	<p>Opposition to FDA's Rx to OTC Paradigm Shift</p>	<p>Our AMA will: (1) submit comments during the public comment period expressing our concerns with the Food and Drug Administration's (FDA's) proposed paradigm shift; (2) continue to monitor FDA's action on this issue; (3) encourage the FDA to study the cost implications switching prescription drugs to over-the-counter status will have on patient out of pocket costs; and (4) strongly encourage the FDA to initiate a formal public comment process before reclassifying any prescription drug to over-the-counter status.</p> <p>(Res. 235, A-12)</p>	<p>Retain – this policy remains relevant.</p>
<p>H-160.946</p>	<p>The Criminalization of Health Care Decision Making</p>	<p>The AMA opposes the attempted criminalization of health care decision-making especially as represented by the current trend toward criminalization of malpractice; it interferes with appropriate decision making and is a disservice to the American public; and will develop model state legislation properly defining criminal conduct and prohibiting the criminalization of health care decision-making, including cases involving allegations of medical malpractice, and implement an appropriate action plan for all components of the Federation to educate opinion leaders, elected officials and the media regarding the detrimental effects on health care resulting from the criminalization of health care decision-making.</p> <p>(Sub. Res. 202, A-95; Reaffirmed: Res. 227, I-98; Reaffirmed: BOT Rep. 2, A-07; Reaffirmation A-09; Reaffirmation: I-12)</p>	<p>Retain – this policy remains relevant.</p>
<p>H-165.841</p>	<p>Comprehensive Health System Reform</p>	<p>Our AMA supports the overall goal of ensuring that every American has access to affordable high quality health care coverage and will work with interested members of Congress to seek legislation consistent with AMA policy.</p> <p>(Sub. Res. 924, I-07; Reaffirmed: Res. 239, A-12)</p>	<p>Sunset this policy.</p> <p>This has been accomplished through the Affordable Care Act and superseded by more recent policy, H-165.838.</p>

<p>H-175.985</p>	<p>Kennedy-Kassebaum: Fraud and Abuse</p>	<p>Our AMA: (1) will work to alleviate the oppressive, burdensome effects on physicians of the Health Insurance Portability and Accountability Act of 1996 (HIPAA); (2) opposes efforts to repeal provisions in Health Insurance Portability and Accountability Act of 1996 (HIPAA) that would alter the standard of proof in criminal and civil fraud cases or that would eliminate the ability of physicians to obtain advisory opinions regarding anti-kickback issues; and thoroughly evaluate and oppose other fraud and abuse proposals that are inappropriately punitive to physicians; (3) will ensure that any proposed criminal fraud and abuse proposals retain the current intent standard of “willfully and knowingly” to be actionable fraud; and that the AMA oppose any effort to lower this evidentiary standard; (4) will vigorously oppose efforts by the Department of Justice to punish and harass physicians for unintentional errors in Medicare claims submissions and the legitimate exercise of professional judgment in determining medically necessary services; (5) continues its efforts to educate the entire Federation about the AMA’s successful amendment of the Health Insurance Portability and Accountability Act (also commonly referred to as the Kassebaum-Kennedy bill) which resulted in language being added so that physicians cannot be prosecuted or fined for inadvertent billing errors, absent an intent to “knowingly and willfully” defraud; (6) educates the public and government officials about the distinction under the law, between inadvertent billing errors and fraud and abuse; and (7) responds vigorously to any public statements that fail to distinguish between inadvertent billing errors and fraud and abuse.</p> <p>(Sub. Res. 222, A-97; Appended: Res. 202, I-98; Reaffirmation A-99;</p>	<p>Retain – this policy remains relevant.</p>
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		Reaffirmation A-01; Reaffirmation I-01; Reaffirmation A-02; Reaffirmed: BOT Rep. 19, A-12)	
H-175.989	Health Care Fraud Legislation	<p>Our AMA: (1) should continue to scrutinize current and future key legislation regarding health care fraud and abuse;</p> <p>(2) should use all appropriate resources available to ensure that any proposed sanctions, penalties, or sentences be commensurate with the offense committed, especially regarding the imposition of criminal penalties in measures that fail even to define the boundaries of a “health care offense” or to establish the requisite intent necessary for conviction;</p> <p>(3) should work with appropriate federal agencies and congressional committees in studying the extent to which health care fraud pervades the current environment;</p> <p>(4) should continue to support legislative measures such as HR 5120, which would establish a national commission to investigate the nature, magnitude, and cost of health care fraud and abuse;</p> <p>(5) should conduct surveys and research in order to develop data on possible abuses in the system;</p> <p>(6) should continue to support the Principles of Medical Ethics concerning fraud by encouraging physicians to accept the responsibility to expose those engaged in fraud and deception;</p> <p>(7) should continue to pursue recent initiatives, including providing assistance to the FBI in a cooperative endeavor as it attempts to identify and prosecute health care fraud, and continue ongoing efforts with the FTC to remove the current legal barriers to professional self-regulatory activity that would assist in the elimination of fraud and abuse;</p> <p>(8) should pursue legislative efforts to enact a program that would award grants to medical societies for the creation of programs specifically targeted at fraud and abuse; and</p> <p>(9) continue to make the relief of oppressive and overzealous application</p>	<p>Sunset this policy.</p> <p>This policy is very specific to a policy trend that was occurring in 1992 that has long been eclipsed by other issues and approaches regarding fraud and abuse issues. Also, the HOD has adopted more current and relevant policy addressing fraud and abuse since 1992, including: H-175.979, Medicare “Fraud and Abuse” Update; H-175.981, Fraud and Abuse Within the Medicare System; H-175.982, Due Process for Physicians; H-175.984, Health Care Fraud and Abuse Update; H-70.952, Medicare Guidelines for Evaluation and Management Codes</p>

		<p>of fraud and abuse regulations a high priority and take whatever action is necessary to challenge improprieties in the application of fraud and abuse laws against physicians.</p> <p>(BOT Rep. Z, I-92; Reaffirmed: Sub. Res. 232, A-96; Reaffirmation A-99; Appended: Sub. Res. 244, A-00; Reaffirmed: Res. 201, I-00; Reaffirmation I-00; Reaffirmation A-02; Reaffirmed: BOT Rep. 19, A-12)</p>	
H-180.954	Privacy of Physician Medical Information	<p>It is the policy of the AMA that a physician's personal medical history is private and should remain confidential. Only information regarding current health status should be required for credentialing purposes.</p> <p>(BOT Rep. 7, I-02; Reaffirmed: CMS Rep. 4, A-12)</p>	Retain – this policy remains relevant.
H-190.960	HIPAA Law and Regulations	<p>Our AMA believes that inadvertent disclosures of protected health information should not lead to the imposition of criminal sanctions.</p> <p>(Sub. Res. 207, A-02; Reaffirmed: CMS Rep. 4, A-12)</p>	Retain – this policy remains relevant.
H-285.909	Designation of Electrodiagnosis / Other Services as Separate Category in Provider Network	<p>Our AMA will: (1) oppose the re-designation of services traditionally provided by broader medical specialties as a separate specialty category for inclusion into a payor's provider network unless compelling evidence shows it will improve patient care; and (2) support the ability for all appropriately trained neurologists and physiatrists to perform electrodiagnosis on patients within their provider network.</p> <p>(Res. 814, I-12)</p>	Retain – this policy remains relevant.
H-285.933	Financial Liability Encountered in Referrals for Alternative Care	<p>The AMA supports legislation that managed care organizations that offer alternative medicine as a covered service not require referral by the primary care physician for that service, and that the primary care physician not be held at risk financially for the costs of those provided alternative medical services.</p>	<p>Retain – this policy remains relevant.</p> <p>Primary care physicians should not be required by health plans to authorize alternative medicine that they do not provide</p>

		(Res. 702, A-98; Reaffirmed: BOT Rep. 36, A-02; Reaffirmed: CMS Rep. 4, A-12)	themselves (e.g., acupuncture).
H-30.938	Support for Medical Amnesty Policies for Underage Alcohol Intoxication	Our AMA supports efforts among universities, hospitals, and legislators to establish medical amnesty policies that protect underage drinkers from punishment for underage drinking when seeking emergency medical attention for themselves or others. (Res. 202, A-12)	Retain – this policy remains relevant.
H-335.964	Funding for the Agency for Healthcare Research and Quality	Our AMA: (1) strongly supports the AHRQ in its activities, programs and initiatives designed to provide evidence-based information to evaluate and improve health care in practice settings; and (2) supports legislation that would greatly expand the scope and budget of the AHRQ as the central federal agency coordinating the issues involved in implementing the changes discussed in the IOM report, Crossing the Quality Chasm. (Res. 811, A-02; Appended: BOT Rep. 14, I-02; Reaffirmed: CMS Rep. 4, A-12)	Retain – this policy remains relevant.
H-383.989	Protecting Physicians with Multiple Tax ID Numbers	Our AMA will support legislation and/or regulation to prevent managed care organizations from requiring physicians to participate under all of their Tax ID Numbers if they participate under one Tax ID Number. (Res. 215, A-12)	Retain – this policy remains relevant.
H-385.971	Physician Negotiations with Third Party Payers	The AMA (1) will aid, encourage and guide medical societies in efforts to directly negotiate with any larger payer of medical services; (2) will negotiate with national third party payers with regard to national policies which arbitrarily interfere with patient care; and (3) will use its legal and legislative resources to the maximum extent to change the laws to permit physicians to fairly and collectively deal with third party payers.	Retain – this policy remains relevant.

		(BOT Rep. MMM, A-91; Reaffirmation A-97; Reaffirmation I-06; Reaffirmed: BOT action in response to referred for decision Res. 201, I-12)	
H-435.944	Clinical Decision Support and Malpractice Risk	<p>Our AMA will: (1) advocate in interested states for legislation that would create a “safe harbor” for physicians who use a consensus-based drug-drug interaction list in their clinical decision support software package; and (2) communicate to governmental authorities in interested states that patients, physicians, hospitals, and the government will all lose out if a “safe harbor” for physicians who use a consensus-based drug-drug interaction list in their clinical decision support software package is not developed.</p> <p>(Res. 228, A-12)</p>	<p>Sunset this policy.</p> <p>This policy was very specific to a policy trend that was occurring in 2012. This has not been an area of recent activity in the states.</p>
H-440.859	American’s Health	<p>Our AMA will: (1) make improving health through increased activity and proper diet a priority; (2) propose legislation calling on the federal government and state governments to develop new and innovative programs in partnership with the private sector that encourage personal responsibility for proper dietary habits and physical activity of individual Americans; and (3) continue to work in conjunction with the American College of Sports Medicine, American Heart Association, US Department of Health and Human Services and any other concerned organizations to provide educational materials that encourage a healthier America through increased physical activity and improved dietary habits.</p> <p>(Res. 201, A-09; Reaffirmation A-12)</p>	<p>Retain – this policy remains relevant.</p>
H-478.994	Health Information Technology	<p>Our AMA will support the principles that when financial assistance for Health IT originates from an inpatient facility: (1) it not unreasonably constrains the physician’s choice of which ambulatory HIT system to purchase; and (2) it promotes voluntary rather than mandatory sharing of Protected Health</p>	<p>Retain – this policy remains relevant.</p>

		<p>Information (HIPAA-PHI) with the facility consistent with the patient's wishes as well as applicable legal and ethical considerations.</p> <p>(Res. 723, A-05; Reaffirmation A-10; Reaffirmed in lieu of Res. 237, A-12)</p>	
<p>H-510.987</p>	<p>Support Integration of Care for Returning Military, Veterans and Their Families by Opening Access to the States' Prescription Monitoring Programs by VA Prescribing Providers</p>	<p>Our AMA urges the Secretary of the Department of Veterans Affairs to implement procedures allowing and encouraging VA-based health care providers to access and utilize state-based prescription drug monitoring programs in order to improve risk assessment and medical management of their patients receiving prescriptions for controlled substances.</p> <p>(BOT action in response to referred for decision Res. 710, A-12)</p>	<p>Sunset this policy.</p> <p>The AMA has extensive policy regarding the use of PDMPs, including VA-specific provisions within H-95.947, "Prescription Drug Monitoring to Prevent Abuse of Controlled Substances," which provides for support for the VA to report prescription information required by the state into the state PDMP; and that physicians and other health care professionals employed by the VA to be eligible to register for and use the state PDMP in which they are practicing even if the physician or other health care professional is not licensed in the state.</p>

REPORT OF THE BOARD OF TRUSTEES

B of T Report 17-A-22

Subject: Expungement, Destruction, and Sealing of Criminal Records for Legal Offenses
Related to Cannabis Use or Possession

Presented by: Bobby Mukkamala, MD, Chair

Referred to: Reference Committee B

1 INTRODUCTION

2

3 At the November 2020 Special Meeting of the AMA House of Delegates (HOD), Policy D-
4 95.960 was adopted asking “That our AMA study the expungement, destruction, and sealing of
5 criminal records for legal offenses related to cannabis use or possession.”

6

7 During the meeting, there was testimony in support of an amendment on the expungement of
8 criminal records for cannabis-related offenses. The AMA Council on Legislation testified that
9 given the legal nature of the proposed recommendation, the issue would benefit from further study.
10 This report discusses the issues raised and provides general information and background for the
11 purposes of informing the AMA HOD. This report should not be relied upon as legal advice or for
12 applicability to any particular factual scenario. An individual interested in pursuing legal action
13 related to the issues raised in this report should consult with a licensed attorney in the state in
14 which the individual resides or action in question occurred. This report also provides relevant
15 AMA policy and presents recommendations for HOD consideration.

16

17 BACKGROUND

18

19 The legal status of cannabis is a patchwork of state and federal law and federal guidance. Colorado
20 and Washington were the first states to legalize cannabis for medical use in 2012. In 2013, the
21 U.S. Department of Justice (DOJ) issued what is referred to as the “Cole Memo.” The Cole Memo
22 essentially stated that the federal government would not interfere with state cannabis laws if the
23 state had a strict regulatory system to protect against criminal activity.¹ At least eight states
24 legalized medical cannabis between 2013-2018. In 2018, the DOJ rescinded the Cole Memo.²

25

26 Currently, adult use of cannabis is legal in at least 18 states and two territories, and for medical use,
27 cannabis is legal in at least 37 states and four territories.³ Cannabis remains a Schedule I Controlled
28 Substance at the federal level, which is defined as having, “a high potential for abuse...no currently
29 accepted medical use in treatment in the United States...[and] There is a lack of accepted safety for
30 use of the drug or other substance under medical supervision.”⁴

31

32 Between 2010 and 2018, there were more than six million arrests related to cannabis. Young
33 people and young adults are the ones primarily arrested, and when charged, prosecuted, or
34 incarcerated, may suffer significant trauma.⁵ People who are Black are 3.6 times more likely to be
35 arrested than people who are white, despite similar rates in usage. Even following legalization,
36 disparities in arrest rates continue.⁶

1 Issues relating to expungement should not, however, be confused with issues relating to the health
2 effects of cannabis use on youth and adolescents. Researchers have found that, “Marijuana use has
3 been associated with several adverse mental health outcomes, including increased incidence of
4 addiction and comorbid substance use, suicidality, and new-onset psychosis. Negative impacts on
5 cognition and academic performance have also been observed.”⁷ A study looking at youth
6 perception of risk done when only eight states legalized cannabis for medical use found youth in
7 these states tended to use cannabis more frequently than in states that did not legalize its use and
8 that youth had lower perceptions of health risks associated with cannabis use.⁸

9
10 DISCUSSION

11
12 As a threshold matter, it is important to recognize that expungement, destruction, and sealing are
13 legal processes. An expungement process may involve multiple steps where the end result is to
14 remove a record of arrest and/or conviction from the official state or federal record. The idea is that
15 post-expungement, the record never existed. While an expungement may “erase” a record,
16 “sealing” hides the record from public view. More specifically, when “sealed,” the record can be
17 accessed under certain circumstances.⁹ Finally, “destruction” of a record generally means to
18 physically destroy it. When a record is “destroyed,” there is no record remaining whatsoever.¹⁰ It is
19 important to note that specific definitions may vary by state.

20
21 The Council on Science and Public Health (CSAPH) has previously discussed how having a
22 criminal record can negatively affect an individual’s employment, housing, education, receipt of
23 public benefits, and other social determinants of health and public health effects.¹¹ There are
24 additional implications for medical students,¹² residents, and other physicians who, if there is a
25 record of a prior cannabis possession arrest or conviction, may be asked to disclose that record on a
26 licensing or employment application. As discussed below, depending on the applicable state and/or
27 federal law, it may not be clear whether expungement or sealing requires or protects against future
28 disclosure. It is beyond the scope of this report to discuss in depth what might occur if a medical
29 student, resident, or physician does disclose the existence of a prior arrest or conviction for a
30 cannabis-related offense.

31
32 Under federal law, the record of a conviction for drug possession may be able to be expunged
33 depending on the circumstances. An individual must qualify for expungement and undertake the
34 process to formally seek expungement. There are different requirements for those 21 years of age
35 and older and those younger than 21. The record of the underlying expungement also offers
36 protection against future adverse use, but it is retained by the DOJ.¹³

37
38 Approximately 20 states have enacted laws or other policies providing for expungement, record
39 sealing, or other similar actions based on acts that are no longer crimes post-enactment of cannabis
40 legalization.^{14,15} Illinois, for example, has created a detailed pathway for expungement of cannabis-
41 related offenses. The specific process and qualification for potential expungement, including
42 automatic expungement, depends on whether the arrest was “minor,” the date of the arrest, whether
43 the individual was an adult or minor, how long it has been since the arrest, whether there were
44 charges filed, amount of cannabis for which the arrest occurred, and other factors.¹⁶ Under
45 California’s Proposition 64, acts that were committed prior to the legalization of adult use
46 cannabis, were made eligible for resentencing, dismissal, or sealing.¹⁷ As in Illinois, eligibility for
47 expungement and sealing of records in California is subject to a wide variety of different
48 requirements. Approximately 500,000 cannabis-related arrest records have been expunged in
49 Illinois following enactment of the law.¹⁸ Despite a law requiring records of cannabis-related
50 offenses to be sealed in California, hundreds of thousands of records remain open, according to
51 pro-cannabis sources.¹⁹

1 Substantial barriers to expungement remain,²⁰ depending on the state, including individual petition
2 requirements, complex filing processes necessitating legal representation, filing fees, hearings
3 without sufficient notice, fingerprinting requirements, and ineligibility due to unpaid debt—even
4 when this debt (fines, fees, or restitution) is related to the offense being expunged.²¹ Further, there
5 is evidence of disparate access to expungement for historically marginalized and minoritized
6 individuals. In fact, a 2017 study reviewing Wisconsin expungements showed that:

7
8 [s]tatewide, only 10 percent of those granted expungements since 2010 are African-American
9 and only 2 percent are Hispanic—much lower numbers than appear to have been eligible (23
10 percent and 6 percent, respectively). Conversely, statewide, 79 percent of those granted
11 expungements were white, while only 63 percent of those generally eligible were white.²²
12

13 Even if a record is expunged or sealed, however, that may not address collateral consequences of
14 the arrest or conviction, e.g., potential professional licensing sanctions, adverse employment
15 actions, and qualification for government benefits, including loans and housing. These collateral
16 consequences can also suppress the local tax base by locking people into unemployment or lower
17 paying jobs and increase taxpayer costs due to increasing likelihood of further involvement in the
18 criminal legal system.²³ As noted by Marion County (Indiana) prosecutor Terry Curry, “If our goal
19 is to have individuals not reoffend, then in our mind it’s appropriate to remove obstacles that are
20 going to inhibit their ability to become productive members of our community.”
21

22 Finally, very few states have enacted laws addressing these collateral effects, and these issues
23 remain controversial at the federal level.²⁴ In addition, state-specific expungement laws have trailed
24 behind legalization efforts.²⁵ Potential interstate conflicts also may arise when an individual has an
25 arrest or conviction in one state but then goes on to reside in a different state. Further complicating
26 the issue, is the fact that without legal representation, it may not be clear whether an individual
27 should seek expungement, sealing, or other legal avenues. This is why the Lawyers’ Committee for
28 Civil Rights Under the Law emphasizes that the legal strategy depends on the situation.²⁶
29

30 In addition, the net social benefits to expungement should not be used to set aside or minimize the
31 health risks associated with cannabis use—particularly for youth and adolescents. Even when states
32 take action to positively address legal inequities and support social determinants of health, there
33 remain significant adverse health effects of cannabis use for youth and adolescents.
34

35 AMA POLICY CONSIDERATIONS 36

37 The AMA opposes legalization of cannabis for medical use, “through the state legislative, ballot
38 initiative, or referendum process.” (D-95.969, “Cannabis Legalization for Medicinal Use”) As
39 explained above, however, expungement of cannabis-related offenses is a process that occurs after-
40 the-fact. The AMA also opposes legalization of cannabis for adult use while supporting, “public
41 health-based strategies, rather than incarceration, in the handling of individuals possessing cannabis
42 for personal use.” (H-95.924, “Cannabis Legalization for Adult Use” [commonly referred to as
43 recreational use]) The expungement process—to the extent that it helps prevent the loss of public
44 health benefits and supports the continuity of social determinants of health—is in line with a public
45 health-based strategy.
46

47 Consistent with this report, the AMA also, “encourages research on the impact of legalization and
48 decriminalization of cannabis in an effort to promote public health and public safety; [and]
49 encourages dissemination of information on the public health impact of legalization and
50 decriminalization of cannabis.” (H-95.924, “Cannabis Legalization for Adult Use” [commonly
51 referred to as recreational use]).

1 The AMA also supports, “fairness in the expungement and sealing of records” for juveniles.
2 (H-60.916, “Youth Incarceration in Adult Facilities”) The AMA further, “[e]ncourages continued
3 research to identify programs and policies that are effective in reducing disproportionate minority
4 contact across all decision points within the juvenile justice system” (H-60.919, “Juvenile Justice
5 System Reform”). As discussed above, arrest and conviction rates for cannabis possession are
6 disproportionately felt by Black and Brown youth and adults. As a result, policies and procedures
7 to facilitate expungement or other legal strategies would appear beneficial to restore future rights
8 and benefits.

9
10 Fundamental fairness and equity principles argue that individuals with an arrest or conviction for
11 cannabis-related offenses—that occurred before legalization that would make such action legal—
12 should not suffer further legal or public health adverse effects. Such a direction from the AMA
13 would not alter its underlying policy opposing legalization of cannabis for medical or adult use.
14 Supporting efforts to improve public health effects, however, would be directly in line with AMA
15 policy on numerous fronts, including support for youth adversely affected by the justice system.
16 Analyzing the relative strengths and weaknesses of every state’s expungement, sealing, and other
17 policies, is beyond the scope of this report. There are, however, multiple national and other
18 resources the AMA could provide as guidance to others when considering options relating to post-
19 arrest and post-conviction policies in states that have legalized cannabis for medical or adult use.

20 21 RECOMMENDATIONS

22
23 The Board recommends that the following recommendations be adopted, and the remainder of the
24 report be filed:

- 25
26 1. That our American Medical Association (AMA) support automatic expungement, sealing, and
27 similar efforts regarding an arrest or conviction for a cannabis-related offense for use or
28 possession that would be legal under subsequent state legalization of adult use or medicinal
29 cannabis. (New HOD Policy)
- 30
31 2. That our AMA support automatic expungement, sealing, and similar efforts regarding an arrest
32 or conviction of a cannabis-related offense for use or possession for a minor upon the minor
33 reaching the age of majority. (New HOD Policy)
- 34
35 3. That our AMA inquire to the Association of American Medical Colleges, Accreditation
36 Council for Graduate Medical Education, Federation of State Medical Boards, and other
37 relevant medical education and licensing authorities, as to the effects of disclosure of a
38 cannabis related offense on a medical school, residency, or licensing application. (Directive to
39 Take Action)
- 40
41 4. That AMA Policy D-95.960, “Public Health Impacts of Cannabis Legalization” be rescinded
42 since this report fulfills the directive contained in the policy. (Rescind HOD Policy)

Fiscal Note: \$5000.

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- ² Marijuana Enforcement. U.S. Department of Justice. January 4, 2018. Available at January 4, 2018
- ³ State Medical Cannabis Laws. National Conference of State Legislatures. Available at <https://www.ncsl.org/research/health/state-medical-marijuana-laws.aspx> Last accessed February 25, 2022.
- ⁴ 21 U.S.C. §812 Schedules of controlled substances.
- ⁵ Pediatrics (2015) 135 (3): e769–e785. <https://doi.org/10.1542/peds.2014-4147>
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- ¹² “Sections 1-3 of the AMCAS® Application: Your Background Information.” American Association of Medical Colleges. Last accessed February 9, 2022. Available at <https://students-residents.aamc.org/how-apply-medical-school-amcas/sections-1-3-amcas-application-your-background-information>
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- ¹⁸ “State Officials: Nearly 500,000 Marijuana Arrest Records Have Been Expunged.” By Amanda Vinicky. WTTW. December 31, 2021. Available at <https://news.wttw.com/2020/12/31/state-officials-nearly-500000-marijuana-arrest-records-have-been-expunged>
- ¹⁹ “California Officials Have Failed to Seal Thousands Of Marijuana Conviction Records.” Marijuana Moment. October 18, 2021. Available at <https://www.marijuanamoment.net/california-officials-have-failed-to-seal-thousands-of-marijuana-conviction-records-by-the-legally-required-deadline/>
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- ²¹ “Fines and Fees Are a Barrier to Criminal Record-Clearing.” Center for American Progress. November 30, 2021. Available at https://www.americanprogress.org/article/fines-and-fees-are-a-barrier-to-criminal-record-clearing/?_ga=2.120630408.188333240.1646612331-783047533.1646612331

²² Problems with Wisconsin's Expungement Law. How the Law is Used and How to Make it More Equitable and Effective. Badger Institute. Available at <https://www.badgerinstitute.org/BI-Files/Reports/ExpungementstoryMay2017.pdf>

²³ "Scrubbing The Past To Give Those With A Criminal Record A Second Chance." By Barbara Brosher. NPR. February 1, 2019. Available at <https://www.npr.org/2019/02/19/692322738/scrubbing-the-past-to-give-those-with-a-criminal-record-a-second-chance><https://www.npr.org/2019/02/19/692322738/scrubbing-the-past-to-give-those-with-a-criminal-record-a-second-chance>

²⁴ Clearing Criminal Records for Cannabis Offenses. National Conference on State Legislatures. April 21, 2020. Available at <https://www.ncsl.org/research/civil-and-criminal-justice/clearing-criminal-records-for-cannabis-offenses.aspx>

²⁵ "In These States, Past Marijuana Crimes Can Go Away." By Sophie Quinton. November 20, 2017. Available at <https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2017/11/20/in-these-states-past-marijuana-crimes-can-go-away>

²⁶ The Lawyers' Committee's Expungement Toolkit. The Lawyers' Committee for Civil Rights Under Law. September 2020. Available at <https://lawyerscommittee.org/wp-content/uploads/2020/10/Expungement-Now-Toolkit-FINAL.pdf>

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 201
(A-22)

Introduced by: Resident and Fellow Section

Subject: The Impact of Midlevel Providers on Medical Education

Referred to: Reference Committee B

- 1 Whereas, A survey in 2017 published in Worldviews Evidence Based Nursing revealed that a
2 majority of the 2,300 nurse respondents did not feel competent in evidence-based practice¹; and
3
4 Whereas, Physicians that speak out about the differences in training received by physicians vs.
5 by mid-level providers are being fired, labeled “disrespectful” or labeled “not team players” in the
6 interdisciplinary team treating patients¹; and
7
8 Whereas, More non-physician post-graduate training programs are being formed across the
9 nation; there is still no mandatory requirement for non-physicians to pursue post-graduate
10 training¹; and
11
12 Whereas, Physicians are expected to continue to maintain certification by proving they continue
13 to educate themselves; mid-level providers are not held to the same standard¹; and
14
15 Whereas, Currently mid-level providers can switch between specialties and subspecialties of
16 medicine and surgery without any formal or regulated training or education¹; and
17
18 Whereas, Physicians are limited in their practice abilities by the post-graduate training they
19 receive¹; therefore be it
20
21 RESOLVED, That our American Medical Association study, using surveys among other tools
22 that protect identities, how commonly bias against physician-led healthcare is experienced
23 within undergraduate medical education and graduate medical education, interprofessional
24 learning and team building work and publish these findings in peer-reviewed journals (Directive
25 to Take Action); and be it further
26
27 RESOLVED, That our AMA work with the Liaison Committee on Medical Education and the
28 Accreditation Council for Graduate Medical Education to ensure all physician undergraduate
29 and graduate training programs recognize and teach physicians that they are the leaders of the
30 healthcare team and are adequately equipped to diagnose and treat patients independently only
31 because of the intensive, regulated, and standardized education they receive (Directive to Take
32 Action); and be it further
33
34 RESOLVED, That our AMA study the harms and benefits of establishing mandatory
35 postgraduate clinical training for nurse practitioners and physician assistants prior to working
36 within a specialty or subspecialty field (Directive to Take Action); and be it further
37
38 RESOLVED, That our AMA study the harms and benefits of establishing national requirements
39 for structured and regulated continued education for nurse practitioners and physician
40 assistants in order to maintain licensure to practice. (Directive to Take Action)

Fiscal Note: Estimated cost of \$50,000 to implement resolution.

Received: 04/04/22

References:

1. Al-Agba, Niran, and Rebekah Bernard. *Patients at Risk: the Rise of the Nurse Practitioner and Physician Assistant in Healthcare*. Universal-Publishers, Inc., 2020.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 202
(A-22)

Introduced by: New York

Subject: AMA Position on All Payer Database Creation

Referred to: Reference Committee B

1 Whereas, Organized medicine worked hard to push for the creation of the FAIRHEALTH
2 database, an independent database of charges; and
3
4 Whereas, Private health insurers are now pushing for legislation to create alternate databases
5 at the state and federal levels known as an All Payer Database; and
6
7 Whereas, The All Payer Database will reflect payments from all payers and as such will be
8 heavily weighted towards poor payments for physicians such as Medicare and Medicaid which
9 are generally lower payments than issued by commercial and self-insured plans; and
10
11 Whereas, Much of this information is already available; and
12
13 Whereas, The private insurers interest in such a database is to use it to replace the
14 FAIRHEALTH database and justify lower payments to physicians; and
15
16 Whereas, Much of the payment data for hospitals is not reliable because hospitals frequently
17 pay employed physicians at a much higher rate than the professional collections; therefore be it
18
19 RESOLVED, That our American Medical Association advocate that any All Payer Database
20 should also provide true payments that hospitals are making to their employed physicians, not
21 just the amount of payment that the insurer is making on the physician's behalf to the hospital.
22 (Directive to Take Action)

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

Received: 03/22/22

RELEVANT AMA POLICY

Price Transparency D-155.987

1. Our AMA encourages physicians to communicate information about the cost of their professional services to individual patients, taking into consideration the insurance status (e.g., self-pay, in-network insured, out-of-network insured) of the patient or other relevant information where possible.
 2. Our AMA advocates that health plans provide plan enrollees or their designees with complete information regarding plan benefits and real time cost-sharing information associated with both in-network and out-of-network provider services or other plan designs that may affect patient out-of-pocket costs.
 3. Our AMA will actively engage with health plans, public and private entities, and other stakeholder groups in their efforts to facilitate price and quality transparency for patients and physicians, and help ensure that entities promoting price transparency tools have processes in place to ensure the accuracy and relevance of the information they provide.
 4. Our AMA will work with states and the federal government to support and strengthen the development of all-payer claims databases.
 5. Our AMA encourages electronic health records vendors to include features that assist in facilitating price transparency for physicians and patients.
 6. Our AMA encourages efforts to educate patients in health economics literacy, including the development of resources that help patients understand the complexities of health care pricing and encourage them to seek information regarding the cost of health care services they receive or anticipate receiving.
 7. Our AMA will request that the Centers for Medicare and Medicaid Services expand its Medicare Physician Fee Schedule Look-up Tool to include hospital outpatient payments.
- Citation: CMS Rep. 4, A-15; Reaffirmed in lieu of: Res. 121, A-16; Reaffirmed in lieu of: Res. 213, I-17; Reaffirmed: BOT Rep. 14, A-18; Reaffirmed in lieu of: Res. 112, A-19; Modified: Res. 213, I-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 203
(A-22)

Introduced by: New York, GLMA - Health Professionals Advancing LGBTQ Equality, American Psychiatric Association, American Academy of Child and Adolescent Psychiatry, American Association of Geriatric Psychiatry, American Academy of Psychiatry and Law, Medical Student Section, Minority Affairs Section

Subject: Ban the Gay/Trans (LGBTQ+) Panic Defense

Referred to: Reference Committee B

- 1 Whereas, The gay or trans panic (to be more inclusive will use “LGBTQ+ panic”) defense
2 strategy is a legal strategy that uses a victim’s sexual orientation or gender identity/expression
3 as an excuse for a defendant’s violent reaction, seeking to legitimize and even to excuse violent
4 and lethal behavior (1); and
5
- 6 Whereas, The LGBTQ+ “panic” defense strategy gives defendants three options of defense: 1)
7 Defense of insanity or diminished capacity 3) Defense of provocation 3)
8 Defense of self-defense (3); and
9
- 10 Whereas, To claim insanity, defendants claim that the sexual orientation or gender of the victim
11 is enough to induce insanity (1); and
12
- 13 Whereas, To claim provocation, defendants claim “victim’s proposition, sometimes termed a
14 “non-violent sexual advance,” was sufficiently “provocative” to induce the defendant to kill the
15 victim”(1); and
16
- 17 Whereas, To claim self defense, “defendants claim they believed that the victim, because of
18 their sexual orientation or gender identity/expression, was about to cause the defendant serious
19 bodily harm (3)”; and
20
- 21 Whereas, Studies have shown that jurors with higher in homonegativity and religious
22 fundamentalism ratings assigned higher victim blame, lower defendant responsibility, and more
23 lenient verdicts in the “LGBTQ+ panic” conditions (5,6,7); and
24
- 25 Whereas, “Gay panic disorder” was removed from the DSM in 1973 because the APA
26 recognized that no such condition exists; and
27
- 28 Whereas, Many murder sentences have been reduced or defendants have been acquitted
29 using the LGBTQ+ “panic” defense strategy such as in the Matthew Shepard case has been
30 used successfully to mitigate a charge from murder to criminally negligent manslaughter as
31 recently as 2018 (1); and
32
- 33 Whereas, The LGBTQ community makes up 3.5% of the US population yet, sexual orientation
34 is the motivator of 17% of hate crime attacks with one in four transgender people becoming the
35 victim of a hate crime in their lifetime (4, 5); and

1 Whereas, The LGBTQ+ “panic” defense has only been banned in 11 states as of February
2 2021, with legislation having been introduced in 12 more states (1, 2); and
3

4 Whereas, At least 57 Transgender or Gender Non-Conforming persons were killed in the US
5 during the year 2021, the highest total since HRC started tracking in 2013, breaking a record
6 from the previous year 2020 (9); and
7

8 Whereas, LGBTQ people over 16 years age are: 4 times more likely to become victims of
9 violence compared to non-LGBTQ people; 6 times more likely to experience violence by
10 someone known to them and 2.5 times more likely to be a victim of violence by a stranger; LBT
11 women are 5 times more likely than non-LBT women to experience violent victimization; GBT
12 men face more than twice the risk of violence compared to non-GBT men; and most violent
13 victimization of LGBTQ people is not reported to law enforcement (10, 11); and
14

15 Whereas, A legal defense based on panic because of the race, ethnicity or sex of the victims of
16 a violent crimes is not permitted, and similar reasoning must disallow a gay or trans (LGBTQ+)
17 panic defense; therefore be it
18

19 RESOLVED, That our American Medical Association seek a federal law banning the use of the
20 so-called “gay or trans (LGBTQ+) panic” defense in homicide, manslaughter, physical or sexual
21 assault cases (Directive to Take Action); and be it further
22

23 RESOLVED, That our AMA develop draft legislation, an issue brief and talking points on the
24 topic of so called “gay or trans (LGBTQ+) panic” defense, that can be used by the AMA in
25 seeking federal legislation, and can be used and adapted by state and specialty medical
26 societies, other allies, and stakeholders when seeking state legislation to ban the use of so-
27 called “gay or trans (LGBTQ+) panic” defense to mitigate personal responsibility for violent
28 crimes such as assault, rape, manslaughter, or homicide. (Directive to Take Action)

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

Received: 03/22/22

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RELEVANT AMA POLICY

Preventing Anti-Transgender Violence H-65.957

Our AMA will: (1) partner with other medical organizations and stakeholders to immediately increase efforts to educate the general public, legislators, and members of law enforcement using verified data related to the hate crimes against transgender individuals highlighting the disproportionate number of Black transgender women who have succumbed to violent deaths; (2) advocate for federal, state, and local law enforcement agencies to consistently collect and report data on hate crimes, including victim demographics, to the FBI; for the federal government to provide incentives for such reporting; and for demographic data on an individual's birth sex and gender identity be incorporated into the National Crime Victimization Survey and the National Violent Death Reporting System, in order to quickly identify positive and negative trends so resources may be appropriately disseminated; (3) advocate for a central law enforcement database to collect data about reported hate crimes that correctly identifies an individual's birth sex and gender identity, in order to quickly identify positive and negative trends so resources may be appropriately disseminated; (4) advocate for stronger law enforcement policies regarding interactions with transgender individuals to prevent bias and mistreatment and increase community trust; and (5) advocate for local, state, and federal efforts that will increase access to mental health treatment and that will develop models designed to address the health disparities that LGBTQ individuals experience.

Citation: Res. 008, A-19

Access to Basic Human Services for Transgender Individuals H-65.964

Our AMA: (1) opposes policies preventing transgender individuals from accessing basic human services and public facilities in line with ones gender identity, including, but not limited to, the use of restrooms; and (2) will advocate for the creation of policies that promote social equality and safe access to basic human services and public facilities for transgender individuals according to ones gender identity.

Citation: Res. 010, A-17

Support of Human Rights and Freedom H-65.965

Our AMA: (1) continues to support the dignity of the individual, human rights and the sanctity of human life, (2) reaffirms its long-standing policy that there is no basis for the denial to any human being of equal rights, privileges, and responsibilities commensurate with his or her individual capabilities and ethical character because of an individual's sex, sexual orientation, gender, gender identity, or transgender status, race, religion, disability, ethnic origin, national origin, or age; (3) opposes any discrimination based on an individual's sex, sexual orientation, gender identity, race, religion, disability, ethnic origin, national origin or age and any other such reprehensible policies; (4) recognizes that hate crimes pose a significant threat to the public health and social welfare of the citizens of the United States, urges expedient passage of appropriate hate crimes prevention legislation in accordance with our AMA's policy through letters to members of Congress; and registers support for hate crimes prevention legislation, via letter, to the President of the United States.

Citation: CCB/CLRPD Rep. 3, A-14; Reaffirmed in lieu of: Res. 001, I-16; Reaffirmation: A-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 204
(A-22)

Introduced by: New York
Subject: Insurance Claims Data
Referred to: Reference Committee B

- 1 Whereas, Insurance company claims data is a repository of public health information, utilization
2 information, practice patterns, and other important information; and
3
4 Whereas, The insurers utilize their claims data in order to develop policy, coverage
5 determinations, and pricing; and
6
7 Whereas, The insurers obtain the data from both at risk plans and plans for which they act in the
8 capacity of Third-Party Administrator (TPA); and
9
10 Whereas, Insurers typically do not share this data, asserting that it is proprietary; and
11
12 Whereas, Asymmetry of information is an impediment to more robust health policy, better and
13 more responsive health policy, more cost-effective policy and new entrants into the insurance
14 marketplace; therefore be it
15
16 RESOLVED, That our American Medical Association seek legislation and regulation to promote
17 open sharing of de-identified health insurance claims data. (Directive to Take Action)

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

Received: 03/22/22

RELEVANT AMA POLICY

Work of the Task Force on the Release of Physician Data H-406.990

Release of Claims and Payment Data from Governmental Programs

The AMA encourages the use of physician data to benefit both patients and physicians and to improve the quality of patient care and the efficient use of resources in the delivery of health care services. The AMA supports this use of physician data only when it preserves access to health care and is used to provide accurate physician performance assessments.

Raw claims data used in isolation have significant limitations. The release of such data from government programs must be subject to safeguards to ensure that neither false nor misleading conclusions are derived that could undermine the delivery of appropriate and quality care. If not addressed, the limitations of such data are significant. The foregoing limitations may include, but are not limited to, failure to consider factors that impact care such as specialty, geographic location, patient mix and demographics, plan design, patient compliance, drug and supply costs, hospital and service costs, professional liability coverage, support staff and other practice costs as well as the potential for mistakes and errors in the data or its attribution.

Raw claims and payment data resulting from government health care programs, including, but not limited to, the Medicare and Medicaid programs should only be released:

1. when appropriate patient privacy is preserved via de-identified data aggregation or if written authorization for release of individually identifiable patient data has been obtained from such patient in accordance with the requirements of the Health Insurance Portability and Accountability Act (HIPAA) and applicable regulations;
2. upon request of physicians [or their practice entities] to the extent the data involve services that they have provided;
3. to law enforcement and other regulatory agencies when there is reasonable and credible reason to believe that a specific physician [or practice entity] may have violated a law or regulation, and the data is relevant to the agency's investigation or prosecution of a possible violation;
4. to researchers/policy analysts for bona fide research/policy analysis purposes, provided the data do not identify specific physicians [or their practice entities] unless the researcher or policy analyst has (a) made a specific showing as to why the disclosure of specific identities is essential; and, (b) executed a written agreement to maintain the confidentiality of any data identifying specific physicians [or their practice entities];
5. to other entities only if the data do not identify specific physicians [or their practice entities]; or
6. if a law is enacted that permits the government to release raw physician-specific Medicare and/or Medicaid claims data, or allows the use of such data to construct profiles of identified physicians or physician practices. Such disclosures must meet the following criteria:
 - (a) the publication or release of this information is deemed imperative to safeguard the public welfare;
 - (b) the raw data regarding physician claims from governmental healthcare programs is:
 - (i) published in conjunction with appropriate disclosures and/or explanatory statements as to the limitations of the data that raise the potential for specific misinterpretation of such data. These statements should include disclosure or explanation of factors that influence the provision of care including geographic location, specialty, patient mix and demographics, health plan design, patient compliance, drug and supply costs, hospital and service costs, professional liability coverage, support staff and other practice costs as well as the potential for mistakes and errors in the data or its attribution, in addition to other relevant factors.
 - (ii) safeguarded to protect against the dissemination of inconsistent, incomplete, invalid or inaccurate physician-specific medical practice data.
 - (c) any physician profiling which draws upon this raw data acknowledges that the data set is not representative of the physicians' entire patient population and uses a methodology that ensures the following:
 - (i) the data are used to profile physicians based on quality of care provided - never on utilization of resources alone - and the degree to which profiling is based on utilization of resources is clearly identified.
 - (ii) data are measured against evidence-based quality of care measures, created by physicians across appropriate specialties.
 - (iii) the data and methodologies used in profiling physicians, including the use of representative and statistically valid sample sizes, statistically valid risk-adjustment methodologies and statistically valid attribution rules produce verifiably accurate results that reflect the quality and cost of care provided by the physicians.
 - (d) any governmental healthcare data shall be protected and shared with physicians before it is released or used, to ensure that physicians are provided with an adequate and timely opportunity to review, respond and appeal the accuracy of the raw data (and its attribution to individual physicians) and any physician profiling results derived from the analysis of physician-specific medical practice data to ensure accuracy prior to their use, publication or release.

Citation: BOT Rep. 18, A-09; Reaffirmed: BOT Rep. 09, A-19; Modified: Speakers Rep., A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 205
(A-22)

Introduced by: New York
Subject: Insurers and Vertical Integration
Referred to: Reference Committee B

1 Whereas, Insurers already enjoy significant marketplace advantages, such as keeping
2 healthcare data opaque from other stakeholders, marketplace consolidation, and monopsony
3 power; and
4
5 Whereas, These advantages have not resulted in cost savings (or even stability) for
6 consumers--in fact cost increases born by consumers have been outsized and correlated with
7 consolidation; and
8
9 Whereas, Insurers have increasingly been pursuing mergers--in the name of promoting
10 efficiency; and
11
12 Whereas, These "efficiencies" rarely, if ever, benefit the consumer; and
13
14 Whereas, These combined entities (especially vertical ones) are more competitive among their
15 competitors than the uncombined ones (accelerating further consolidation); and
16
17 Whereas, The combined entities are also positioned (due to their superior access to capital) to
18 unfairly disrupt entities at other points in the supply chain such as medical practices, community
19 pharmacies, and safety net hospitals; therefore be it
20
21 RESOLVED, That our American Medical Association seek legislation and regulation to prevent
22 health payers (except non-profit HMO's) from owning or operating other entities in the health
23 care supply chain. (Directive to Take Action)

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

Received: 03/22/22

RELEVANT AMA POLICY

Health Insurance Company Purchase by Pharmacy Chains D-160.920

Our AMA will: (1) continue to analyze and identify the ramifications of the proposed CVS/Aetna or other similar merger in health insurance, pharmacy benefit manager (PBM), and retail pharmacy markets and what effects that these ramifications may have on physician practices and on patient care; (2) continue to convene and activate its AMA-state medical association and national medical specialty society coalition to coordinate CVS/Aetna-related advocacy activity; (3) communicate our AMAs concerns via written statements and testimony (if applicable) to the U.S. Department of Justice (DOJ), state attorneys general and departments of insurance; (4) work to secure state level hearings on the merger; and (5) identify and work with national antitrust and other legal and industry experts and allies.

Citation: BOT Action in response to referred for decision Res. 234, I-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 206
(A-22)

Introduced by: New York

Subject: Medicare Advantage Plan Mandates

Referred to: Reference Committee B

1 Whereas, Some municipalities are requiring their retirees to change from traditional Medicare
2 health insurance coverage to Medicare Advantage plans; and
3
4 Whereas, Medicare Advantage plans may have restrictive networks; and
5
6 Whereas, Medicare Advantage plans further privatize patients' Medicare, without discussion or
7 agreement by the persons concerned, all in the interest of saving money for the employer; and
8
9 Whereas, Forcing use of Medicare Advantage plans does not consider the retiree's personal
10 health concerns, including the ability to find continued care with their own doctors or hospitals
11 with whom they may have long relationships; therefore be it
12
13 RESOLVED, That our American Medical Association advocate for federal legislation to ensure
14 that no person should be mandated to change from traditional Medicare to Medicare Advantage
15 plans. (Directive to Take Action)

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

Received: 03/22/22

RELEVANT AMA POLICY

Ending Medicare Advantage Auto-Enrollment H-285.905

Our AMA will work with the Centers for Medicare and Medicaid Services and/or Congress to end the procedure of "auto-enrollment" of individuals into Medicare Advantage Plans.

Citation: Res. 216, I-16

Deemed Participation and Misleading Marketing by Medicare Advantage Private Fee for Service Plans D-330.930

Our AMA will continue its efforts to educate physicians and the general public on the implications of participating in programs offered under Medicare Advantage and educate physicians and the public about the lack of secondary coverage (Medigap policies) with Medicare Advantage plans and how this may affect enrollees.

Citation: BOT Action in response to referred for decision Res. 711, I-06; Reaffirmation A-08;

Modified: CMS Rep. 01, A-19

Elimination of Subsidies to Medicare Advantage Plans D-390.967

1. Our AMA will seek to have all subsidies to private plans offering alternative coverage to Medicare beneficiaries eliminated, that these private Medicare plans compete with traditional

Medicare fee-for-service plans on a financially neutral basis and have accountability to the Centers for Medicare and Medicaid Services.

2. Our AMA will seek to prohibit all private plans offering coverage to Medicare beneficiaries from deeming any physician to be a participating physician without a signed contract specific to that product, and that our AMA work with CMS to prohibit all-products clauses from applying to Medicare Advantage plans and private fee-for-service plans.

Citation: Res. 229, A-07; Modified: CMS Rep. 01, A-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 207
(A-22)

Introduced by: New York

Subject: Physician Tax Fairness

Referred to: Reference Committee B

1 Whereas, In 2018, President Trump signed the Tax Cuts and Jobs Act; and
2
3 Whereas, This legislation includes a tax break for owners of certain pass-through entities, many
4 of which include physician practices structured as such and can include S corporations,
5 partnerships and some limited liability companies; and
6
7 Whereas, This may benefit those who earn below the threshold of \$207,500 or less for a single
8 filer (where the deduction phases out when taxable income exceeds \$157,500) or \$415,000 or
9 less for a married couple filing jointly (where the deduction phases out starting at \$315,000); and
10
11 Whereas, The new tax law disallows this 20% deduction for taxpayers with income above the
12 threshold in specified service businesses which are defined as those in which the principal asset
13 is the reputation or skill of the owners and which category includes physicians; and
14
15 Whereas, Many physicians, especially those in two physician households, will not qualify under
16 the new tax law, and combined with the decrease in the deductions allowed for state and local
17 taxes, home mortgage, etc., many physicians have been adversely affected and will pay more in
18 taxes; and
19
20 Whereas, The effect of this law will be a continued trend of decreased physician self-
21 employment and thus overall lower physician reimbursement; therefore be it
22
23 RESOLVED, That our American Medical Association lobby that physicians be excluded from
24 being considered a specified service business as defined by the Internal Revenue Service.
25 (Directive to Take Action)

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

Received: 03/22/22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 208
(A-22)

Introduced by: New York

Subject: Prohibit Ghost Guns

Referred to: Reference Committee B

1 Whereas, Homemade, difficult to trace firearms are increasingly turning up at crime scenes; and
2
3 Whereas, The most important part of a gun is the lower receiver - the 'chassis' of the weapon,
4 the part housing vital components such as the hammer and trigger; and
5
6 Whereas, Under federal law, the lower receiver is considered a firearm - while other gun
7 components do not require a background check for purchase; and
8
9 Whereas, Dozens of companies sell what are known as "80%" lower receivers - ones that are
10 80% finished, lack a serial number and can be used to make a homemade gun; and
11
12 Whereas, The Gun Control Act (1968) and the Brady Gun Violence Prevention Act (1993) allow
13 for homemade weapons; and
14
15 Whereas, Ghost guns don't have any unique markings and therefore present black holes to
16 police investigators; and
17
18 Whereas, Ghost guns provide an easy avenue for people banned from owning guns to obtain
19 them; and
20
21 Whereas, According to the Bureau of Alcohol, Tobacco, Firearms and Explosives (ATF) 30% of
22 all weapons recovered by the bureau in California were homemade; and
23
24 Whereas, These weapons have been connected with mass shootings, police shootouts and
25 arms trafficking; therefore be it
26
27 RESOLVED, That our American Medical Association support state and federal legislation and
28 regulation that would subject homemade weapons to the same regulations and licensing
29 requirements as traditional weapons. (New HOD Policy)

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

Received: 03/22/22

RELEVANT AMA POLICY

Firearms as a Public Health Problem in the United States - Injuries and Death H-145.997

1. Our AMA recognizes that uncontrolled ownership and use of firearms, especially handguns, is a serious threat to the public's health inasmuch as the weapons are one of the main causes of intentional and unintentional injuries and deaths.

Therefore, the AMA:

- (A) encourages and endorses the development and presentation of safety education programs that will engender more responsible use and storage of firearms;
- (B) urges that government agencies, the CDC in particular, enlarge their efforts in the study of firearm-related injuries and in the development of ways and means of reducing such injuries and deaths;
- (C) urges Congress to enact needed legislation to regulate more effectively the importation and interstate traffic of all handguns;
- (D) urges the Congress to support recent legislative efforts to ban the manufacture and importation of nonmetallic, not readily detectable weapons, which also resemble toy guns; (5) encourages the improvement or modification of firearms so as to make them as safe as humanly possible;
- (E) encourages nongovernmental organizations to develop and test new, less hazardous designs for firearms;
- (F) urges that a significant portion of any funds recovered from firearms manufacturers and dealers through legal proceedings be used for gun safety education and gun-violence prevention; and
- (G) strongly urges US legislators to fund further research into the epidemiology of risks related to gun violence on a national level.

2. Our AMA will advocate for firearm safety features, including but not limited to mechanical or smart technology, to reduce accidental discharge of a firearm or misappropriation of the weapon by a non-registered user; and support legislation and regulation to standardize the use of these firearm safety features on weapons sold for non-military and non-peace officer use within the U.S.; with the aim of establishing manufacturer liability for the absence of safety features on newly manufactured firearms.

Citation: CSA Rep. A, I-87; Reaffirmed: BOT Rep. I-93-50; Appended: Res. 403, I-99; Reaffirmation A-07; Reaffirmation A-13; Appended: Res. 921, I-13; Reaffirmed: CSAPH Rep. 04, A-18; Reaffirmation: A-18; Reaffirmation: I-18; Appended: Res. 405, A-19

Firearm Availability H-145.996

1. Our AMA: (a) advocates a waiting period and background check for all firearm purchasers; (b) encourages legislation that enforces a waiting period and background check for all firearm purchasers; and (c) urges legislation to prohibit the manufacture, sale or import of lethal and non-lethal guns made of plastic, ceramics, or other non-metallic materials that cannot be detected by airport and weapon detection devices.

2. Our AMA supports requiring the licensing/permitting of firearms-owners and purchasers, including the completion of a required safety course, and registration of all firearms.

3. Our AMA supports "gun violence restraining orders" for individuals arrested or convicted of domestic violence or stalking, and supports extreme risk protection orders, commonly known as "red-flag" laws, for individuals who have demonstrated significant signs of potential violence. In supporting restraining orders and "red-flag" laws, we also support the importance of due process so that individuals can petition for their rights to be restored.

Citation: Res. 140, I-87; Reaffirmed: BOT Rep. 8, I-93; Reaffirmed: BOT Rep. 50, I-93; Reaffirmed: CSA Rep. 8, A-05; Reaffirmed: CSAPH Rep. 1, A-15; Modified: BOT Rep. 12, A-16; Appended: Res. 433, A-18; Reaffirmation: I-18; Modified: BOT Rep. 11, I-18

Ban on Handguns and Automatic Repeating Weapons H-145.985

It is the policy of the AMA to:

(1) Support interventions pertaining to firearm control, especially those that occur early in the life of the weapon (e.g., at the time of manufacture or importation, as opposed to those involving possession or use). Such interventions should include but not be limited to:

(a) mandatory inclusion of safety devices on all firearms, whether manufactured or imported into the United States, including built-in locks, loading indicators, safety locks on triggers, and increases in the minimum pressure required to pull triggers;

(b) bans on the possession and use of firearms and ammunition by unsupervised youths under the age of 21;

(c) bans of sales of firearms and ammunition from licensed and unlicensed dealers to those under the age of 21 (excluding certain categories of individuals, such as military and law enforcement personnel);

(d) the imposition of significant licensing fees for firearms dealers;

(e) the imposition of federal and state surtaxes on manufacturers, dealers and purchasers of handguns and semiautomatic repeating weapons along with the ammunition used in such firearms, with the attending revenue earmarked as additional revenue for health and law enforcement activities that are directly related to the prevention and control of violence in U.S. society; and

(f) mandatory destruction of any weapons obtained in local buy-back programs.

(2) Support legislation outlawing the Black Talon and other similarly constructed bullets.

(3) Support the right of local jurisdictions to enact firearm regulations that are stricter than those that exist in state statutes and encourage state and local medical societies to evaluate and support local efforts to enact useful controls.

(4) Oppose concealed carry reciprocity federal legislation that would require all states to recognize concealed carry firearm permits granted by other states and that would allow citizens with concealed gun carry permits in one state to carry guns across state lines into states that have stricter laws.

(5) Support the concept of gun buyback programs as well as research to determine the effectiveness of the programs in reducing firearm injuries and deaths.

Citation: BOT Rep. 50, I-93; Reaffirmed: CSA Rep. 8, A-05; Reaffirmation A-14; Appended: Res. 427, A-18; Reaffirmation: A-18; Modified: Res. 244, A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 209
(A-22)

Introduced by: Medical Student Section

Subject: Supporting Collection of Data on Medical Repatriation

Referred to: Reference Committee B

- 1 Whereas, Forced medical repatriation is the involuntary return of civilians in need of medical
2 treatment to their country of origin by healthcare professionals¹; and
3
- 4 Whereas, Forced medical repatriation results in an involuntary transfer of a patient to a foreign
5 country, provoking an unwarranted intersection between immigration enforcement and the
6 healthcare system²; and
7
- 8 Whereas, Of the estimated 10.5 million undocumented immigrants in the United States in 2017,
9 a study found expenditures on immigrants in 2016 accounted for less than 10% of the overall
10 healthcare spending in a population with the highest risk of being uninsured among the non-
11 elderly population²⁻⁴; and
12
- 13 Whereas, Under the Emergency Medical Treatment and Labor Act of 1986 (EMTALA), federally
14 funded health institutions with emergency care capabilities are mandated to treat all patients
15 with emergent medical conditions who present to their facility until deemed stable, regardless of
16 their insurance coverage or financial status⁵; and
17
- 18 Whereas, Once deemed stable, medical centers must consider medical repatriation if no long-
19 term care alternative is available to the patient as a cost-saving mechanism⁶; and
20
- 21 Whereas, Care centers like St. Joseph's Hospital and Medical Center in Phoenix, Arizona,
22 partake in forced medical repatriation for undocumented immigrant patients and a Florida
23 patient experienced involuntary deportation prior to the completion of their appeal or asylum
24 verdict⁷⁻⁹; and
25
- 26 Whereas, Forced medical repatriation has led to serious medical consequences for patients,
27 including the exacerbation of existing medical conditions^{10,11}; and
28
- 29 Whereas, Patients experienced a lapse and deterioration of care due to the inability of the
30 patient's country of origin to provide adequate treatment and concurrent separation from their
31 community in the U.S. during a time which may require emotional, physical and financial
32 support^{6,7,9,12}; and
33
- 34 Whereas, Hospitals fail to inform patients, or their guardians of potential adverse medical
35 consequences related to repatriation^{7,13}; and
36
- 37 Whereas, Forced medical repatriation increases health disparities among migrant communities
38 and deters immigrants from seeking necessary medical services^{14,15}; and

1 Whereas, Forced medical repatriation often violates the Centers for Medicare and Medicaid
2 Services' Conditions of Participation regulation which commits hospitals to ensure patients have
3 the right to conduct informed decisions regarding their care^{16,17}; and
4

5 Whereas, Forced medical repatriation violates the patient's constitutional right to due process,
6 especially if the patient is able to claim asylum¹⁸; and
7

8 Whereas, The *AMA Journal of Ethics* encourages health care systems to seek routes of care to
9 avoid forced medical repatriation and the *AMA Code of Ethics* Opinion 1.1.8 states that
10 "physicians should resist any discharge requests that are likely to compromise a patient's
11 safety" and that the "discharge plan should be developed without regard to socioeconomic
12 status, immigration status, or other clinically irrelevant considerations"^{2,19,20}; and
13

14 Whereas, The AMA is pursuing policy focused on alternative routes for immigrant healthcare
15 through Health Care Payment for Undocumented Persons (D-440.985) and Federal Funding for
16 Safety Net Care for Undocumented Aliens (H-160.956)^{21,22}; and
17

18 Whereas, Data on repatriation of civilians is not reported through any government agency or
19 otherwise, and there is a lack of documentation^{7,23}; therefore be it
20

21 RESOLVED, That our American Medical Association ask the Department of Health and Human
22 Services to collect and de-identify any and all instances of medical repatriations from the United
23 States to other countries by medical centers to further identify the harms of this practice
24 (Directive to Take Action); and be it further
25

26 RESOLVED, That our AMA denounce the practice of forced medical repatriation. (New HOD
27 Policy)

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

Date Received: 04/08/22

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RELEVANT AMA POLICY

EMTALA -- Major Regulatory and Legislative Developments D-130.982

Our AMA: (1) continue to work diligently to clarify and streamline the EMTALA requirements to which physicians are subject; (2) continue to work diligently with the Department of Health and Human Services (HHS) to further limit the scope of EMTALA, address the underlying problems of emergency care, and provide appropriate compensation and adequate funding for physicians providing EMTALA-mandated services; (3) communicate to physicians its understanding that following inpatient admission of a patient initially evaluated in an emergency department and stabilized, care will not be governed by the EMTALA regulations; and (4) continue strongly advocating to the Federal government that, following inpatient admission of a patient evaluated in an emergency department, where a patient is not yet stable, EMTALA regulations shall not apply.

BOT Rep. 17, I-02, Reaffirmation: A-07, Modified: BOT Rep. 22, A-17

Access to Emergency Services H-130.970

1. Our AMA supports the following principles regarding access to emergency services; and these principles will form the basis for continued AMA legislative and private sector advocacy efforts to assure appropriate patient access to emergency services:

(A) Emergency services should be defined as those health care services that are provided in a hospital emergency facility after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson, who possesses an average knowledge of health and medicine, to result in: (1) placing the patient's health in serious jeopardy; (2) serious impairment to bodily function; or (3) serious dysfunction of any bodily organ or part.

(B) All physicians and health care facilities have an ethical obligation and moral responsibility to provide needed emergency services to all patients, regardless of their ability to pay. (Reaffirmed by CMS Rep. 1, I-96)

(C) All health plans should be prohibited from requiring prior authorization for emergency services.

(D) Health plans may require patients, when able, to notify the plan or primary physician at the time of presentation for emergency services, as long as such notification does not delay the initiation of appropriate assessment and medical treatment.

(E) All health payers should be required to cover emergency services provided by physicians and hospitals to plan enrollees, as required under Section 1867 of the Social Security Act (i.e., medical screening examination and further examination and treatment needed to stabilize an "emergency medical condition" as defined in the Act) without regard to prior authorization or the emergency care physician's contractual relationship with the payer.

(F) Failure to obtain prior authorization for emergency services should never constitute a basis for denial of payment by any health plan or third-party payer whether it is retrospectively determined that an emergency existed or not.

(G) States should be encouraged to enact legislation holding health plans and third-party payers liable for patient harm resulting from unreasonable application of prior authorization requirements or any restrictions on the provision of emergency services.

(H) Health plans should educate enrollees regarding the appropriate use of emergency facilities and the availability of community-wide 911 and other emergency access systems that can be utilized when for any reason plan resources are not readily available.

(I) In instances in which no private or public third-party coverage is applicable, the individual who seeks emergency services is responsible for payment for such services.

2. Our AMA will work with state insurance regulators, insurance companies and other stakeholders to immediately take action to halt the implementation of policies that violate the "prudent layperson" standard of determining when to seek emergency care.

CMS Rep. A, A-89, Modified: CMS Rep. 6, I-95, Reaffirmation: A-97, Reaffirmed: Sub. Res. 707, A-98, Reaffirmed: Res. 705, A-99, Reaffirmed: CMS Rep. 3, I-99, Reaffirmation: A-00, Reaffirmed: Sub. Res. 706, I-00, Amended: Res. 229, A-01, Reaffirmation and Reaffirmed: Res. 708, A-02, Reaffirmed: CMS Rep. 4, A-12, Reaffirmed: CMS Rep. 07, A-16, Appended: Res. 128, A-17, Reaffirmation: A-18, Reaffirmed in lieu of: Res. 807, I-18

Emergency Medical Treatment and Active Labor Act (EMTALA) H-130.950

Our AMA: (1) will seek revisions to the Emergency Medical Treatment and Active Labor Act ((EMTALA)) and its implementing regulations that will provide increased due process protections to physicians before sanctions are imposed under (EMTALA); (2) expeditiously identify solutions to the patient care and legal problems created by current Emergency Medical Treatment and Active Labor Act ((EMTALA)) rules and regulations; (3) urgently seeks return to the original congressional intent of (EMTALA) to prevent hospitals with emergency departments from turning away or transferring patients without health insurance; and (4) strongly opposes any regulatory or legislative changes that would further increase liability for failure to comply with ambiguous (EMTALA) requirements.

Sub. Res. 214, A-97, Reaffirmation: I-98, Reaffirmation: A-99, Appended: Sub. Res. 235 and Reaffirmation A-00, Reaffirmation: A-07, Reaffirmed: BOT Rep. 22, A-17)

Emergency Transfer Responsibilities H-130.957

Our AMA supports seeking amendments to Section 1867 of the Social Security Act, pertaining to patient transfer, to:

- (1) require that the Office of the Inspector General (IG) request and receive the review of the Quality Improvement Organization (QIO) prior to imposing sanctions;
- (2) make the QIO determination in alleged patient transfer violations binding upon the IG;
- (3) expand the scope of QIO review to include a determination on whether the medical benefits reasonably expected from the provision of appropriate medical treatment at another facility outweighed the potential risks;
- (4) restore the knowing standard of proof for physician violation;
- (5) recognize appropriate referral of patients from emergency departments to physician offices;
- (6) clarify ambiguous terms such as emergency medical transfer and stabilized transfer;
- (7) clarify ambiguous provisions regarding the extent of services which must be provided in examining/treating a patient;
- (8) clarify the appropriate role of the on-call specialist, including situations where the on-call specialist may be treating other patients; and
- (9) clarify that a discharge from an emergency department is not a transfer within the meaning of the act.

Sub. Res. 78, A-91, Reaffirmation: A-00, Reaffirmed: BOT Rep. 6, A-10; Modified: BOT Rep. 04, A-20

Repeal of COBRA Anti-Physician Provisions H-130.959

It is the policy of the AMA (1) to seek legal or legislative opportunities to clarify that Section 1867 of the Social Security Act applies only to inappropriate transfers from hospital emergency departments and not to issues of malpractice; and (2) to continue to seek appropriate modifications of Section 1867 of the Social Security Act to preclude liability for discharges from the hospital, including emergency department and outpatient facility.

Sub. Res. 145, I-90, Reaffirmed: Sunset Report, I-00, Reaffirmed: BOT Rep. 6, A-10; Reaffirmed: BOT Rep. 04, A-20

Health Care Payment for Undocumented Persons D-440.985

Our AMA shall assist states on the issue of the lack of reimbursement for care given to undocumented immigrants in an attempt to solve this problem on a national level.

Res. 148, A-02, Reaffirmation: A-07, Reaffirmed: CMS Rep. 1, A-17, Reaffirmation: A-19; Reaffirmation: I-19

Opposition to Criminalization of Medical Care Provided to Undocumented Immigrant Patients H-440.876

1. Our AMA: (a) opposes any policies, regulations or legislation that would criminalize or punish physicians and other health care providers for the act of giving medical care to patients who are undocumented immigrants; (b) opposes any policies, regulations, or legislation requiring physicians and other health care providers to collect and report data regarding an individual patient's legal resident status; and (c) opposes proof of citizenship as a condition of providing health care. 2. Our AMA will work with local and state medical societies to immediately, actively and publicly oppose any legislative proposals that would criminalize the provision of health care to undocumented residents.

Res. 920, I-06, Reaffirmed and Appended: Res. 140, A-07, Modified: CCB/CLRPD, Rep. 2, A-14

Federal Funding for Safety Net Care for Undocumented Aliens H-160.956

Our AMA will lobby Congress to adequately appropriate and dispense funds for the current programs that provide reimbursement for the health care of undocumented aliens.

Sub. Res. 207, A-93, Reaffirmed: BOT Rep. 17, I-94, Reaffirmed: Ref Com B, A-96, Reaffirmation: A-02, Reaffirmation: A-07, Reaffirmed: BOT Rep. 22, A-17, Reaffirmation: A-19; Reaffirmation: I-19

Presence and Enforcement Actions of Immigration and Customs Enforcement (ICE) in Healthcare D-160.921

Our AMA: (1) advocates for and supports legislative efforts to designate healthcare facilities as sensitive locations by law; (2) will work with appropriate stakeholders to educate medical providers on the rights of undocumented patients while receiving medical care, and the designation of healthcare facilities as sensitive locations where U.S. Immigration and Customs Enforcement (ICE) enforcement actions should not occur; (3) encourages healthcare facilities to clearly demonstrate and promote their status as sensitive locations; and (4) opposes the presence of ICE enforcement at healthcare facilities.

Res. 232, I-17)

Addressing Immigrant Health Disparities H-350.957

1. Our American Medical Association recognizes the unique health needs of refugees and encourages the exploration of issues related to refugee health and support legislation and policies that address the unique health needs of refugees.
 2. Our AMA: (A) urges federal and state government agencies to ensure standard public health screening and indicated prevention and treatment for immigrant children, regardless of legal status, based on medical evidence and disease epidemiology; (B) advocates for and publicizes medically accurate information to reduce anxiety, fear, and marginalization of specific populations; and (C) advocates for policies to make available and effectively deploy resources needed to eliminate health disparities affecting immigrants, refugees or asylees.
 3. Our AMA will call for asylum seekers to receive all medically appropriate care, including vaccinations in a patient centered, language and culturally appropriate way upon presentation for asylum regardless of country of origin.
- Res. 804, I-09, Appended: Res. 409, A-15, Reaffirmation: A-19, Appended: Res. 423, A-19; Reaffirmation: I-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 210
(A-22)

Introduced by: Medical Student Section

Subject: Reducing the Prevalence of Sexual Assault by Testing Sexual Assault Evidence Kits

Referred to: Reference Committee B

- 1 Whereas, Rape and/or sexual assault is common in the United States, with between 135,755
2 and 393,980 rapes and/or sexual assaults committed in 2017 alone^{1,2}; and
3
- 4 Whereas, 43.6% of women and 24.8% of men have experienced some form of sexual violence,
5 including unwanted sexual contact of any kind, in their lifetimes³; and
6
- 7 Whereas, Rape and sexual assault are associated with a wide range of medical and
8 psychological sequelae, including direct physical trauma, PTSD, depression, social phobias,
9 mood regulation deficiencies, impaired sexual function, anxiety, self-harm, suicidal ideation and
10 suicide attempts⁴⁻¹⁴; and
11
- 12 Whereas, Data suggests that a significant proportion of rapes and/or sexual assaults are
13 committed by serial offenders¹⁵⁻¹⁹; and
14
- 15 Whereas, Identification and incarceration of perpetrators of violent sexual crimes reduces the
16 incidence of future sexual violence committed by these serial offenders¹⁷⁻²³; and
17
- 18 Whereas, Sexual assault evidence kits (SAEKs), which refer to kits used to collect and store
19 evidence from a victim of sexual assault during a sexual assault forensic examination, are
20 extremely useful in the identification and prosecution of perpetrators of violent sexual crime and
21 are positively associated with successful prosecutions^{17,19,22,23-27}; and
22
- 23 Whereas, Even when suspects cannot be immediately identified on the basis of the DNA
24 signature derived from a SAEK, law enforcement officials can upload the DNA profile to the
25 Federal Bureau of Investigation's Combined DNA Index System (CODIS), which can assist in
26 the later identification of the perpetrator²⁸; and
27
- 28 Whereas, Despite the obvious utility of testing SAEKs, many remain untested and stored in law
29 enforcement evidence warehouses ("backlogged"), with estimates placing the number of
30 backlogged kits as high as 200,000 nationwide^{19,29}; and
31
- 32 Whereas, The cause of backlogged SAEKs have been attributed to lack of standardized policies
33 and procedures, including federal guidelines, inadequate training of law enforcement officers,
34 outdated laboratory policies and lack of resources, such as funding³⁰; and
35
- 36 Whereas, The United States Department of Justice's Violence Against Women Act of 1994
37 (VAWA) and its subsequent reauthorizations provides grants to programs offering medical
38 services to sexual assault survivors contingent on those programs incurring the full cost of
39 forensic medical exams through the offices of State Attorney's General³¹⁻³³; and

1 Whereas, Standardized insurance billing procedures that include copays and other cost-sharing
2 payments cause victims of sexual assault to be billed for part of the cost of testing forensic
3 evidence, notwithstanding federal mandates like VAWA^{34,35}; and
4

5 Whereas, The Bureau of Justice Assistance in the US Department of Justice administers the
6 Sexual Assault Kit Initiative (SAKI), a grant program that assists police departments in testing
7 backlogged SAEKs, has resulted in the disbursement of \$43 million and the testing of 50,500
8 kits⁴⁰⁻⁴²; and
9

10 Whereas, Counties that have voluntarily worked to test all backlogged SAEKs in their
11 possession have been extraordinarily successful in solving previously unsolved rapes and
12 sexual assaults^{17,19,21,22,36-40}; and
13

14 Whereas, Many of these SAEKs, if tested earlier, would have led to the identification and
15 incarceration of serial offenders that would have prevented later assaults^{17,19-22,36-38}; and
16

17 Whereas, The \$9.6 million SAEK testing initiative in Cuyahoga County, Ohio financed new
18 forensic examinations in addition to comprehensive coverage of investigations on
19 backlogged kits with a net estimated savings of \$38.7 million, highlighting the cost effectiveness
20 of testing SAEKs^{41,42}; and
21

22 Whereas, Existing AMA Policy H-80.999 outlines the rights of sexual assault victims but neither
23 explicitly describes the right to have collected medical forensic evidence be tested in a timely
24 manner nor addresses the backlog of untested sexual assault evidence kits; therefore be it

1 RESOLVED, That our American Medical Association amend Policy H-80.999, "Sexual Assault
2 Survivors," by addition to read as follows:

3
4 H-80.999 – SEXUAL ASSAULT SURVIVORS

- 5 1. Our AMA supports the preparation and dissemination of information and best
6 practices intended to maintain and improve the skills needed by all practicing
7 physicians involved in providing care to sexual assault survivors.
8 2. Our AMA advocates for the legal protection of sexual assault survivors' rights and
9 work with state medical societies to ensure that each state implements these
10 rights, which include but are not limited to, the right to: (a) receive a medical
11 forensic examination free of charge, which includes but is not limited to HIV/STD
12 testing and treatment, pregnancy testing, treatment of injuries, and collection of
13 forensic evidence; (b) preservation of a sexual assault evidence collection kit for
14 at least the maximum applicable statute of limitations (c) notification of any
15 intended disposal of a sexual assault evidence kit with the opportunity to be
16 granted further preservation; (d) be informed of these rights and the policies
17 governing the sexual assault evidence kit; and (e) access to emergency
18 contraception information and treatment for pregnancy prevention.
19 3. Our AMA will collaborate with relevant stakeholders to develop recommendations
20 for implementing best practices in the treatment of sexual assault survivors,
21 including through engagement with the joint working group established for this
22 purpose under the Survivor's Bill of Rights Act of 2016.
23 4. Our AMA will advocate for increased post-pubertal patient access to Sexual
24 Assault Nurse Examiners, and other trained and qualified clinicians, in the
25 emergency department for medical forensic examinations.
26 5. Our AMA will advocate at the state and federal level for (a) the immediate
27 processing of all "backlogged" and new sexual assault examination kits; and (b)
28 additional funding to facilitate the immediate testing of sexual assault evidence
29 kits. (Modify Current HOD Policy)

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

Date Received: 04/08/22

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RELEVANT AMA POLICY

Sexual Assault Survivors H-80.999

1. Our AMA supports the preparation and dissemination of information and best practices intended to maintain and improve the skills needed by all practicing physicians involved in providing care to sexual assault survivors.
 2. Our AMA advocates for the legal protection of sexual assault survivors' rights and work with state medical societies to ensure that each state implements these rights, which include but are not limited to, the right to: (a) receive a medical forensic examination free of charge, which includes but is not limited to HIV/STD testing and treatment, pregnancy testing, treatment of injuries, and collection of forensic evidence; (b) preservation of a sexual assault evidence collection kit for at least the maximum applicable statute of limitation; (c) notification of any intended disposal of a sexual assault evidence kit with the opportunity to be granted further preservation; (d) be informed of these rights and the policies governing the sexual assault evidence kit; and (e) access to emergency contraception information and treatment for pregnancy prevention.
 3. Our AMA will collaborate with relevant stakeholders to develop recommendations for implementing best practices in the treatment of sexual assault survivors, including through engagement with the joint working group established for this purpose under the Survivor's Bill of Rights Act of 2016.
 4. Our AMA will advocate for increased post-pubertal patient access to Sexual Assault Nurse Examiners, and other trained and qualified clinicians, in the emergency department for medical forensic examinations.
- Sub. Res. 101, A-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CSAPH Rep. 1, A-10; Modified: Res. 202, I-17; Appended: Res. 902, I-18

Sexual Assault Survivor Services H-80.998

Our AMA supports the function and efficacy of sexual assault survivor services, supports state adoption of the sexual assault survivor rights established in the Survivors' Bill of Rights Act of 2016, encourages sexual assault crisis centers to continue working with local police to help sexual assault survivors, and encourages physicians to support the option of having a counselor present while the sexual assault survivor is receiving medical care.

Res. 56, A-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: CSA Rep. 8, A-05; Reaffirmed: CSAPH Rep. 1, A-15; Modified: Res. 202, I-17

Addressing Sexual Assault on College Campuses H-515.956

Our AMA: (1) supports universities' implementation of evidence-driven sexual assault prevention programs that specifically address the needs of college students and the unique challenges of the collegiate setting; (2) will work with relevant stakeholders to address the issues of rape, sexual abuse, and physical abuse on college campuses; and (2) will strongly express our concerns about the problems of rape, sexual abuse, and physical abuse on college campuses.

Res. 402, A-16; Appended: Res. 424, A-18

HIV, Sexual Assault and Violence H-20.900

Our AMA: (1) believes that HIV testing and Post-Exposure Prophylaxis (PEP) should be offered to all survivors of sexual assault who present within 72 hours of a substantial exposure risk, that these survivors should be encouraged to be retested in six months if the initial test is negative, and that strict confidentiality of test results be maintained; and (2) supports: (a) education of physicians about the effective use of HIV Post-Exposure Prophylaxis (PEP) and the U.S. PEP Clinical Practice Guidelines, and (b) increased access to, and coverage for, PEP for HIV, as well as enhanced public education on its effective use.

CSA Rep. 4, A-03; Modified: CSAPH Rep. 1, A-13; Modified: Res. 905, I-18

Access to Emergency Contraception H-75.985

It is the policy of our AMA: (1) that physicians and other health care professionals should be encouraged to play a more active role in providing education about emergency contraception, including access and informed consent issues, by discussing it as part of routine family planning and contraceptive counseling; (2) to enhance efforts to expand access to emergency contraception, including making emergency contraception pills more readily available through pharmacies, hospitals, clinics, emergency rooms, acute care centers, and physicians' offices; (3) to recognize that information about emergency contraception is part of the comprehensive information to be provided as part of the emergency treatment of sexual assault victims; (4) to support educational programs for physicians and patients regarding treatment options for the emergency treatment of sexual assault victims, including information about emergency contraception; and (5) to encourage writing advance prescriptions for these pills as requested by their patients until the pills are available over-the-counter.

CMS Rep. 1, I-00; Appended: Res. 408, A-02; Modified: Res. 443, A-04; Reaffirmed: CSAPH Rep. 1, A-14

Insurance Discrimination Against Victims of Domestic Violence H-185.976

Our AMA: (1) opposes the denial of insurance coverage to victims of domestic violence and abuse and seeks federal legislation to prohibit such discrimination; and (2) advocates for equitable coverage and appropriate reimbursement for all health care, including mental health care, related to family and intimate partner violence.

Res. 814, I-94; Appended: Res. 419, I-00; Reaffirmation A-09; Reaffirmed: CMS Rep. 01, A-19

AMA Code of Medical Ethics 8.10 Preventing, Identifying and Treating Violence and Abuse

All patients may be at risk for interpersonal violence and abuse, which may adversely affect their health or ability to adhere to medical recommendations. In light of their obligation to promote the well-being of patients, physicians have an ethical obligation to take appropriate action to avert the harms caused by violence and abuse.

To protect patients' well-being, physicians individually should:

(a) Become familiar with:

- (i) how to detect violence or abuse, including cultural variations in response to abuse;
- (ii) community and health resources available to abused or vulnerable persons;
- (iii) public health measures that are effective in preventing violence and abuse;
- (iv) legal requirements for reporting violence or abuse.

(b) Consider abuse as a possible factor in the presentation of medical complaints.

(c) Routinely inquire about physical, sexual, and psychological abuse as part of the medical history.

(d) Not allow diagnosis or treatment to be influenced by misconceptions about abuse, including beliefs that abuse is rare, does not occur in "normal" families, is a private matter best resolved without outside interference, or is caused by victims' own actions.

(e) Treat the immediate symptoms and sequelae of violence and abuse and provide ongoing care for patients to address long-term consequences that may arise from being exposed to violence and abuse.

(f) Discuss any suspicion of abuse sensitively with the patient, whether or not reporting is legally mandated, and direct the patient to appropriate community resources.

(g) Report suspected violence and abuse in keeping with applicable requirements. Before doing so, physicians should:

- (i) inform patients about requirements to report;

(ii) obtain the patient's informed consent when reporting is not required by law. Exceptions can be made if a physician reasonably believes that a patient's refusal to authorize reporting is coerced and therefore does not constitute a valid informed treatment decision.

(h) Protect patient privacy when reporting by disclosing only the minimum necessary information.

Collectively, physicians should:

(i) Advocate for comprehensive training in matters pertaining to violence and abuse across the continuum of professional education.

(j) Provide leadership in raising awareness about the need to assess and identify signs of abuse, including advocating for guidelines and policies to reduce the volume of unidentified cases and help ensure that all patients are appropriately assessed.

(k) Advocate for mechanisms to direct physicians to community or private resources that might be available to aid their patients.

(l) Support research in the prevention of violence and abuse and collaborate with public health and community organizations to reduce violence and abuse.

(m) Advocate for change in mandatory reporting laws if evidence indicates that such reporting is not in the best interests of patients.

Issued: 2016

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 211
(A-22)

Introduced by: American Academy of Neurology, American Academy of Orthopaedic Surgeons, American Academy of Otolaryngology-Head and Neck Surgery, American Academy of Physical Medicine and Rehabilitation, American Association of Neurological Surgeons, American College of Cardiology, American College of Emergency Physicians, American College of Physicians, American College of Surgeons, American Gastroenterological Association, American Society for Gastrointestinal Endoscopy, American Society for Surgery of the Hand, American Society of Echocardiography, American Society of Nuclear Cardiology, American Urological Association, California, Congress of Neurological Surgeons, North American Spine Society, Society for Cardiovascular Angiography & Interventions, Society of Cardiovascular Computed Tomography, Washington

Subject: Repeal or Modification of the Medicare Appropriate Use Criteria (AUC) Program

Referred to: Reference Committee B

1 Whereas, In 2014, Congress passed the Protecting Access to Medicare Act (PAMA) [Public
2 Law 113-93], establishing the Medicare Appropriate Use Criteria (AUC) Program for advanced
3 diagnostic imaging; and
4

5 Whereas, Eight years after PAMA's enactment, the Centers for Medicare & Medicaid Services
6 (CMS) continues to face challenges in completing the rulemaking and implementation of the
7 AUC program, fueling existing concerns about the complexity of the law, associated costs, and
8 regulatory burden sustained by physicians and other health care providers to meet the program
9 requirements; and
10

11 Whereas, The AUC program, if ever fully implemented, would impact a substantial number of
12 clinicians, as it would apply to every clinician who orders or furnishes an advanced diagnostic
13 imaging test, unless a statutory or hardship exemption applies; and
14

15 Whereas, Practitioners whose ordering patterns are considered outliers will be subject to prior
16 authorization--at a time when physicians are working to advance policies that reduce the
17 administrative burdens associated with prior authorization; and
18

19 Whereas, The program will be a financial burden for many practices, as it is estimated to cost
20 \$75,000 or more for a practice to implement a Clinical Decision Support Mechanism (CDSM)
21 that complies with the AUC Program rules¹; and
22

23 Whereas, The law is prescriptive, requiring clinicians to use only CDSMs qualified by CMS and
24 only AUC developed by certain qualified entities--preventing the use of other clinical decision
25 support tools and evidenced-based guidelines for advanced diagnostic imaging developed by
26 medical societies and other health care institutions; and

¹ Association for Medical Imaging Management; 2017 <https://ahralink.files.wordpress.com/2017/03/cds-survey-2017.pdf>

1 Whereas, The AUC program creates a complex exchange of information between clinicians that
2 is not yet supported by interoperable electronic health record systems and relies on claims-
3 based reporting at a time when CMS is migrating from claims reporting for quality data; and
4

5 Whereas, Since PAMA's enactment, the AUC program has become obsolete given the
6 subsequent enactment of the Medicare Access and CHIP Reauthorization Act (MACRA) of
7 2015 and the rise of new health care payment and delivery models via the Quality Payment
8 Program (QPP) (alternative payment models and Merit-based Incentive Payment System)
9 designed to hold clinicians responsible for health care resource use; and
10

11 Whereas, Five years after the program's intended start date, technical challenges, including the
12 need for claims processing edits to prevent claim denials, have further eroded physician
13 confidence in and support for the program; and
14

15 Whereas, Awareness of the program among physicians and other health care professionals
16 remains low, which is supported by CMS' estimate--based on CY2020 Medicare claims during
17 the program's education and operations testing phase--that between 9-10 percent of all claims
18 subject to the AUC program reported information sufficient to be considered compliant with the
19 program; and
20

21 Whereas, In the CY 2022 Medicare Physician Fee Schedule final rule, CMS finalized its
22 proposal to begin the payment penalty phase of the AUC program until the later of January 1,
23 2023, or the January 1 of the year following the end of the COVID-19 public health emergency;
24 and
25

26 Whereas, Congress and CMS must seriously consider the degree to which the AUC program
27 and QPP requirements overlap and create duplicative reporting burdens for physicians already
28 overwhelmed by the variety of other administrative burdens associated with care delivery; and
29

30 Whereas, There is widespread agreement in the medical community that the program cannot be
31 implemented as originally envisioned without imposing undue burden and cost on physician
32 practices; therefore be it
33

34 RESOLVED, That our American Medical Association Policy H-320.940, "Medicare's Appropriate
35 Use Criteria Program," be amended by addition and deletion to read as follows:
36

37 Our AMA will continue to advocate to Congress for delay the effective date either the
38 full repeal of the Medicare Appropriate Use Criteria (AUC) Program or legislative
39 modifications to the program in such a manner that until the Centers for Medicare &
40 Medicaid Services (CMS) can adequately address technical and workflow
41 challenges, with its implementation and any interaction between maximizes alignment
42 with the Quality Payment Program (QPP), and the use of advanced diagnostic imaging
43 appropriate use criteria, creates provider flexibility for the consultation of AUC or
44 advanced diagnostic imaging guidelines using a mechanism best suited for their
45 practice, specialty and workflow. (Modify Current HOD Policy)

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

Received: 04/08/22

RELEVANT AMA POLICY

Medicare's Appropriate Use Criteria Program H-320.940

Our AMA will continue to advocate to delay the effective date of the Medicare Appropriate Use Criteria (AUC) Program until the Centers for Medicare & Medicaid Services (CMS) can adequately address technical and workflow challenges with its implementation and any interaction between the Quality Payment Program (QPP) and the use of advanced diagnostic imaging appropriate use criteria.

Citation: Res. 229, A-17; Reaffirmed - BOT Action in response to referred for decision: Res. 245, A-19 and Res. 247, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 212
(A-22)

Introduced by: Michigan

Subject: Medication for Opioid Use Disorder in Physician Health Programs

Referred to: Reference Committee B

1 Whereas, Physician Health Programs (PHPs) are designed to allow physicians with potentially
2 impairing conditions who either come forward or are referred to be given the opportunity for
3 evaluation, rehabilitation, treatment, and monitoring without disciplinary action in an anonymous,
4 confidential, and respectful manner; and

5
6 Whereas, The PHP model is intended to ensure participants receive effective clinical care for
7 mental, physical, and substance abuse disorders and access to a variety of clinical interventions
8 and support; and

9
10 Whereas, Currently, physicians referred to PHPs who are diagnosed with opioid use disorder
11 (OUD) involving monitoring or sanctions may be subjected to punitive action by their respective
12 licensing boards; and

13
14 Whereas, The stigma associated with illness and impairment, particularly impairment resulting
15 from mental illness, including substance use disorders, can be a powerful obstacle to seeking
16 treatment, especially in the medical community where the presence of this stigma has been
17 described in the literature; and

18
19 Whereas, The US Food and Drug Administration recommends approved medications for the
20 treatment of opioid use disorder (MOUD) including methadone, buprenorphine, and naltrexone
21 be available to all patients; and

22
23 Whereas, MOUD has been proven to help maintain recovery and prevent death in patients with
24 opioid use disorder (OUD); and

25
26 Whereas, It is reported that patients who use MOUD remain in therapy longer than those who
27 do not, and are less likely to use illicit opioids; and

28
29 Whereas, A 2019 report from the National Academies of Sciences, Engineering, and Medicine
30 stated that “there is no scientific evidence that justifies withholding medications from OUD
31 patients in any setting” and that such practices amount to “denying appropriate medical
32 treatment,” and that such practices amount to “denying appropriate medical treatment”; and

33
34 Whereas, Clinicians should consider a patient’s preferences, past treatment history, current
35 state of illness, and treatment setting when deciding between the use of methadone,
36 buprenorphine, and naltrexone; and

37
38 Whereas, Additional considerations apply to health professionals who are actively engaged in,
39 or planning to return to, safety sensitive work; and

1 Whereas, Treatment programs offering the best possible outcomes are critical to ensuring a
2 pathway to recovery and continuation of clinical practice in a safe and ethical manner with
3 patient protection at the forefront; and
4

5 Whereas, The American Society of Addiction Medicine's *Public Policy Statement on Physicians*
6 *and other Healthcare Professionals with Addiction* includes the recommendation that
7 "Healthcare professionals should be offered the full range of evidence-based treatments,
8 including medication for addiction, in whatever setting they receive treatment. Regulatory
9 agencies (including state licensing boards), professional liability insurers, and credentialing
10 bodies should not discriminate against the type of treatment an individual receives based on
11 unjustified assumptions that certain treatments cause impairment;" therefore be it
12

13 RESOLVED, That our American Medical Association reaffirm policy H-95.913, "Discrimination
14 Against Physicians in Treatment with Medication for Opioid Use Disorders" (Reaffirm HOD
15 Policy); and be it further
16

17 RESOLVED, That our AMA modify policy D-405.990, "Educating Physicians About Physician
18 Health Programs and Advocating for Standards," by addition to read as follows:
19

20 Our AMA will:

21 (1) work closely with the Federation of State Physician Health Programs (FSPHP) to
22 educate our members as to the availability and services of state physician health
23 programs to continue to create opportunities to help ensure physicians and medical
24 students are fully knowledgeable about the purpose of physician health programs
25 and the relationship that exists between the physician health program and the
26 licensing authority in their state or territory;

27 (2) continue to collaborate with relevant organizations on activities that address
28 physician health and wellness;

29 (3) in conjunction with the FSPHP, develop model state legislation and/or legislative
30 guidelines addressing the design and implementation of physician health programs
31 including, but not limited to, the allowance for safe-haven or non-reporting of
32 physicians to a licensing board, and/or acceptance of Physician Health Program
33 compliance as an alternative to disciplinary action when public safety is not at risk,
34 and especially for any physicians who voluntarily self-report their physical, mental,
35 and substance use disorders and engage with a Physician Health Program and who
36 successfully complete the terms of participation;

37 (4) work with FSPHP to develop messaging for all Federation members to consider
38 regarding elimination of stigmatization of mental illness and illness in general in
39 physicians and physicians in training;

40 (5) continue to work with and support FSPHP efforts already underway to design
41 and implement the physician health program review process, Performance
42 Enhancement and Effectiveness Review (PEER™), to improve accountability,
43 consistency and excellence among its state member PHPs. The AMA will partner
44 with the FSPHP to help advocate for additional national sponsors for this project;
45 and

46 (6) continue to work with the FSPHP and other appropriate stakeholders on issues
47 of affordability, cost effectiveness, and diversity of treatment options. (Modify
48 Current HOD Policy)

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

Received: 04/08/22

RELEVANT AMA POLICY

Discrimination Against Physicians in Treatment with Medication for Opioid Use Disorders (MOUD) H-95.913

1. Our AMA affirms: (a) that no physician or medical student should be presumed to be impaired by substance or illness solely because they are diagnosed with a substance use disorder; and (b) that no physician or medical student should be presumed impaired because they and their treating physician have chosen medication for opioid use disorder (MOUD) to address the substance use disorder, including but not limited to methadone and buprenorphine.
2. Our AMA strongly encourages the leadership of physician health and wellness programs, state medical boards, hospital and health system credentialing bodies, and employers to help end stigma and discrimination against physicians and medical students with substance use disorders and allow and encourage the usage of medication for opioid use disorder (MOUD), including but not limited to methadone or buprenorphine, when clinically appropriate and as determined by the physician or medical student (as patient) and their treating physician, without penalty (such as restriction of privileges, licensure, ability to prescribe medications or other treatments, or other limits on their ability to practice medicine), solely because the physician's or medical student's treatment plan includes MOUD.
3. Our AMA will survey physician health programs and state medical boards and report back about the prevalence of MOUD among physicians under monitoring for OUD, types of MAT utilized, and practice limitations or other punitive measures, if any, imposed solely on the basis of medication choice.

Citation: Res. 001, A-21

Educating Physicians About Physician Health Programs and Advocating for Standards D-405.990

Our AMA will:

- (1) work closely with the Federation of State Physician Health Programs (FSPHP) to educate our members as to the availability and services of state physician health programs to continue to create opportunities to help ensure physicians and medical students are fully knowledgeable about the purpose of physician health programs and the relationship that exists between the physician health program and the licensing authority in their state or territory;
- (2) continue to collaborate with relevant organizations on activities that address physician health and wellness;
- (3) in conjunction with the FSPHP, develop state legislative guidelines addressing the design and implementation of physician health programs;
- (4) work with FSPHP to develop messaging for all Federation members to consider regarding elimination of stigmatization of mental illness and illness in general in physicians and physicians in training;
- (5) continue to work with and support FSPHP efforts already underway to design and implement the physician health program review process, Performance Enhancement and Effectiveness Review (PEER™), to improve accountability, consistency and excellence among its state member PHPs. The AMA will partner with the FSPHP to help advocate for additional national sponsors for this project; and
- (6) continue to work with the FSPHP and other appropriate stakeholders on issues of affordability, cost effectiveness, and diversity of treatment options.

Citation: Res. 402, A-09; Modified: CSAPH Rep. 2, A-11; Reaffirmed in lieu of Res. 412, A-12; Appended: BOT action in response to referred for decision Res. 403, A-12; Reaffirmed: BOT Rep. 15, A-19; Modified: Res. 321, A-19

Physician Impairment H-95.955

(1) The AMA defines physician impairment as any physical, mental or behavioral disorder that interferes with ability to engage safely in professional activities and will address all such conditions in its Physician Health Program.

(2) The AMA encourages state medical society-sponsored physician health and assistance programs to take appropriate steps to address the entire range of illnesses with the potential to cause impairment that affect physicians, to develop case finding mechanisms for all types of physician impairments, and to collect data on the prevalence of conditions affecting physician health.

(3) The AMA encourages additional research in the area of physician illness with the potential to cause impairment, particularly in the type and impact of external factors adversely affecting physicians, including workplace stress, litigation issues, and restructuring of the health care delivery systems.

Citation: CSA Rep. 1, A-95; Reaffirmed: BOT Rep. 17, I-99; Reaffirmed: CSAPH Rep. 1, A-09; Reaffirmed: BOT Rep. 15, A-19; Modified: CSAPH Rep. 01, A-19

Support the Elimination of Barriers to Medication-Assisted Treatment for Substance Use Disorder D-95.968

1. Our AMA will: (a) advocate for legislation that eliminates barriers to, increases funding for, and requires access to all appropriate FDA-approved medications or therapies used by licensed drug treatment clinics or facilities; and (b) develop a public awareness campaign to increase awareness that medical treatment of substance use disorder with medication-assisted treatment is a first-line treatment for this chronic medical disease.

2. Our AMA supports further research into how primary care practices can implement medication-assisted treatment (MAT) into their practices and disseminate such research in coordination with primary care specialties.

3. The AMA Opioid Task Force will increase its evidence-based educational resources focused on methadone maintenance therapy (MMT) and publicize those resources to the Federation.

Citation: Res. 222, A-18; Appended: BOT Rep. 02, I-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 213
(A-22)

Introduced by: Michigan

Subject: Resentencing for Individuals Convicted of Marijuana-Based Offenses

Referred to: Reference Committee B

1 Whereas, Incarceration is a key issue under the domain of Social and Community Context in the
2 Social Determinants of Health topic area of Healthy People 2020 due to numerous disparities in
3 inmate mental and physical health compared to the population, as well as the increased rate of
4 mental health disorders in the children of incarcerated parents; and

5
6 Whereas, There is a clear link between incarceration and health, with incarcerated individuals
7 showing higher risk of chronic conditions such as cardiovascular disease, hypertension, and
8 cancer compared to the general population; a study in March 2013 found that each additional
9 year an individual spends in prison corresponds with a decline in life expectancy by two years;
10 and

11
12 Whereas, Incarcerated populations are particularly vulnerable to the coronavirus disease 2019
13 (COVID-19) given the demographics of those experiencing incarceration in addition to the
14 inability to properly "social distance", high population turnover, unsanitary living conditions, poor
15 ventilation systems, inability or inadequacy to properly test and track COVID-19 cases and
16 exposure which have led to an estimated 113,664 COVID-19 cases and 887 related deaths
17 among incarcerated people as of August 2020; and

18
19 Whereas, Arrests for marijuana possession, regardless of whether the person was later
20 convicted on these charges, have been shown to negatively impact opportunities such as
21 finding employment, housing, and obtaining student loans, which can lead to widespread and
22 multifactorial individual health consequences; furthermore, criminalization of drug use is
23 associated with increased stigma and discrimination of drug users and that stigma and
24 discrimination is also a causal factor for decreased mental and physical health; and

25
26 Whereas, Nationally, African Americans are three times more likely to be arrested for marijuana
27 possession than Whites, a finding that cannot be explained by differences in use; and

28
29 Whereas, A 2014 report by the National Research Council found that mandatory minimum
30 sentences for drug offenders "have few, if any, deterrent effects;" and

31
32 Whereas, Eighteen states, two territories, and the District of Columbia have legalized the use of
33 recreational and medicinal marijuana, and in the past four years, 23 states have passed laws
34 addressing expungement of certain marijuana convictions, pairing these laws with other policies
35 to its decriminalization or legalization; and

36
37 Whereas, In 2018, California became the first state to enact legislation ordering its Department
38 of Justice to conduct a review of criminal records and identify past convictions eligible for
39 sentence dismissal or re-designation in accordance with the Adult Use of Marijuana Act; the
40 outcomes of this legislation showed that reductions in criminal penalties for drug possession

1 reduce racial and ethnic disparities in the criminal justice system, allowing for improvements in
2 health inequalities linked to social determinants of health; and

3
4 Whereas, Illinois passed a bill in May 2019, to expunge convictions for non-violent crimes of
5 possession, manufacturing, and distribution of up to 30 grams and possession up to 500 grams,
6 and Colorado and Massachusetts have approved legislation allowing individuals convicted for
7 possession to petition to seal criminal records of misdemeanor offenses that are no longer
8 considered crimes; and

9
10 Whereas, A recent study examining the impact of this type of expungement found that those
11 who do obtain expungement have extremely low subsequent crime rates and experience a
12 significant increase in their wage and employment trajectories and an overall positive impact on
13 the lives of those affected; however, of those legally eligible for expungement, only 6.5 percent
14 obtain it within five years of eligibility, findings that support the development of “automatic”
15 expungement procedures; and

16
17 Whereas, Those who have received resentencing for past offenses, including decriminalized
18 marijuana-based charges, have experienced an increase of 22 percent in wages on average
19 within one year of resentencing as well as lower subsequent crime rates that compare favorably
20 to the general population; and

21
22 Whereas, Our AMA has policy (H-95.924) supporting public health-based strategies, rather than
23 incarceration, in the handling of individuals possessing cannabis for personal use and
24 encouraging research on the impact of legalization and decriminalization of cannabis in an effort
25 to promote public health and public safety; and

26
27 Whereas, Legislation has been considered at the federal level to, among other provisions,
28 remove marijuana from the list of controlled substances under the Controlled Substances Act
29 and create an opportunity for individuals with marijuana law convictions to petition for
30 expungement and resentencing; therefore be it

31
32 RESOLVED, That our American Medical Association adopt policy supporting the expungement,
33 destruction, or sealing of criminal records for marijuana offenses that would now be considered
34 legal (New HOD Policy); and be it further

35
36 RESOLVED, That our AMA adopt policy supporting the elimination of violations or other
37 penalties for persons under parole, probation, pre-trial, or other state or local criminal
38 supervision for a marijuana offense that would now be considered legal. (New HOD Policy)

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

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RELEVANT AMA POLICY

Cannabis Legalization for Adult Use (commonly referred to as recreational use) H-95.924

Our AMA: (1) believes that cannabis is a dangerous drug and as such is a serious public health concern; (2) believes that the sale of cannabis for adult use should not be legalized (with adult defined for these purposes as age 21 and older); (3) discourages cannabis use, especially by persons vulnerable to the drug's effects and in high-risk populations such as youth, pregnant women, and women who are breastfeeding; (4) believes states that have already legalized cannabis (for medical or adult use or both) should be required to take steps to regulate the product effectively in order to protect public health and safety including but not limited to: regulating retail sales, marketing, and promotion intended to encourage use; limiting the potency of cannabis extracts and concentrates; requiring packaging to convey meaningful and easily understood units of consumption, and requiring that for commercially available edibles, packaging must be child-resistant and come with messaging about the hazards about unintentional ingestion in children and youth; (5) laws and regulations related to legalized cannabis use should consistently be evaluated to determine their effectiveness; (6) encourages local, state, and federal public health agencies to improve surveillance efforts to ensure data is available on the short- and long-term health effects of cannabis, especially emergency department visits and hospitalizations, impaired driving, workplace impairment and worker-related injury and safety, and prevalence of psychiatric and addictive disorders, including cannabis use disorder; (7) supports public health based strategies, rather than incarceration, in the handling of individuals possessing cannabis for personal use; (8) encourages research on the impact of legalization and decriminalization of cannabis in an effort to promote public health and public safety; (9) encourages dissemination of information on the public health impact of legalization and decriminalization of cannabis; (10) will advocate for stronger public health messaging on the health effects of cannabis and cannabinoid inhalation and ingestion, with an emphasis on reducing initiation and frequency of cannabis use among adolescents, especially high potency products; use among women who are pregnant or contemplating pregnancy; and avoiding cannabis-impaired driving; (11) supports social equity programs to address the impacts of cannabis prohibition and enforcement policies that have disproportionately impacted marginalized and minoritized communities; and (12) will coordinate with other health organizations to develop resources on the impact of cannabis on human health and on methods for counseling and educating patients on the use cannabis and cannabinoids.

Citation: CSAPH Rep. 05, I-17; Appended: Res. 913, I-19; Modified: CSAPH Rep. 4, I-20

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 214
(A-22)

Introduced by: Ohio

Subject: Eliminating Unfunded or Unproven Mandates and Regulations

Referred to: Reference Committee B

1 Whereas, Beginning in 2020, Centers for Medicare and Medicaid Services (CMS) will be
2 demanding that “providers” utilize approved “technology” using practice guidelines when
3 ordering imaging studies; and
4

5 Whereas, Such guidelines represent an unfunded mandate for physicians already struggling
6 with massive governmental regulatory burden and underpayment; and
7

8 Whereas, These technologies or “Augmented Intelligence,” are limited in their ability to apply
9 clinical context, thus limiting a physician’s ability to order appropriate testing under unique
10 circumstances and stagnating their work-flow, placing patients at risk; and
11

12 Whereas, The technology required for this mandatory decision support is extremely expensive,
13 especially for smaller and independent physician practices; therefore be it
14

15 RESOLVED, That our American Medical Association advocate for policies that allow for
16 physician judgment and documented medical decision-making to supersede government
17 regulation--including the utilization of Augmented Intelligence--in instances of disputes in patient
18 care (Directive to Take Action); and be it further
19

20 RESOLVED, That our AMA advocate for policies that require “proof of concept,” in the form of
21 independently demonstrated quality improvement, prior to the implementation of any
22 government, insurance company or other third party mandate or regulation on patient care and
23 the physician-patient relationship (Directive to Take Action); and be it further
24

25 RESOLVED, That our AMA advocate for policies requiring government, insurance company or
26 other third party entities to fully fund any mandates or regulations imposed on patient care and
27 the physician-patient relationship. (Directive to Take Action)

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

Received: 04/08/22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 215
(A-22)

Introduced by: American College of Cardiology, American Society of Echocardiography, American Society of Nuclear Cardiology, Heart Rhythm Society, Society for Cardiovascular Angiography and Interventions, Society of Cardiovascular Computed Tomography

Subject: Transforming Professional Licensure to the 21st Century

Referred to: Reference Committee B

1 Whereas, The US Supreme Court in 1889 affirmed the power of individual states to regulate
2 medical practice within their borders, in conjunction with the exercise of appropriate professional
3 responsibility by local medical societies and all practicing physicians, to protect the public health
4 and safety; and
5

6 Whereas, The Flexner Report of 1911 transformed the nature and process of medical education
7 in America to a comprehensive national standard, with national medical board examinations,
8 nationally accredited residency programs and national certifications from medical specialty
9 boards; and
10

11 Whereas, Individual state medical boards, having verified an applicant's standardized general
12 medical training, professional character and compliance with local state regulations, issue broad
13 general medical licenses which are not specialty specific nor tailored to anticipated need for
14 direct physical interaction or face-to-face contact between the patient and the professional being
15 licensed; and
16

17 Whereas, Individual state medical boards also evaluate a licensed physician's ongoing
18 professional conduct, reviewing complaints from patients, malpractice data, information from
19 hospitals and other health care institution and reports from government agencies, imposing
20 discipline as necessary to protect the public; and
21

22 Whereas, Congress established the National Practitioner Data Bank in 1986 as a nationwide
23 repository for reports containing information on medical malpractice payments and certain
24 adverse actions related to health care practitioners, providers, and suppliers in order to improve
25 health care quality, protect the public and reduce health care fraud and abuse, preventing
26 practitioners from moving state to state without disclosure or discovery of previous damaging
27 performance; and
28

29 Whereas, The Federation of State Medical Boards, the Federation Credential Verification
30 Service, the National Board of Medical Examiners, the Interstate Medical Licensing Compact
31 and other national organizations serve to streamline and facilitate collaboration among the 70
32 independent state-based medical boards authorized to regulate medical practice within their
33 borders; and
34

35 Whereas, Current state licensing procedures, while constantly improving, fail to promote
36 efficient use of modern telecommunication and delivery of a broad range of health care services
37 across state lines, are unnecessarily complex, nonuniform, redundant, expensive, time

1 consuming, and poorly focused on actual patient care, resulting in the inhibition of free flow of
2 professional expertise and services across state lines; and
3

4 Whereas, Telemedicine has developed rapidly over the last decades into an integrated system
5 of healthcare delivery that incorporates many different remote diagnostic and monitoring
6 devices and other technologies that are not dependent on in-person or face-to-face patient
7 encounters; and
8

9 Whereas, Incentives to reduce the high cost of medical care have led to shorter hospital stays,
10 increased use of outpatient facilities and home care with less intense in-person physician
11 supervision, and more frequent collaborative care delivered by non-physician professionals; and
12

13 Whereas, Telemedicine has been proven effective in many scenarios, in remote or rural
14 settings, urban areas with limited public transportation, in nursing homes, detention centers,
15 prisons, and for people with physical and mental disabilities limiting their mobility; and
16

17 Whereas, The use of telemedicine has grown exponentially during the COVID pandemic to
18 protect both patients and caregivers from spread of infectious disease; and
19

20 Whereas, Telemedicine may be especially helpful in addressing disparities in access to medical
21 care based on economic, racial, ethnic, and geographic factors; and
22

23 Whereas, There is a worsening shortage of physicians particularly in rural or urban communities
24 that lack comprehensive, supportive, up-to-date medical services and cultural, educational, and
25 recreational amenities outside the workplace; and
26

27 Whereas, Current AMA policy H-480.969 requires full and unrestricted licensure in the state of
28 residence where telemedicine is practiced, where the patient is physically located, with certain
29 exceptions; and
30

31 Whereas, Current AMA policy H-160.950 requires a physician to be responsible for managing
32 the health care of patients in all practice settings, including medication prescriptive authority,
33 and to be immediately available at all times for supervision and consultation by a nurse
34 practitioner; and
35

36 Whereas, Half of the states allow nurse practitioners to practice independently without physician
37 supervision; and
38

39 Whereas, 70% of physicians are now employed by large groups, hospitals, private capital
40 groups, insurance companies and ERISA-qualified managed care organizations which often
41 care for patients in many states and employ non-physicians to assist in patient care, using many
42 varying protocols for physician supervision of non-physician professionals, and assessment of
43 an individual physician's competence; and
44

45 Whereas, Recent and continuing changes in the ownership and structure of physician practice
46 can raise licensing issues related to conflicts of interest, anti-competitive activity, restraint of
47 trade and interference with interstate commerce related to restriction of physician licensing; and
48

49 Whereas, Policy objectives for licensing and interstate health care delivery should incorporate
50 the best practices of individual states, recognizing rapid evolution in the structure of health care
51 delivery including current capabilities of telemedicine in various medical specialties and by non-
52 physician professionals, into a single comprehensive policy that promotes accessible, quality,

1 affordable, appropriately accredited and accountable care, distributed to all members of our
2 society; therefore be it

3
4 RESOLVED, That our American Medical Association address the issue of state licensure in a
5 comprehensive manner including studying the best mechanisms to ensure interstate licensure
6 for practitioners practicing in multiple states, optimizing state licensure practices to allow for
7 seamless telemedicine practice across state lines, and addressing long delays in practitioners
8 obtaining state licensures which lead to delays in medical care (Directive to Take Action); and
9 be it further

10
11 RESOLVED, That our AMA research the feasibility of convening a meeting of appropriate
12 stakeholders, including but not limited to state medical boards, medical specialty societies, state
13 medical societies, payers, organizations representing non-physician medical professionals,
14 Centers for Medicare and Medicaid Services-approved accrediting agencies, and patients to
15 develop recommendations to modernize the state medical licensure system including creating
16 mechanisms for multi-state licensure, streamlining the process of obtaining medical licensure,
17 and facilitate practice across state lines (Directive to Take Action); and be it further

18
19 RESOLVED, That our AMA report back on these recommendations by the 2022 Interim
20 Meeting. (Directive to Take Action)

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

Received: 04/06/22

RELEVANT AMA POLICY

Guidelines for Integrated Practice of Physician and Nurse Practitioner H-160.950

Our AMA endorses the following guidelines and recommends that these guidelines be considered and quoted only in their entirety when referenced in any discussion of the roles and responsibilities of nurse practitioners: (1) The physician is responsible for the supervision of nurse practitioners and other advanced practice nurses in all settings.

(2) The physician is responsible for managing the health care of patients in all practice settings.

(3) Health care services delivered in an integrated practice must be within the scope of each practitioner's professional license, as defined by state law.

(4) In an integrated practice with a nurse practitioner, the physician is responsible for supervising and coordinating care and, with the appropriate input of the nurse practitioner, ensuring the quality of health care provided to patients.

(5) The extent of involvement by the nurse practitioner in initial assessment, and implementation of treatment will depend on the complexity and acuity of the patients' condition, as determined by the supervising/collaborating physician.

(6) The role of the nurse practitioner in the delivery of care in an integrated practice should be defined through mutually agreed upon written practice protocols, job descriptions, and written contracts.

(7) These practice protocols should delineate the appropriate involvement of the two professionals in the care of patients, based on the complexity and acuity of the patients' condition.

(8) At least one physician in the integrated practice must be immediately available at all times for supervision and consultation when needed by the nurse practitioner.

(9) Patients are to be made clearly aware at all times whether they are being cared for by a physician or a nurse practitioner.

(10) In an integrated practice, there should be a professional and courteous relationship between physician and nurse practitioner, with mutual acknowledgment of, and respect for each other's contributions to patient care.

(11) Physicians and nurse practitioners should review and document, on a regular basis, the care of all patients with whom the nurse practitioner is involved. Physicians and nurse practitioners must work closely enough together to become fully conversant with each other's practice patterns.

Citation: (CMS Rep. 15 - I-94; BOT Rep. 6, A-95; Reaffirmed: Res. 240, A-00; Reaffirmation A-00; Reaffirmed: BOT Rep. 28, A-09; Reaffirmed: BOT Rep. 9, I-11; Reaffirmed: Joint CME-CMS Rep., I-12; Reaffirmed: BOT Rep. 16, A-13)

Independent Practice of Medicine by Advanced Practice Registered Nurses H-35.988

Our AMA, in the public interest, opposes enactment of legislation to authorize the independent practice of medicine by any individual who has not completed the states requirements for licensure to engage in the practice of medicine

and surgery in all of its branches. Our AMA opposes enactment of the Advanced Practice Registered Nurse (APRN) Multistate Compact, due to the potential of the APRN Compact to supersede state laws that require APRNs to practice under physician supervision, collaboration or oversight.

Citation: Sub. Res. 53, I-82; Reaffirmed: A-84; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmed: BOT Rep. 28, A-03; Reaffirmed: BOT Rep. 9, I-11; Modified: Res. 214, I-17; Modified: BOT Rep. 15, A-18

Physician Assistants and Nurse Practitioners H-160.947

Our AMA will develop a plan to assist the state and local medical societies in identifying and lobbying against laws that allow advanced practice nurses to provide medical care without the supervision of a physician.

The suggested Guidelines for Physician/Physician Assistant Practice are adopted to read as follows (these guidelines shall be used in their entirety):

- (1) The physician is responsible for managing the health care of patients in all settings.
- (2) Health care services delivered by physicians and physician assistants must be within the scope of each practitioner's authorized practice, as defined by state law.
- (3) The physician is ultimately responsible for coordinating and managing the care of patients and, with the appropriate input of the physician assistant, ensuring the quality of health care provided to patients.
- (4) The physician is responsible for the supervision of the physician assistant in all settings.
- (5) The role of the physician assistant in the delivery of care should be defined through mutually agreed upon guidelines that are developed by the physician and the physician assistant and based on the physician's delegatory style.
- (6) The physician must be available for consultation with the physician assistant at all times, either in person or through telecommunication systems or other means.
- (7) The extent of the involvement by the physician assistant in the assessment and implementation of treatment will depend on the complexity and acuity of the patient's condition and the training, experience, and preparation of the physician assistant, as adjudged by the physician.
- (8) Patients should be made clearly aware at all times whether they are being cared for by a physician or a physician assistant.
- (9) The physician and physician assistant together should review all delegated patient services on a regular basis, as well as the mutually agreed upon guidelines for practice.
- (10) The physician is responsible for clarifying and familiarizing the physician assistant with his/her supervising methods and style of delegating patient care.

Citation: BOT Rep. 6, A-95; Reaffirmed: Res 240 and Reaffirmation A-00; Reaffirmed: Res. 213, A-02; Modified: CLRPD Rep. 1, A-03; Reaffirmed: BOT Rep. 9, I-11; Reaffirmed: Joint CME-CMS Rep., I-12; Reaffirmed: BOT Rep. 16, A-13

Opposition to the Department of Veterans Affairs Proposed Rulemaking on APRN Practices D-35.979

1. Our AMA will express to the U.S. Department of Veterans Affairs (VA) that the plan to substitute physicians by using Advanced Practice Registered Nurses (APRNs) in independent practice, not in physician-led teams, is antithetical to multiple established policies of our AMA and thus should not be implemented.
2. Our AMA staff will assess the feasibility of seeking federal legislation that prevents the VA from enacting regulations for veterans' medical care that is not consistent with physician-led health care teams or to mandate that the VA adopt policy regarding the same.
3. Our AMA will call upon Congress and the Administration to disapprove or otherwise overturn rules and regulations at the federal level that would expand the scope of practice of APRNs, and comment to the Director of Regulation Management within the Department of Veterans Affairs of this position during the current comment period.
4. Our AMA will collaborate with other medical professional organizations to vigorously oppose the final adoption of the VA's proposed rulemaking expanding the role of APRNs within the VA.

Citation: Res. 239, A-16

COVID-19 Emergency and Expanded Telemedicine Regulations D-480.963

Our AMA: (1) will continue to advocate for the widespread adoption of telehealth services in the practice of medicine for physicians and physician-led teams post SARS-COV-2; (2) will advocate that the Federal government, including the Centers for Medicare & Medicaid Services (CMS) and other agencies, state governments and state agencies, and the health insurance industry, adopt clear and uniform laws, rules, regulations, and policies relating to telehealth services that: (a) provide equitable coverage that allows patients to access telehealth services wherever they are located, and (b) provide for the use of accessible devices and technologies, with appropriate privacy and security protections, for connecting physicians and patients; (3) will advocate for equitable access to telehealth services, especially for at-risk and under-resourced patient populations and communities, including but not limited to supporting increased funding and planning for telehealth infrastructure such as broadband and internet-connected devices for both physician practices and patients; and (4) supports the use of telehealth to reduce health disparities and promote access to health care.

Citation: Alt. Res. 203, I-20; Reaffirmed: CMS Rep. 7, A-21

Increasing Access to Broadband Internet to Reduce Health Disparities H-478.980

Our AMA will advocate for the expansion of broadband and wireless connectivity to all rural and underserved areas of the United States while at all times taking care to protecting existing federally licensed radio services from harmful interference that can be caused by broadband and wireless services.

Citation: Res. 208, I-18; Reaffirmed: CMS Rep. 7, A-21

Established Patient Relationships and Telemedicine D-480.964

Our AMA will:

- 1) work with state medical associations to encourage states that are not part of the Interstate Medical Licensure Compact to consider joining the Compact as a means of enhancing patient access to and proper regulation of telemedicine services;
- (2) advocate to the Interstate Medical Licensure Compact Commission and Federation of State Medical Boards for reduced application fees and secondary state licensure(s) fees processed through the Interstate Medical Licensure Compact;
- (3) work with interested state medical associations to encourage states to pass legislation enhancing patient access to and proper regulation of telemedicine services, in accordance with AMA Policy H-480.946, "Coverage of and Payment for Telemedicine"; and
- (4) continue to support state efforts to expand physician licensure recognition across state lines in accordance with the standards and safeguards outlined in Policy H-480.946.

Citation: CMS Rep. 1, I-19; Appended: CMS Rep. 8, A-21

State Authority and Flexibility in Medical Licensure for Telemedicine D-480.999

Our AMA will continue its opposition to a single national federalized system of medical licensure.

Citation: (CME Rep. 7, A-99; Reaffirmed and Modified: CME Rep. 2, A-09; Reaffirmed in lieu of Res. 920, I-13; Reaffirmed: BOT Rep. 3, I-14)

Principles of and Actions to Address Primary Care Workforce H-200.949

1. Our patients require a sufficient, well-trained supply of primary care physicians--family physicians, general internists, general pediatricians, and obstetricians/gynecologists--to meet the nation's current and projected demand for health care services.
2. To help accomplish this critical goal, our American Medical Association (AMA) will work with a variety of key stakeholders, to include federal and state legislators and regulatory bodies; national and state specialty societies and medical associations, including those representing primary care fields; and accreditation, certification, licensing, and regulatory bodies from across the continuum of medical education (undergraduate, graduate, and continuing medical education).
3. Through its work with these stakeholders, our AMA will encourage development and dissemination of innovative models to recruit medical students interested in primary care, train primary care physicians, and enhance both the perception and the reality of primary care practice, to encompass the following components: a) Changes to medical school admissions and recruitment of medical students to primary care specialties, including counseling of medical students as they develop their career plans; b) Curriculum changes throughout the medical education continuum; c) Expanded financial aid and debt relief options; d) Financial and logistical support for primary care practice, including adequate reimbursement, and enhancements to the practice environment to ensure professional satisfaction and practice sustainability; and e) Support for research and advocacy related to primary care.
4. Admissions and recruitment: The medical school admissions process should reflect the specific institution's mission. Those schools with missions that include primary care should consider those predictor variables among applicants that are associated with choice of these specialties.
5. Medical schools, through continued and expanded recruitment and outreach activities into secondary schools, colleges, and universities, should develop and increase the pool of applicants likely to practice primary care by seeking out those students whose profiles indicate a likelihood of practicing in primary care and underserved areas, while establishing strict guidelines to preclude discrimination.
6. Career counseling and exposure to primary care: Medical schools should provide to students career counseling related to the choice of a primary care specialty, and ensure that primary care physicians are well-represented as teachers, mentors, and role models to future physicians.
7. Financial assistance programs should be created to provide students with primary care experiences in ambulatory settings, especially in underserved areas. These could include funded preceptorships or summer work/study opportunities.
8. Curriculum: Voluntary efforts to develop and expand both undergraduate and graduate medical education programs to educate primary care physicians in increasing numbers should be continued. The establishment of appropriate administrative units for all primary care specialties should be encouraged.
9. Medical schools with an explicit commitment to primary care should structure the curriculum to support this objective. At the same time, all medical schools should be encouraged to continue to change their curriculum to put more emphasis on primary care.
10. All four years of the curriculum in every medical school should provide primary care experiences for all students, to feature increasing levels of student responsibility and use of ambulatory and community-based settings.

11. Federal funding, without coercive terms, should be available to institutions needing financial support to expand resources for both undergraduate and graduate medical education programs designed to increase the number of primary care physicians. Our AMA will advocate for public (federal and state) and private payers to a) develop enhanced funding and related incentives from all sources to provide education for medical students and resident/fellow physicians, respectively, in progressive, community-based models of integrated care focused on quality and outcomes (such as the patient-centered medical home and the chronic care model) to enhance primary care as a career choice; b) fund and foster innovative pilot programs that change the current approaches to primary care in undergraduate and graduate medical education, especially in urban and rural underserved areas; and c) evaluate these efforts for their effectiveness in increasing the number of students choosing primary care careers and helping facilitate the elimination of geographic, racial, and other health care disparities.
12. Medical schools and teaching hospitals in underserved areas should promote medical student and resident/fellow physician rotations through local family health clinics for the underserved, with financial assistance to the clinics to compensate their teaching efforts.
13. The curriculum in primary care residency programs and training sites should be consistent with the objective of training generalist physicians. Our AMA will encourage the Accreditation Council for Graduate Medical Education to (a) support primary care residency programs, including community hospital-based programs, and (b) develop an accreditation environment and novel pathways that promote innovations in graduate medical education, using progressive, community-based models of integrated care focused on quality and outcomes (such as the patient-centered medical home and the chronic care model).
14. The visibility of primary care faculty members should be enhanced within the medical school, and positive attitudes toward primary care among all faculty members should be encouraged.
15. Support for practicing primary care physicians: Administrative support mechanisms should be developed to assist primary care physicians in the logistics of their practices, along with enhanced efforts to reduce administrative activities unrelated to patient care, to help ensure professional satisfaction and practice sustainability.
16. There should be increased financial incentives for physicians practicing primary care, especially those in rural and urban underserved areas, to include scholarship or loan repayment programs, relief of professional liability burdens, and Medicaid case management programs, among others. Our AMA will advocate to state and federal legislative and regulatory bodies, among others, for development of public and/or private incentive programs, and expansion and increased funding for existing programs, to further encourage practice in underserved areas and decrease the debt load of primary care physicians. The imposition of specific outcome targets should be resisted, especially in the absence of additional support to the schools.
17. Our AMA will continue to advocate, in collaboration with relevant specialty societies, for the recommendations from the AMA/Specialty Society RVS Update Committee (RUC) related to reimbursement for E&M services and coverage of services related to care coordination, including patient education, counseling, team meetings and other functions; and work to ensure that private payers fully recognize the value of E&M services, incorporating the RUC-recommended increases adopted for the most current Medicare RBRVS.
18. Our AMA will advocate for public (federal and state) and private payers to develop physician reimbursement systems to promote primary care and specialty practices in progressive, community-based models of integrated care focused on quality and outcomes such as the patient-centered medical home and the chronic care model consistent with current AMA Policies H-160.918 and H-160.919.
19. There should be educational support systems for primary care physicians, especially those practicing in underserved areas.
20. Our AMA will urge urban hospitals, medical centers, state medical associations, and specialty societies to consider the expanded use of mobile health care capabilities.
21. Our AMA will encourage the Centers for Medicare & Medicaid Services to explore the use of telemedicine to improve access to and support for urban primary care practices in underserved settings.
22. Accredited continuing medical education providers should promote and establish continuing medical education courses in performing, prescribing, interpreting and reinforcing primary care services.
23. Practicing physicians in other specialties--particularly those practicing in underserved urban or rural areas--should be provided the opportunity to gain specific primary care competencies through short-term preceptorships or postgraduate fellowships offered by departments of family medicine, internal medicine, pediatrics, etc., at medical schools or teaching hospitals. In addition, part-time training should be encouraged, to allow physicians in these programs to practice concurrently, and further research into these concepts should be encouraged.
24. Our AMA supports continued funding of Public Health Service Act, Title VII, Section 747, and encourages advocacy in this regard by AMA members and the public.
25. Research: Analysis of state and federal financial assistance programs should be undertaken, to determine if these programs are having the desired workforce effects, particularly for students from disadvantaged groups and those that are underrepresented in medicine, and to gauge the impact of these programs on elimination of geographic, racial, and other health care disparities. Additional research should identify the factors that deter students and physicians from choosing and remaining in primary care disciplines. Further, our AMA should continue to monitor trends in the choice of a primary care specialty and the availability of primary care graduate medical education positions. The results of these and related research endeavors should support and further refine AMA policy to enhance primary care as a career choice.

Telemedicine Encounters by Third Party Vendors D-480.968

1. Our AMA will develop model legislation and/or regulations requiring telemedicine services or vendors to coordinate care with the patient's medical home and/or existing treating physicians, which includes at a minimum identifying the patient's existing medical home and/or treating physicians and providing to the treating physician a copy of the medical record, with the patient's consent.
2. The model legislation and/or regulations will also require the vendor to abide by laws addressing the privacy and security of patients' medical information
3. Our AMA will include in that model state legislation the following concepts based on AMA policy: (a) A valid patient-physician relationship must be established before the provision of telemedicine services; (b) Physicians and other health practitioners delivering telemedicine services must be licensed in the state where the patient receives services, or be providing these services as otherwise authorized by that state's medical board; and (c) The standards and scope of telemedicine services should be consistent with related in-person services.
4. Our AMA will educate and advocate to AMA members on the use and implementation of telemedicine and other related technology in their practices to improve access, convenience, and continuity of care for their patients.

Citation: Res. 234, A-16

The Promotion of Quality Telemedicine H-480.969

(1) It is the policy of the AMA that medical boards of states and territories should require a full and unrestricted license in that state for the practice of telemedicine, unless there are other appropriate state-based licensing methods, with no differentiation by specialty, for physicians who wish to practice telemedicine in that state or territory. This license category should adhere to the following principles:

- (a) exemption from such a licensure requirement for physician-to-physician consultations;
- (b) exemption from such a licensure requirement for telemedicine practiced across state lines in the event of an emergent or urgent circumstance, the definition of which for the purposes of telemedicine should show substantial deference to the judgment of the attending and consulting physicians as well as to the views of the patient;
- (c) allowances, by exemption or other means, for out-of-state physicians providing continuity of care to a patient, where there is an established ongoing relationship and previous in-person visits, for services incident to an ongoing care plan or one that is being modified; and
- (d) application requirements that are non-burdensome, issued in an expeditious manner, have fees no higher than necessary to cover the reasonable costs of administering this process, and that utilize principles of reciprocity with the licensure requirements of the state in which the physician in question practices.

(2) The AMA urges the FSMB and individual states to recognize that a physician practicing certain forms of telemedicine (e.g., teleradiology) must sometimes perform necessary functions in the licensing state (e.g., interaction with patients, technologists, and other physicians) and that the interstate telemedicine approach adopted must accommodate these essential quality-related functions.

(3) The AMA urges national medical specialty societies to develop and implement practice parameters for telemedicine in conformance with: Policy 410.973 (which identifies practice parameters as "educational tools"); Policy 410.987 (which identifies practice parameters as "strategies for patient management that are designed to assist physicians in clinical decision making," and states that a practice parameter developed by a particular specialty or specialties should not preclude the performance of the procedures or treatments addressed in that practice parameter by physicians who are not formally credentialed in that specialty or specialties); and Policy 410.996 (which states that physician groups representing all appropriate specialties and practice settings should be involved in developing practice parameters, particularly those which cross lines of disciplines or specialties).

Citation: CME/CMS Rep., A-96; Amended: CME Rep. 7, A-99; Reaffirmed: CME Rep. 2, A-09; Reaffirmed: CME Rep. 6, A-10; Reaffirmed: CME Rep. 6, A-12; Reaffirmed in lieu of Res. 805, I-12; Reaffirmed: BOT Rep. 22, A-13; Reaffirmed in lieu of Res. 920, I-13; Reaffirmed: CMS Rep. 7, A-14; Reaffirmed: BOT Rep. 3, I-14; Reaffirmed: CMS Rep. 1, I-19; Modified: CMS Rep. 8, A-21

Coverage of and Payment for Telemedicine H-480.946

1. Our AMA believes that telemedicine services should be covered and paid for if they abide by the following principles:

- a) A valid patient-physician relationship must be established before the provision of telemedicine services, through:
 - A face-to-face examination, if a face-to-face encounter would otherwise be required in the provision of the same service not delivered via telemedicine; or
 - A consultation with another physician who has an ongoing patient-physician relationship with the patient. The physician who has established a valid physician-patient relationship must agree to supervise the patient's care; or
 - Meeting standards of establishing a patient-physician relationship included as part of evidence-based clinical practice guidelines on telemedicine developed by major medical specialty societies, such as those of radiology and pathology.

Exceptions to the foregoing include on-call, cross coverage situations; emergency medical treatment; and other exceptions that become recognized as meeting or improving the standard of care. If a medical home does not exist, telemedicine providers should facilitate the identification of medical homes and treating physicians where in-person services can be delivered in coordination with the telemedicine services.

- b) Physicians and other health practitioners delivering telemedicine services must abide by state licensure laws and state medical practice laws and requirements in the state in which the patient receives services.
 - c) Physicians and other health practitioners delivering telemedicine services must be licensed in the state where the patient receives services, or be providing these services as otherwise authorized by that state's medical board.
 - d) Patients seeking care delivered via telemedicine must have a choice of provider, as required for all medical services.
 - e) The delivery of telemedicine services must be consistent with state scope of practice laws.
 - f) Patients receiving telemedicine services must have access to the licensure and board certification qualifications of the health care practitioners who are providing the care in advance of their visit.
 - g) The standards and scope of telemedicine services should be consistent with related in-person services.
 - h) The delivery of telemedicine services must follow evidence-based practice guidelines, to the degree they are available, to ensure patient safety, quality of care and positive health outcomes.
 - i) The telemedicine service must be delivered in a transparent manner, to include but not be limited to, the identification of the patient and physician in advance of the delivery of the service, as well as patient cost-sharing responsibilities and any limitations in drugs that can be prescribed via telemedicine.
 - j) The patient's medical history must be collected as part of the provision of any telemedicine service.
 - k) The provision of telemedicine services must be properly documented and should include providing a visit summary to the patient.
 - l) The provision of telemedicine services must include care coordination with the patient's medical home and/or existing treating physicians, which includes at a minimum identifying the patient's existing medical home and treating physicians and providing to the latter a copy of the medical record.
 - m) Physicians, health professionals and entities that deliver telemedicine services must establish protocols for referrals for emergency services.
2. Our AMA believes that delivery of telemedicine services must abide by laws addressing the privacy and security of patients' medical information.
 3. Our AMA encourages additional research to develop a stronger evidence base for telemedicine.
 4. Our AMA supports additional pilot programs in the Medicare program to enable coverage of telemedicine services, including, but not limited to store-and-forward telemedicine.
 5. Our AMA supports demonstration projects under the auspices of the Center for Medicare and Medicaid Innovation to address how telemedicine can be integrated into new payment and delivery models.
 6. Our AMA encourages physicians to verify that their medical liability insurance policy covers telemedicine services, including telemedicine services provided across state lines if applicable, prior to the delivery of any telemedicine service.
 7. Our AMA encourages national medical specialty societies to leverage and potentially collaborate in the work of national telemedicine organizations, such as the American Telemedicine Association, in the area of telemedicine technical standards, to the extent practicable, and to take the lead in the development of telemedicine clinical practice guidelines.
- Citation: CMS Rep. 7, A-14; Reaffirmed: BOT Rep. 3, I-14; Reaffirmed in lieu of Res. 815, I-15; Reaffirmed: CME Rep. 06, A-16; Reaffirmed: CMS Rep. 06, I-16; Reaffirmed: Res. 111, A-17; Reaffirmation: A-18; Reaffirmed: CMS Rep. 1, I-19; Reaffirmed: CMS Rep. 8, A-21

Evolving Impact of Telemedicine H-480.974

Our AMA:

- (1) will evaluate relevant federal legislation related to telemedicine;
- (2) urges CMS, AHRQ, and other concerned entities involved in telemedicine to fund demonstration projects to evaluate the effect of care delivered by physicians using telemedicine-related technology on costs, quality, and the physician-patient relationship;
- (3) urges professional organizations that serve medical specialties involved in telemedicine to develop appropriate practice parameters to address the various applications of telemedicine and to guide quality assessment and liability issues related to telemedicine;
- (4) encourages professional organizations that serve medical specialties involved in telemedicine to develop appropriate educational resources for physicians for telemedicine practice;
- (5) encourages development of a code change application for CPT codes or modifiers for telemedical services, to be submitted pursuant to CPT processes;
- (6) will work with CMS and other payers to develop and test, through these demonstration projects, appropriate reimbursement mechanisms;
- (7) will develop a means of providing appropriate continuing medical education credit, acceptable toward the Physician's Recognition Award, for educational consultations using telemedicine;
- (8) will work with the Federation of State Medical Boards and the state and territorial licensing boards to develop licensure guidelines for telemedicine practiced across state boundaries; and
- (9) will leverage existing expert guidance on telemedicine by collaborating with the American Telemedicine Association (www.americantelemed.org) to develop physician and patient specific content on the use of telemedicine services--encrypted and unencrypted.

Citation: CMS/CME Rep., A-94; Reaffirmation A-01; Reaffirmation A-11; Reaffirmed: CMS Rep. 7, A-11; Reaffirmed in lieu of Res. 805, I-12; Appended: BOT Rep. 26, A-13; Modified: BOT Rep. 22, A-13; Reaffirmed: CMS Rep. 7, A-14; Reaffirmed: CME Rep. 06, A-16; Reaffirmation: A-18

Addressing Equity in Telehealth H-480.937

Our AMA:

- (1) recognizes access to broadband internet as a social determinant of health;
- (2) encourages initiatives to measure and strengthen digital literacy, with an emphasis on programs designed with and for historically marginalized and minoritized populations;
- (3) encourages telehealth solution and service providers to implement design functionality, content, user interface, and service access best practices with and for historically minoritized and marginalized communities, including addressing culture, language, technology accessibility, and digital literacy within these populations;
- (4) supports efforts to design telehealth technology, including voice-activated technology, with and for those with difficulty accessing technology, such as older adults, individuals with vision impairment and individuals with disabilities;
- (5) encourages hospitals, health systems and health plans to invest in initiatives aimed at designing access to care via telehealth with and for historically marginalized and minoritized communities, including improving physician and non-physician provider diversity, offering training and technology support for equity-centered participatory design, and launching new and innovative outreach campaigns to inform and educate communities about telehealth;
- (6) supports expanding physician practice eligibility for programs that assist qualifying health care entities, including physician practices, in purchasing necessary services and equipment in order to provide telehealth services to augment the broadband infrastructure for, and increase connected device use among historically marginalized, minoritized and underserved populations;
- (7) supports efforts to ensure payers allow all contracted physicians to provide care via telehealth;
- (8) opposes efforts by health plans to use cost-sharing as a means to incentivize or require the use of telehealth or in-person care or incentivize care from a separate or preferred telehealth network over the patient's current physicians; and
- (9) will advocate that physician payments should be fair and equitable, regardless of whether the service is performed via audio-only, two-way audio-video, or in-person.

Citation: CMS Rep. 7, A-21

1.2.12 Ethical Practice in Telemedicine

Innovation in technology, including information technology, is redefining how people perceive time and distance. It is reshaping how individuals interact with and relate to others, including when, where, and how patients and physicians engage with one another.

Telehealth and telemedicine span a continuum of technologies that offer new ways to deliver care. Yet as in any mode of care, patients need to be able to trust that physicians will place patient welfare above other interests, provide competent care, provide the information patients need to make well-considered decisions about care, respect patient privacy and confidentiality, and take steps to ensure continuity of care. Although physicians fundamental ethical responsibilities do not change, the continuum of possible patient-physician interactions in telehealth/telemedicine give rise to differing levels of accountability for physicians.

All physicians who participate in telehealth/telemedicine have an ethical responsibility to uphold fundamental fiduciary obligations by disclosing any financial or other interests the physician has in the telehealth/telemedicine application or service and taking steps to manage or eliminate conflicts of interests. Whenever they provide health information, including health content for websites or mobile health applications, physicians must ensure that the information they provide or that is attributed to them is objective and accurate.

Similarly, all physicians who participate in telehealth/telemedicine must assure themselves that telemedicine services have appropriate protocols to prevent unauthorized access and to protect the security and integrity of patient information at the patient end of the electronic encounter, during transmission, and among all health care professionals and other personnel who participate in the telehealth/telemedicine service consistent with their individual roles.

Physicians who respond to individual health queries or provide personalized health advice electronically through a telehealth service in addition should:

- (a) Inform users about the limitations of the relationship and services provided.
- (b) Advise site users about how to arrange for needed care when follow-up care is indicated.
- (c) Encourage users who have primary care physicians to inform their primary physicians about the online health consultation, even if in-person care is not immediately needed.

Physicians who provide clinical services through telehealth/telemedicine must uphold the standards of professionalism expected in in-person interactions, follow appropriate ethical guidelines of relevant specialty societies and adhere to applicable law governing the practice of telemedicine. In the context of telehealth/telemedicine they further should:

- (d) Be proficient in the use of the relevant technologies and comfortable interacting with patients and/or surrogates electronically.

(e) Recognize the limitations of the relevant technologies and take appropriate steps to overcome those limitations. Physicians must ensure that they have the information they need to make well-grounded clinical recommendations when they cannot personally conduct a physical examination, such as by having another health care professional at the patients site conduct the exam or obtaining vital information through remote technologies.

(f) Be prudent in carrying out a diagnostic evaluation or prescribing medication by:

(i) establishing the patients identity;

(ii) confirming that telehealth/telemedicine services are appropriate for that patients individual situation and medical needs;

(iii) evaluating the indication, appropriateness and safety of any prescription in keeping with best practice guidelines and any formulary limitations that apply to the electronic interaction; and

(iv) documenting the clinical evaluation and prescription.

(g) When the physician would otherwise be expected to obtain informed consent, tailor the informed consent process to provide information patients (or their surrogates) need about the distinctive features of telehealth/telemedicine, in addition to information about medical issues and treatment options. Patients and surrogates should have a basic understanding of how telemedicine technologies will be used in care, the limitations of those technologies, the credentials of health care professionals involved, and what will be expected of patients for using these technologies.

(h) As in any patient-physician interaction, take steps to promote continuity of care, giving consideration to how information can be preserved and accessible for future episodes of care in keeping with patients preferences (or the decisions of their surrogates) and how follow-up care can be provided when needed. Physicians should assure themselves how information will be conveyed to the patients primary care physician when the patient has a primary care physician and to other physicians currently caring for the patient.

Collectively, through their professional organizations and health care institutions, physicians should:

(i) Support ongoing refinement of telehealth/telemedicine technologies, and the development and implementation of clinical and technical standards to ensure the safety and quality of care.

(j) Advocate for policies and initiatives to promote access to telehealth/telemedicine services for all patients who could benefit from receiving care electronically.

(k) Routinely monitor the telehealth/telemedicine landscape to:

(i) identify and address adverse consequences as technologies and activities evolve; and

(ii) identify and encourage dissemination of both positive and negative outcomes.

[AMA Principles of Medical Ethics: I,IV,VI,IX](#)

The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law.

Issued: 2016

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 216
(A-22)

Introduced by: Medical Student Section

Subject: Advocating for the Elimination of Hepatitis C Treatment Restrictions

Referred to: Reference Committee B

1 Whereas, An estimated 2.4 million Americans are living with Hepatitis C Virus (HCV) infection,
2 and acute HCV infection rates doubled from 2012 to 2019^{1,2}; and
3

4 Whereas, Even with improvements in HCV treatment, projections for the next 35 years estimate
5 that 157,000 U.S. patients will develop hepatocellular carcinoma, 203,000 will develop
6 decompensated cirrhosis, and 320,000 will die due to HCV³; and
7

8 Whereas, The prevalence of HCV among Medicaid enrollees is 7.5 times higher than
9 prevalence among the commercially insured population, demonstrating the disproportionate
10 impact of HCV on marginalized populations⁴; and
11

12 Whereas, Structural barriers to accessing HCV therapy persist, as many state Medicaid
13 programs, prisons and jails, and private insurers implement non-medically indicated restrictions,
14 including *fibrosis restrictions* (requirement that patients have severe liver damage before
15 receiving HCV treatment coverage), *sobriety restrictions* (requirement of abstinence from drugs
16 and/or alcohol before HCV treatment), and *prescriber restrictions* (limitations on the type of
17 clinician that can prescribe HCV treatment, such as requiring primary care doctors to consult
18 with or request direct prescription from a hepatologist)^{5,6}; and
19

20 Whereas, Consensus guidelines from the American Association for the Study of Liver Diseases
21 (AASLD) and the Infectious Diseases Society of America (IDSA) recommend with Level 1A
22 evidence that nearly all people with acute or chronic HCV should receive treatment with direct-
23 acting antivirals (DAAs), which can cure over 95% of individuals with HCV⁷; and
24

25 Whereas, The AASLD/IDSA guidelines emphasize with Level 1A evidence that “there are no
26 data to support the utility of pretreatment screening for illicit drug or alcohol use in identifying a
27 population more likely to successfully complete HCV therapy”⁷; and
28

29 Whereas, The AASLD/IDSA guidelines emphasize with Level 1A evidence that initiating therapy
30 in patients with lower-stage fibrosis augments the clinical and public health benefits of virologic
31 cure, and treatment delay may decrease the benefit of virologic cure⁷; and
32

33 Whereas, While treatment restrictions were primarily created to help payors mitigate the high
34 cost of HCV treatment regimens, numerous studies have demonstrated that these restrictive
35 policies are more costly and less effective than unrestricted strategies⁸⁻¹³; and
36

37 Whereas, In spite of expert consensus that HCV treatment restrictions are neither medically
38 indicated nor effective, as of April 2021, four states still have fibrosis restrictions, 28 states have
39 sobriety restrictions, and 18 states have prescriber restrictions^{5,6}; and

1 Whereas, A 2018 study found that 35.5% of patients across 45 states (including 52.4% of
2 commercial enrollees, 34.5% of Medicaid enrollees, and 14.7% of Medicare enrollees) who
3 received prescriptions for DAAs were denied DAA coverage due to fibrosis, sobriety, or
4 prescriber restrictions¹⁴; and

5
6 Whereas, The wholesale cost of a DAA treatment course has dropped over the last decade
7 from \$80,000+ to as low as \$20,000¹⁵; and

8
9 Whereas, The Centers for Medicare and Medicaid Services issued a letter to states in 2015 that
10 HCV treatment access restrictions may violate Medicaid statutory requirements¹⁶; and

11
12 Whereas, The U.S. Department of Health and Human Services' Viral Hepatitis National
13 Strategic Plan for 2021-2025 includes a disparities goal of reducing the proportion of states with
14 fibrosis, sobriety, and prescriber restrictions¹⁷; and

15
16 Whereas, Restricted access to HCV treatment disproportionately exacerbates health and
17 financial inequities for American Indian/Alaska Native (AIAN) populations, who face double the
18 acute HCV incidence rates of non-Hispanic whites and the highest rates of HCV-related
19 mortality of any racial/ethnic group, as well as other structurally vulnerable immigrant and
20 minoritized communities¹⁸⁻²⁰; and

21
22 Whereas, While there is a legal responsibility to provide healthcare to AIAN patients served by
23 the Indian Health Service (IHS), the agency serves as a payor of last resort, meaning federal
24 and state-level coverage restrictions (i.e., via Medicare and Medicaid) can adversely impact IHS
25 and AIAN populations²⁰⁻²³; and

26
27 Whereas, Our AMA supports increased funding and negotiation for affordable pricing of HCV
28 treatment "so that all Americans for whom HCV treatment would have a substantial proven
29 benefit will be able to receive this treatment" (H-440.845), which should include nearly all people
30 with HCV in accordance with expert guidelines⁷; therefore be it

31
32 RESOLVED, That our American Medical Association amend policy H-440.845, "Advocacy for
33 Hepatitis C Virus Education, Prevention, Screening and Treatment," by addition to read as
34 follows:

35
36 **Advocacy for Hepatitis C Virus Education, Prevention, Screening and Treatment,**
37 **H-440.845**

38
39 Our AMA will: (1) encourage the adoption of birth year-based screening practices for
40 hepatitis C, in alignment with Centers for Disease Control and Prevention (CDC)
41 recommendations; (2) encourage the CDC, Indian Health Service (IHS), and state
42 Departments of Public Health to develop and coordinate Hepatitis C Virus infection
43 educational and prevention efforts; (3) support hepatitis C virus (HCV) prevention,
44 screening, and treatment programs that are targeted toward maximum public health
45 benefit; (4) advocate, in collaboration with state and specialty medical societies, as well
46 as patient advocacy groups, for the elimination of sobriety requirements, fibrosis
47 restrictions, and prescriber restrictions for coverage of HCV treatment by public and
48 private payors; (5) support programs aimed at training providers in the treatment and
49 management of patients infected with HCV; (6) support adequate funding by, and
50 negotiation for affordable pricing for HCV antiviral treatments between the government,
51 insurance companies, and other third party payers, so that all Americans for whom HCV
52 treatment would have a substantial proven benefit will be able to receive this treatment;

1 (76) recognize correctional physicians, and physicians in other public health settings, as
2 key stakeholders in the development of HCV treatment guidelines; (87) encourage
3 equitable reimbursement for those providing treatment; (9) encourage the allocation of
4 targeted funding to increase HCV treatment for IHS patients insured by plans subject to
5 HCV treatment restrictions. (Modify Current HOD Policy)

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

Received: 04/08/22

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RELEVANT AMA POLICY

Advocacy for Hepatitis C Virus Education, Prevention, Screening and Treatment H-440.845

Our AMA will: (1) encourage the adoption of birth year-based screening practices for hepatitis C, in alignment with Centers for Disease Control and Prevention (CDC) recommendations; (2) encourage the CDC and state Departments of Public Health to develop and coordinate Hepatitis C Virus infection educational and prevention efforts; (3) support hepatitis C virus (HCV) prevention, screening, and treatment programs that are targeted toward maximum public health benefit; (4) support programs aimed at training providers in the treatment and management of patients infected with HCV; (5) support adequate funding by, and negotiation for affordable pricing for HCV antiviral treatments between the government, insurance companies, and other third party payers, so that all Americans for whom HCV treatment would have a substantial proven benefit will be able to receive this treatment; (6) recognize correctional physicians, and physicians in other public health settings, as key stakeholders in the development of HCV treatment guidelines; and (7) encourage equitable reimbursement for those providing treatment. Citation: Res. 906, I-12; Modified: Res. 511, A-15; Modified: Res. 410, A-17

Support for Standardized Diagnosis and Treatment of Hepatitis C Virus in the Population of Incarcerated Persons H-430.985

Our AMA: (1) supports the implementation of routine screening for Hepatitis C virus (HCV) in prisons; (2) will advocate for the initiation of treatment for HCV when determined to be appropriate by the treating physician in incarcerated patients with the infection who are seeking treatment; and (3) supports negotiation for affordable pricing for therapies to treat and cure HCV among correctional facility health care providers, correctional facility health care payors, and drug companies to maximize access to these disease-altering medications. Citation: Res. 404, A-17

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; Reaffirmed: CSAPH Rep. 2, I-19; Reaffirmed: CMS Rep. 4, I-19; Reaffirmed: CMS Rep. 6, I-20

US Physician Shortage H-200.954

Our AMA:

- (1) explicitly recognizes the existing shortage of physicians in many specialties and areas of the US;
- (2) supports efforts to quantify the geographic maldistribution and physician shortage in many specialties;
- (3) supports current programs to alleviate the shortages in many specialties and the maldistribution of physicians in the US;
- (4) encourages medical schools and residency programs to consider developing admissions policies and practices and targeted educational efforts aimed at attracting physicians to practice in underserved areas and to provide care to underserved populations;
- (5) encourages medical schools and residency programs to continue to provide courses, clerkships, and longitudinal experiences in rural and other underserved areas as a means to support educational program objectives and to influence choice of graduates' practice locations;
- (6) encourages medical schools to include criteria and processes in admission of medical students that are predictive of graduates' eventual practice in underserved areas and with underserved populations;
- (7) will continue to advocate for funding from public and private payers for educational programs that provide experiences for medical students in rural and other underserved areas;
- (8) will continue to advocate for funding from all payers (public and private sector) to increase the number of graduate medical education positions in specialties leading to first certification;
- (9) will work with other groups to explore additional innovative strategies for funding graduate medical education positions, including positions tied to geographic or specialty need;
- (10) continues to work with the Association of American Medical Colleges (AAMC) and other relevant groups to monitor the outcomes of the National Resident Matching Program; and
- (11) continues to work with the AAMC and other relevant groups to develop strategies to address the current and potential shortages in clinical training sites for medical students.
- (12) will: (a) promote greater awareness and implementation of the Project ECHO (Extension for Community Healthcare Outcomes) and Child Psychiatry Access Project models among academic health centers and community-based primary care physicians; (b) work with stakeholders to identify and mitigate barriers to broader implementation of these models in the United States; and (c) monitor whether health care payers offer additional payment or incentive payments for physicians who engage in clinical practice improvement activities as a result of their participation in programs such as Project ECHO and the Child Psychiatry Access Project; and if confirmed, promote awareness of these benefits among physicians.
- (13) will work to augment the impact of initiatives to address rural physician workforce shortages.

Citation: Res. 807, I-03; Reaffirmation I-06; Reaffirmed: CME Rep. 7, A-08; Appended: CME Rep. 4, A-10; Appended: CME Rep. 16, A-10; Reaffirmation: I-12; Reaffirmation A-13; Appended: Res. 922, I-13; Modified: CME Rep. 7, A-14; Reaffirmed: CME Rep. 03, A-16; Appended: Res. 323, A-19; Appended: CME Rep. 3, I-21

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 217
(A-22)

Introduced by: Resident and Fellow Section

Subject: Preserving the Practice of Medicine

Referred to: Reference Committee B

1 Whereas, The book *Patients at Risk: The Rise of the Nurse Practitioner and Physician Assistant*
2 *in Healthcare* by Niran Al-Agba, M.D. and Rebekah Bernard, M.D. published in 2020, seeks to
3 educate patients about the safety of the providers treating them and empower physicians to
4 regain control of the practice of medicine¹; and

5
6 Whereas, The corporatization of medicine, at the expense of quality safe healthcare, has led to
7 physicians being replaced by non-physician providers, especially in states with legislatively-
8 enshrined independent practice for non-physician providers¹; and

9
10 Whereas, News reports and articles note instances of thoracic surgeons and obstetrician
11 gynecologists supervising social workers in the provision of group therapy² and plastic surgeons
12 supervising physician assistants who advertise themselves as “dermatologists”³; and

13
14 Whereas, Anecdotal evidence suggests numerous non-physician providers practicing in various
15 fields with nominal supervision by physicians who are not trained in those fields; and

16
17 Whereas, Physicians without appropriate training to supervise non-physician providers outside
18 of their expertise defeats the purpose of scope-of-practice laws, endangering patients; and

19
20 Whereas, Studies show that care provided by non-physician providers is more expensive and
21 invasive due to more frequent office visits, lab testing, imaging and home visits^{4,5}; and

22
23 Whereas, No credible controlled trial has been performed to evaluate the quality of care
24 provided by non-physicians vs. physicians in settings that are truly characterized as
25 “independent practice”⁵; and

26
27 Whereas, Non-physician providers seeking independent practice inaccurately cite studies to
28 claim non-physicians supervised by physicians have equal outcomes to physicians⁵, and

29
30 Whereas, An increasing number of healthcare organizations preferentially fill the schedules of
31 non-physician providers over physicians to increase profit⁵; and

32
33 Whereas, There are efforts by the National Organization of Nurse Practitioner Faculties by
34 2025 to convert Master of Science in Nursing (MSN) degrees into Doctor of Nursing Practice
35 degrees (DNP), many of which are online programs without clear standards of curricula⁶;
36 therefore be it

37
38 RESOLVED, That our American Medical Association oppose mandates from employers to
39 supervise non-physician providers as a condition for physician employment and in physician
40 employment contracts (New HOD Policy); and be it further

1 RESOLVED, That our AMA work with relevant regulatory agencies to ensure physicians are
2 notified in writing when their license is being used to “supervise” non-physician providers
3 (Directive to Take Action); and be it further
4

5 RESOLVED, That our AMA conduct a systematic study to collect and analyze publicly available
6 physician supervision data from all sources to determine how many allied health professionals
7 are being supervised by physicians in fields which are not a core part of those physicians’
8 completed residencies and fellowships (Directive to Take Action); and be it further
9

10 RESOLVED, That our AMA study the impact scope-of practice advocacy by physicians has had
11 on physician employment and termination (Directive to Take Action); and be it further
12

13 RESOLVED, That our AMA study the views of patients on physician and non-physician care to
14 identify best practices in educating the general population on the value of physician-led care,
15 and study the utility of a physician-reported database to track and report institutions that replace
16 physicians with non-physician providers in order to aid patients in seeking physician-led medical
17 care (Directive to Take Action); and be it further
18

19 RESOLVED, That our AMA work with relevant stakeholders to commission an independent
20 study comparing medical care provided by physician-led health care teams vs. care provided by
21 unsupervised non-physician providers, which reports on the quality of health outcomes, cost
22 effectiveness, and access to necessary medical care, and to publish the findings in a peer-
23 reviewed medical journal. (Directive to Take Action)

Fiscal Note: Estimated cost of \$462,000 to implement this resolution.

Received: 04/08/22

References:

1. Al-Agba, Niran, and Rebekah Bernard. *Patients at Risk: the Rise of the Nurse Practitioner and Physician Assistant in Healthcare*. Universal-Publishers, Inc., 2020
2. Ornstein C and ProPublica. Illinois leads Medicare billings for group therapy. Chicago Tribune. 13 Jul 2014. chicagotribune.com/lifestyles/health/ct-medicare-group-therapy-met-20140713-story.html. Accessed 18 Sep 2019.
3. Al-agba N. The P.A. Problem: Who You See and What You Get. The Healthcare Blog. 24 Nov 2017. <https://thehealthcareblog.com/blog/2017/11/24/the-p-a-problem/>. Accessed 18 Sep 2019.
4. The First U.S. Study on Nurses' Evidence-Based Practice Competencies Indicates Major Deficits That Threaten Healthcare Quality, Safety, and Patient Outcomes - PubMed (nih.gov)
5. Al-Agba, Niran, and Rebekah Bernard. *Patients at Risk: the Rise of the Nurse Practitioner and Physician Assistant in Healthcare*. Universal-Publishers, Inc., 2020.
6. NP to DNP: In Less Than 10 Years, All Nurse Practitioners May Need to Hold a DNP - Regis College Online

RELEVANT AMA POLICY

Practicing Medicine by Non-Physicians H-160.949

Our AMA: (1) urges all people, including physicians and patients, to consider the consequences of any health care plan that places any patient care at risk by substitution of a non-physician in the diagnosis, treatment, education, direction and medical procedures where clear-cut documentation of assured quality has not been carried out, and where such alters the traditional pattern of practice in which the physician directs and supervises the care given;
(2) continues to work with constituent societies to educate the public regarding the differences in the scopes of practice and education of physicians and non-physician health care workers;
(3) continues to actively oppose legislation allowing non-physician groups to engage in the practice of medicine without physician (MD, DO) training or appropriate physician (MD, DO) supervision;
(4) continues to encourage state medical societies to oppose state legislation allowing non-physician groups to engage in the practice of medicine without physician (MD, DO) training or

appropriate physician (MD, DO) supervision;
(5) through legislative and regulatory efforts, vigorously support and advocate for the requirement of appropriate physician supervision of non-physician clinical staff in all areas of medicine; and

(6) opposes special licensing pathways for “assistant physicians” (i.e., those who are not currently enrolled in an Accreditation Council for Graduate Medical Education training program, or have not completed at least one year of accredited graduate medical education in the U.S).
Citation: Res. 317, I-94; Modified by Res. 501, A-97; Appended: Res. 321, I-98; Reaffirmation A-99; Appended: Res. 240, Reaffirmed: Res. 708 and Reaffirmation A-00; Reaffirmed: CME Rep. 1, I-00; Reaffirmed: CMS Rep. 6, A-10; Reaffirmed: Res. 208, I-10; Reaffirmed: Res. 224, A-11; Reaffirmed: BOT Rep. 9, I-11; Reaffirmed: Res. 107, A-14; Appended: Res. 324, A-14; Modified: CME Rep. 2, A-21;

Physician Assistants and Nurse Practitioners H-160.947

Our AMA will develop a plan to assist the state and local medical societies in identifying and lobbying against laws that allow advanced practice nurses to provide medical care without the supervision of a physician.

The suggested Guidelines for Physician/Physician Assistant Practice are adopted to read as follows (these guidelines shall be used in their entirety):

- (1) The physician is responsible for managing the health care of patients in all settings.
- (2) Health care services delivered by physicians and physician assistants must be within the scope of each practitioner's authorized practice, as defined by state law.
- (3) The physician is ultimately responsible for coordinating and managing the care of patients and, with the appropriate input of the physician assistant, ensuring the quality of health care provided to patients.
- (4) The physician is responsible for the supervision of the physician assistant in all settings.
- (5) The role of the physician assistant in the delivery of care should be defined through mutually agreed upon guidelines that are developed by the physician and the physician assistant and based on the physician's delegatory style.
- (6) The physician must be available for consultation with the physician assistant at all times, either in person or through telecommunication systems or other means.
- (7) The extent of the involvement by the physician assistant in the assessment and implementation of treatment will depend on the complexity and acuity of the patient's condition and the training, experience, and preparation of the physician assistant, as adjudged by the physician.
- (8) Patients should be made clearly aware at all times whether they are being cared for by a physician or a physician assistant.
- (9) The physician and physician assistant together should review all delegated patient services on a regular basis, as well as the mutually agreed upon guidelines for practice.
- (10) The physician is responsible for clarifying and familiarizing the physician assistant with his/her supervising methods and style of delegating patient care.

Citation: BOT Rep. 6, A-95; Reaffirmed: Res 240 and Reaffirmation A-00; Reaffirmed: Res. 213, A-02; Modified: CLRPD Rep. 1, A-03; Reaffirmed: BOT Rep. 9, I-11; Reaffirmed: Joint CME-CMS Rep., I-12; Reaffirmed: BOT Rep. 16, A-13

Guidelines for Integrated Practice of Physician and Nurse Practitioner H-160.950

Our AMA endorses the following guidelines and recommends that these guidelines be considered and quoted only in their entirety when referenced in any discussion of the roles and responsibilities of nurse practitioners: (1) The physician is responsible for the supervision of nurse practitioners and other advanced practice nurses in all settings.

- (2) The physician is responsible for managing the health care of patients in all practice settings.
- (3) Health care services delivered in an integrated practice must be within the scope of each

practitioner's professional license, as defined by state law.

(4) In an integrated practice with a nurse practitioner, the physician is responsible for supervising and coordinating care and, with the appropriate input of the nurse practitioner, ensuring the quality of health care provided to patients.

(5) The extent of involvement by the nurse practitioner in initial assessment, and implementation of treatment will depend on the complexity and acuity of the patients' condition, as determined by the supervising/collaborating physician.

(6) The role of the nurse practitioner in the delivery of care in an integrated practice should be defined through mutually agreed upon written practice protocols, job descriptions, and written contracts.

(7) These practice protocols should delineate the appropriate involvement of the two professionals in the care of patients, based on the complexity and acuity of the patients' condition.

(8) At least one physician in the integrated practice must be immediately available at all times for supervision and consultation when needed by the nurse practitioner.

(9) Patients are to be made clearly aware at all times whether they are being cared for by a physician or a nurse practitioner.

(10) In an integrated practice, there should be a professional and courteous relationship between physician and nurse practitioner, with mutual acknowledgment of, and respect for each other's contributions to patient care.

(11) Physicians and nurse practitioners should review and document, on a regular basis, the care of all patients with whom the nurse practitioner is involved. Physicians and nurse practitioners must work closely enough together to become fully conversant with each other's practice patterns.

Citation: (CMS Rep. 15 - I-94; BOT Rep. 6, A-95; Reaffirmed: Res. 240, A-00; Reaffirmation A-00; Reaffirmed: BOT Rep. 28, A-09; Reaffirmed: BOT Rep. 9, I-11; Reaffirmed: Joint CME-CMS Rep., I-12; Reaffirmed: BOT Rep. 16, A-13)

Principles Guiding AMA Policy Regarding Supervision of Medical Care Delivered by Advanced Practice Nurses in Integrated Practice H-360.987

Our AMA endorses the following principles: (1) Physicians must retain authority for patient care in any team care arrangement, e.g., integrated practice, to assure patient safety and quality of care.

(2) Medical societies should work with legislatures and licensing boards to prevent dilution of the authority of physicians to lead the health care team.

(3) Exercising independent medical judgment to select the drug of choice must continue to be the responsibility only of physicians.

(4) Physicians should recognize physician assistants and advanced practice nurses under physician leadership, as effective physician extenders and valued members of the health care team.

(5) Physicians should encourage state medical and nursing boards to explore the feasibility of working together to coordinate their regulatory initiatives and activities.

(6) Physicians must be responsible and have authority for initiating and implementing quality control programs for nonphysicians delivering medical care in integrated practices.

Citation: (BOT Rep. 23, A-96; Reaffirmation A-99; Reaffirmed: Res. 240, and Reaffirmation A-00; Reaffirmed: CMS Rep. 6, A-10; Reaffirmed: BOT Rep. 9, I-11; Reaffirmation A-12; Reaffirmed: BOT Rep. 16, A-13)

Practice Agreements Between Physicians and Advance Practice Nurses and the Physician to Advance Practice Nurse Supervisory Ratio H-35.969

Our AMA will: (1) continue to work with the Federation in developing necessary state advocacy resource tools to assist the Federation in: (a) addressing the development of practice agreements between practicing physicians and advance practice nurses, and (b) responding to or developing state legislation or regulations governing these practice agreements, and that the AMA make these tools available on the AMA Advocacy Resource Center Web site; and (2) support the development of methodologically valid research comparing physician-APRN practice agreements and their respective effectiveness.

Citation: BOT Rep. 28, A-09; Reaffirmed: BOT Rep. 09, A-19;

Regulation of Advanced Practice Nurses H-35.964

1. AMA policy is that advanced practice registered nurses (APRNs) should be subject to the jurisdiction of state medical licensing and regulatory boards for regulation of their performance of medical acts.

2. Our AMA will develop model legislation to create a joint regulatory board composed of members of boards of medicine and nursing, with authority over APRNs.

Citation: BOT Action in response to referred for decision Amendment B-3 to Res. 233 A-17

Protecting Physician Led Health Care H-35.966

Our American Medical Association will continue to work with state and specialty medical associations and other organizations to collect, analyze and disseminate data on the expanded use of allied health professionals, and of the impact of this practice on healthcare access (including in poor, underserved, and rural communities), quality, and cost in those states that permit independent practice of allied health professionals as compared to those that do not. This analysis should include consideration of practitioner settings and patient risk-adjustment.

Citation: Res. 238, A-15; Reaffirmed: BOT Rep. 20, A-17;

Education Programs Offered to, for or by Allied Health Professionals Associated with a Hospital H-35.978

The AMA encourages hospital medical staffs to have a process whereby physicians will have input to and provide review of education programs provided by their hospital for the benefit of allied health professionals working in that hospital, for the education of patients served by that hospital, and for outpatient educational programs provided by that hospital.

Citation: (BOT Rep. B, A-93; Adopts Res. 317, A-92; Reaffirmed: CME Rep. 2, A-03; Reaffirmed: CME Rep. 2, A-13)

Health Workforce H-200.994

The AMA endorses the following principle on health manpower: Both physicians and allied health professionals have legal and ethical responsibilities for patient care, even though ultimate responsibility for the individual patient's medical care rests with the physician. To assure quality patient care, the medical profession and allied health professionals should have continuing dialogue on patient care functions that may be delegated to allied health professionals consistent with their education, experience and competency.

Citation: (BOT Rep. C, I-81; Reaffirmed: Sunset Report, I-98; Modified: CME Rep. 2, I-03; Reaffirmed: CME Rep. 2, A-13)

Health Care Quality Improvement Act of 1986 Amendments H-275.965

The AMA supports modification of the federal Health Care Quality Improvement Act in order to provide immunity from federal antitrust liability to those medical staffs credentialing and conducting good faith peer review for allied health professionals to the same extent that immunity applies to credentialing of physicians and dentists.

Citation: (Res. 203, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmation A-05; Reaffirmed: BOT Rep. 10, A-15)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 218
(A-22)

Introduced by: American Association of Physicians of Indian Origin

Subject: Expedited Immigrant Green Card Visa for J-1 Visa Waiver Physicians Serving in Underserved Areas

Referred to: Reference Committee B

- 1 Whereas, J-1 visa IMG resident physicians sign in for serving in underserved areas for three
2 years to become eligible to stay in US as permanent residents instead of mandatory return to
3 native countries as required per J-1 visa regulation; and
4
5 Whereas, Their service is extremely helpful in improving the health of US citizens especially in
6 low income and rural communities; and
7
8 Whereas, Substantial care to COVID patients was provided by these J-1 visa waiver physicians
9 and they saved lives; and
10
11 Whereas, The waiting period for getting the Green Card Visa for physicians of certain countries
12 is longer than 10 years at present due to per country limit of 7% of H1b to immigrant (Green
13 Card) availability, and the J-1 visa waiver physicians have to join the end of the very long queue
14 of 1.2 million applicants for certain countries, and their children are becoming status less at
15 age 21; and
16
17 Whereas, These J-1 visa waiver physicians provide a great national service to US citizens, and
18 deserve priority in visa allotment; therefore be it
19
20 RESOLVED, That our American Medical Association lobby US Congress and the US
21 Administration that the J-1 visa waiver physicians serving in underserved areas be given highest
22 priority in visa conversion to green cards upon completion of their service commitment
23 obligation and be exempted from per country limitation of H-1 to green card visa conversion.
24 (Directive to Take Action)

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

Received: 04/20/22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 219
(A-22)

Introduced by: American College of Emergency Physicians

Subject: Due Process and Independent Contractors

Referred to: Reference Committee B

1 Whereas, Physicians often hesitate to speak out because of the prospect of losing their jobs or
2 suffering other types of retaliation due to a possible or real threat if they expressed concerns
3 about quality of care¹; and
4

5 Whereas, Physicians have been retaliated against numerous times for raising concerns
6 regarding patient safety, harassment, and/or fraud and these physicians have been affected
7 mentally and financially as results of such retaliation and job loss and many report worsening
8 anxiety, depression, financial hardships, family trouble and need to relocate²; and
9

10 Whereas, The interests of patients are best served when physicians practice in a stable, fair,
11 equitable, and supportive environment and quality patient care is best promoted within a
12 framework of fair and appropriate contractual relationships among various involved parties; and
13

14 Whereas, The COVID-19 pandemic put to the test physicians' ability to speak publicly about
15 troublesome issues and in the first few weeks, healthcare facilities were struggling to obtain
16 personal protective equipment (PPE) and to create policies that would keep patients and
17 caregivers safe^{3,4}; and
18

19 Whereas, The Joint Commission and the Health Care Quality Improvement Act of 1986 require
20 hospitals to give physicians appropriate due process before taking an adverse action on their
21 privileges; and
22

23 Whereas, There are also a number of state and federal laws that protect employees from
24 discrimination or retribution for "whistle-blowing," but these protections may be weakened or
25 inapplicable if the physician is an independent contractor⁵; and
26

27 Whereas, Our AMA Principles for Physician Employment (H-225.950) states in part "Employed
28 physicians should be free to exercise their personal and professional judgment in voting,
29 speaking and advocating on any manner regarding patient care interests, the profession, health
30 care in the community, and the independent exercise of medical judgment. Employed
31 physicians should not be deemed in breach of their employment agreements, nor be retaliated

¹ McNamara RM, Beier K, Blumstein H, Weiss LD, Wood J. A survey of emergency physicians regarding due process, financial pressures, and the ability to advocate for patients. J Emerg Med. 2013 Jul;45(1):111-6.e3. doi: 10.1016/j.jemermed.2012.12.019. Epub 2013 Apr 18. PMID: 23602793.

² https://www.nbcnews.com/health/health-care/doctor-fired-er-warns-effect-profit-firms-us-health-care-rcna19975?utm_source=pocket_mylist (last accessed April 6, 2022)

³ <https://www.medscape.com/viewarticle/950074>

⁴ <https://verdictsearch.com/verdict/hospitals-firing-of-doctor-was-retaliation-plaintiff-alleged/>

<https://www.reliasmedia.com/articles/146234-enforcement-action-likely-if-hospital-retaliates-against-ed-staff>

<https://www.npr.org/sections/health-shots/2020/05/29/865042307/an-er-doctor-lost-his-job-after-criticizing-his-hospital-on-covid-19-now-hes-sui>

⁵ <https://www.aaemrsa.org/get-involved/residents/key-contract-issues>

1 against by their employers, for asserting these interests. Employed physicians also should enjoy
2 academic freedom to pursue clinical research and other academic pursuits within the ethical
3 principles of the medical profession and the guidelines of the organization;” and
4

5 Whereas, The State of Arizona recently passed Arizona House Bill 2622 (2021) to address
6 many of these concerns, and several other states have enacted similar legislation, each with
7 their own strengths and weaknesses; and
8

9 Whereas, Our AMA policies are silent on those physicians who work as independent contractors
10 and might be subject to retaliatory actions by their contractors rather than their employer;
11 therefore be it
12

13 RESOLVED, That our American Medical Association develop a model state legislative template
14 and principles for federal legislation in order to protect physicians from corporate, workplace,
15 and/or employer retaliation when reporting safety, harassment, or fraud concerns at the places
16 of work (licensed health care institution) or in the government, which includes independent and
17 third-party contractors providing patient services at said facilities. (Directive to Take Action)

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

Received: 04/27/22

RELEVANT AMA POLICY

AMA Principles for Physician Employment H-225.950

1. Addressing Conflicts of Interest

a) A physician's paramount responsibility is to his or her patients. Additionally, given that an employed physician occupies a position of significant trust, he or she owes a duty of loyalty to his or her employer. This divided loyalty can create conflicts of interest, such as financial incentives to over- or under-treat patients, which employed physicians should strive to recognize and address.

b) Employed physicians should be free to exercise their personal and professional judgment in voting, speaking and advocating on any manner regarding patient care interests, the profession, health care in the community, and the independent exercise of medical judgment. Employed physicians should not be deemed in breach of their employment agreements, nor be retaliated against by their employers, for asserting these interests. Employed physicians also should enjoy academic freedom to pursue clinical research and other academic pursuits within the ethical principles of the medical profession and the guidelines of the organization.

c) In any situation where the economic or other interests of the employer are in conflict with patient welfare, patient welfare must take priority.

d) Physicians should always make treatment and referral decisions based on the best interests of their patients. Employers and the physicians they employ must assure that agreements or understandings (explicit or implicit) restricting, discouraging, or encouraging particular treatment or referral options are disclosed to patients.

(i) No physician should be required or coerced to perform or assist in any non-emergent procedure that would be contrary to his/her religious beliefs or moral convictions; and

(ii) No physician should be discriminated against in employment, promotion, or the extension of staff or other privileges because he/she either performed or assisted in a lawful, non-emergent procedure, or refused to do so on the grounds that it violates his/her religious beliefs or moral convictions.

e) Assuming a title or position that may remove a physician from direct patient-physician relationships--such as medical director, vice president for medical affairs, etc.--does not override professional ethical obligations. Physicians whose actions serve to override the individual patient care decisions of other physicians are themselves engaged in the practice of medicine and are subject to professional ethical obligations and may be legally responsible for such decisions. Physicians who hold administrative

leadership positions should use whatever administrative and governance mechanisms exist within the organization to foster policies that enhance the quality of patient care and the patient care experience.

Refer to the AMA Code of Medical Ethics for further guidance on conflicts of interest.

2. Advocacy for Patients and the Profession

a) Patient advocacy is a fundamental element of the patient-physician relationship that should not be altered by the health care system or setting in which physicians practice, or the methods by which they are compensated.

b) Employed physicians should be free to engage in volunteer work outside of, and which does not interfere with, their duties as employees.

3. Contracting

a) Physicians should be free to enter into mutually satisfactory contractual arrangements, including employment, with hospitals, health care systems, medical groups, insurance plans, and other entities as permitted by law and in accordance with the ethical principles of the medical profession.

b) Physicians should never be coerced into employment with hospitals, health care systems, medical groups, insurance plans, or any other entities. Employment agreements between physicians and their employers should be negotiated in good faith. Both parties are urged to obtain the advice of legal counsel experienced in physician employment matters when negotiating employment contracts.

c) When a physician's compensation is related to the revenue he or she generates, or to similar factors, the employer should make clear to the physician the factors upon which compensation is based.

d) Termination of an employment or contractual relationship between a physician and an entity employing that physician does not necessarily end the patient-physician relationship between the employed physician and persons under his/her care. When a physician's employment status is unilaterally terminated by an employer, the physician and his or her employer should notify the physician's patients that the physician will no longer be working with the employer and should provide them with the physician's new contact information. Patients should be given the choice to continue to be seen by the physician in his or her new practice setting or to be treated by another physician still working with the employer. Records for the physician's patients should be retained for as long as they are necessary for the care of the patients or for addressing legal issues faced by the physician; records should not be destroyed without notice to the former employee. Where physician possession of all medical records of his or her patients is not already required by state law, the employment agreement should specify that the physician is entitled to copies of patient charts and records upon a specific request in writing from any patient, or when such records are necessary for the physician's defense in malpractice actions, administrative investigations, or other proceedings against the physician.

(e) Physician employment agreements should contain provisions to protect a physician's right to due process before termination for cause. When such cause relates to quality, patient safety, or any other matter that could trigger the initiation of disciplinary action by the medical staff, the physician should be afforded full due process under the medical staff bylaws, and the agreement should not be terminated before the governing body has acted on the recommendation of the medical staff. Physician employment agreements should specify whether or not termination of employment is grounds for automatic termination of hospital medical staff membership or clinical privileges. When such cause is non-clinical or not otherwise a concern of the medical staff, the physician should be afforded whatever due process is outlined in the employer's human resources policies and procedures.

(f) Physicians are encouraged to carefully consider the potential benefits and harms of entering into employment agreements containing without cause termination provisions. Employers should never terminate agreements without cause when the underlying reason for the termination relates to quality, patient safety, or any other matter that could trigger the initiation of disciplinary action by the medical staff.

(g) Physicians are discouraged from entering into agreements that restrict the physician's right to practice medicine for a specified period of time or in a specified area upon termination of employment.

(h) Physician employment agreements should contain dispute resolution provisions. If the parties desire an alternative to going to court, such as arbitration, the contract should specify the manner in which disputes will be resolved.

Refer to the AMA Annotated Model Physician-Hospital Employment Agreement and the AMA Annotated Model Physician-Group Practice Employment Agreement for further guidance on physician employment contracts.

4. Hospital Medical Staff Relations

- a) Employed physicians should be members of the organized medical staffs of the hospitals or health systems with which they have contractual or financial arrangements, should be subject to the bylaws of those medical staffs, and should conduct their professional activities according to the bylaws, standards, rules, and regulations and policies adopted by those medical staffs.
- b) Regardless of the employment status of its individual members, the organized medical staff remains responsible for the provision of quality care and must work collectively to improve patient care and outcomes.
- c) Employed physicians who are members of the organized medical staff should be free to exercise their personal and professional judgment in voting, speaking, and advocating on any matter regarding medical staff matters and should not be deemed in breach of their employment agreements, nor be retaliated against by their employers, for asserting these interests.
- d) Employers should seek the input of the medical staff prior to the initiation, renewal, or termination of exclusive employment contracts.

Refer to the AMA Conflict of Interest Guidelines for the Organized Medical Staff for further guidance on the relationship between employed physicians and the medical staff organization.

5. Peer Review and Performance Evaluations

- a) All physicians should promote and be subject to an effective program of peer review to monitor and evaluate the quality, appropriateness, medical necessity, and efficiency of the patient care services provided within their practice settings.
- b) Peer review should follow established procedures that are identical for all physicians practicing within a given health care organization, regardless of their employment status.
- c) Peer review of employed physicians should be conducted independently of and without interference from any human resources activities of the employer. Physicians--not lay administrators--should be ultimately responsible for all peer review of medical services provided by employed physicians.
- d) Employed physicians should be accorded due process protections, including a fair and objective hearing, in all peer review proceedings. The fundamental aspects of a fair hearing are a listing of specific charges, adequate notice of the right to a hearing, the opportunity to be present and to rebut evidence, and the opportunity to present a defense. Due process protections should extend to any disciplinary action sought by the employer that relates to the employed physician's independent exercise of medical judgment.
- e) Employers should provide employed physicians with regular performance evaluations, which should be presented in writing and accompanied by an oral discussion with the employed physician. Physicians should be informed before the beginning of the evaluation period of the general criteria to be considered in their performance evaluations, for example: quality of medical services provided, nature and frequency of patient complaints, employee productivity, employee contribution to the administrative/operational activities of the employer, etc.
- (f) Upon termination of employment with or without cause, an employed physician generally should not be required to resign his or her hospital medical staff membership or any of the clinical privileges held during the term of employment, unless an independent action of the medical staff calls for such action, and the physician has been afforded full due process under the medical staff bylaws. Automatic rescission of medical staff membership and/or clinical privileges following termination of an employment agreement is tolerable only if each of the following conditions is met:
 - i. The agreement is for the provision of services on an exclusive basis; and
 - ii. Prior to the termination of the exclusive contract, the medical staff holds a hearing, as defined by the medical staff and hospital, to permit interested parties to express their views on the matter, with the medical staff subsequently making a recommendation to the governing body as to whether the contract should be terminated, as outlined in AMA Policy H-225.985; and

iii. The agreement explicitly states that medical staff membership and/or clinical privileges must be resigned upon termination of the agreement.

Refer to the AMA Principles for Incident-Based Peer Review and Disciplining at Health Care Organizations (AMA Policy H-375.965) for further guidance on peer review.

6. Payment Agreements

a) Although they typically assign their billing privileges to their employers, employed physicians or their chosen representatives should be prospectively involved if the employer negotiates agreements for them for professional fees, capitation or global billing, or shared savings. Additionally, employed physicians should be informed about the actual payment amount allocated to the professional fee component of the total payment received by the contractual arrangement.

b) Employed physicians have a responsibility to assure that bills issued for services they provide are accurate and should therefore retain the right to review billing claims as may be necessary to verify that such bills are correct. Employers should indemnify and defend, and save harmless, employed physicians with respect to any violation of law or regulation or breach of contract in connection with the employer's billing for physician services, which violation is not the fault of the employee.

Our AMA will disseminate the AMA Principles for Physician Employment to graduating residents and fellows and will advocate for adoption of these Principles by organizations of physician employers such as, but not limited to, the American Hospital Association and Medical Group Management Association.

BOT Rep. 6, I-12 [Reaffirmed: CMS Rep. 6, I-13](#) Modified in lieu of Res. 2, I-13 Modified: Res. 737, A-14
Reaffirmed: BOT Rep. 21, A-16 [Reaffirmed: CMS Rep. 05, A-17](#) [Reaffirmed: CMS Rep. 07, A-19](#)
[Reaffirmed: CMS Rep. 11, A-19](#) Modified: BOT Rep. 13, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 220
(A-22)

Introduced by: Aerospace Medical Association

Subject: Vital Nature of Board-Certified Physicians in Aerospace Medicine

Referred to: Reference Committee B

1 Whereas, Aerospace medicine is an internationally recognized, unique specialty of medicine
2 with advanced education requirements supporting all domains of aviation and space flight; and
3
4 Whereas, In over a century of support, the Aerospace Medicine Team, led by aerospace
5 medicine physicians, has advanced the art and science of every human flight endeavor,
6 resulting in improved safety, reduced mishaps, and enhanced mission accomplishment; and
7
8 Whereas, Aerospace medicine physicians are required to maintain their professional knowledge
9 and standing with state medical licensure, current specialty board certifications, continuing
10 medical education activities, and ongoing privileging; and have extensive knowledge, skills, and
11 professional self-regulation in the full and total range of the practice of aerospace medicine; and
12
13 Whereas, In an effort to reduce costs and pass-on legal liability, there has been a trend in
14 managed medical care, US commercial airlines/space activities and in the US governmental
15 departments to replace aerospace medicine physicians with non-aerospace medicine and mid-
16 level providers, resulting in significantly increased risk and reduced safety margins; and
17
18 Whereas, 193 countries are signatories to the Convention on International Civil Aviation
19 (“Chicago Convention”), which obliges the governments to reciprocally implement certain
20 international regulatory standards, including physician responsibility pertaining to medical fitness
21 of license holders, prevention of ill health and management of public health events in aviation;
22 therefore be it
23
24 RESOLVED, That our American Medical Association recognize the unique contributions and
25 advanced qualifications of aerospace medicine professionals, and specifically oppose any and
26 all efforts to remove, reduce or replace aerospace medicine physician leadership in civilian,
27 corporate or government aerospace medicine programs and aircrew healthcare support teams;
28 (Directive to Take Action) and be it further
29
30 RESOLVED, That our AMA advocate for compliance with international agreements, to include
31 advocating against other mid-level provider scope of practice expansions that threaten the
32 safety, health, and well-being of aircrew, patients, support personnel and the flying public.
33 (Directive to Take Action)

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

Received: 04/25/22

RELEVANT AMA POLICY

The Structure and Function of Interprofessional Health Care Teams H-160.912

1. Our AMA defines 'team-based health care' as the provision of health care services by a physician-led team of at least two health care professionals who work collaboratively with each other and the patient and family to accomplish shared goals within and across settings to achieve coordinated, high-quality, patient-centered care.
 2. Our AMA will advocate that the physician leader of a physician-led interprofessional health care team be empowered to perform the full range of medical interventions that she or he is trained to perform.
 3. Our AMA will advocate that all members of a physician-led interprofessional health care team be enabled to perform medical interventions that they are capable of performing according to their education, training and licensure and the discretion of the physician team leader in order to most effectively provide quality patient care.
 4. Our AMA adopts the following principles to guide physician leaders of health care teams:
 - a. Focus the team on patient and family-centered care.
 - b. Make clear the team's mission, vision and values.
 - c. Direct and/or engage in collaboration with team members on patient care.
 - d. Be accountable for clinical care, quality improvement, efficiency of care, and continuing education.
 - e. Foster a respectful team culture and encourage team members to contribute the full extent of their professional insights, information and resources.
 - f. Encourage adherence to best practice protocols that team members are expected to follow.
 - g. Manage care transitions by the team so that they are efficient and effective, and transparent to the patient and family.
 - h. Promote clinical collaboration, coordination, and communication within the team to ensure efficient, quality care is provided to the patient and that knowledge and expertise from team members is shared and utilized.
 - i. Support open communication among and between the patient and family and the team members to enhance quality patient care and to define the roles and responsibilities of the team members that they encounter within the specific team, group or network.
 - j. Facilitate the work of the team and be responsible for reviewing team members' clinical work and documentation.
 - k. Review measures of 'population health' periodically when the team is responsible for the care of a defined group.
 5. Our AMA encourages independent physician practices and small group practices to consider opportunities to form health care teams such as through independent practice associations, virtual networks or other networks of independent providers.
 6. Our AMA will advocate that the structure, governance and compensation of the team should be aligned to optimize the performance of the team leader and team members.
- Citation: Joint CME-CMS Rep., I-12; Reaffirmation I-13; Reaffirmed: CMS Rep. 1, I-15;
Reaffirmed: BOT Action in response to referred for decision: Res. 718, A-17

Models / Guidelines for Medical Health Care Teams H-160.906

1. Our AMA defines 'physician-led' in the context of team-based health care as the consistent use by a physician of the leadership knowledge, skills and expertise necessary to identify, engage and elicit from each team member the unique set of training, experience, and qualifications needed to help patients achieve their care goals, and to supervise the application of these skills.
2. Our AMA supports the following elements that should be considered when planning a team-based care model according to the needs of each physician practice:
Patient-Centered:

- a. The patient is an integral member of the team.
- b. A relationship is established between the patient and the team at the onset of care, and the role of each team member is explained to the patient.
- c. Patient and family-centered care is prioritized by the team and approved by the physician team leader.
- d. Team members are expected to adhere to agreed-upon practice protocols.
- e. Improving health outcomes is emphasized by focusing on health as well as medical care.
- f. Patients' access to the team, or coverage as designated by the physician-led team, is available twenty-four hours a day, seven days a week.
- g. Safety protocols are developed and followed by all team members.

Teamwork:

- h. Medical teams are led by physicians who have ultimate responsibility and authority to carry out final decisions about the composition of the team.
- i. All practitioners commit to working in a team-based care model.
- j. The number and variety of practitioners reflects the needs of the practice.
- k. Practitioners are trained according to their unique function in the team.
- l. Interdependence among team members is expected and relied upon.
- m. Communication about patient care between team members is a routine practice.
- n. Team members complete tasks according to agreed-upon protocols as directed by the physician leader.

Clinical Roles and Responsibilities:

- o. Physician leaders are focused on individualized patient care and the development of treatment plans.
- p. Non-physician practitioners are focused on providing treatment within their scope of practice consistent with their education and training as outlined in the agreed upon treatment plan or as delegated under the supervision of the physician team leader.
- q. Care coordination and case management are integral to the team's practice.
- r. Population management monitors the cost and use of care, and includes registry development for most medical conditions.

Practice Management:

- s. Electronic medical records are used to the fullest capacity.
- t. Quality improvement processes are used and continuously evolve according to physician-led team-based practice assessments.
- u. Data analytics include statistical and qualitative analysis on cost and utilization, and provide explanatory and predictive modeling.
- v. Prior authorization and precertification processes are streamlined through the adoption of electronic transactions.

Citation: CMS Rep. 6, A-14; Reaffirmed: CMS Rep. 07, A-16; Reaffirmed: CMS Rep. 05, A-17

Payment Mechanisms for Physician-Led Team-Based Health Care H-160.908

1. Our AMA advocates that physicians who lead team-based care in their practices receive the payments for health care services provided by the team and establish payment disbursement mechanisms that foster physician-led team-based care.
2. Our AMA advocates that payment models for physician-led team-based care should be determined by physicians working collaboratively with hospital and payer partners to design models best suited for their particular circumstances.
3. Our AMA advocates that physicians make decisions about payment disbursement in consideration of team member contributions, including but not limited to:
 - a. Volume of services provided;
 - b. Intensity of services provided;
 - c. Profession of the team member;
 - d. Training and experience of the team member; and

e. Quality of care provided.

4. Our AMA advocates that an effective payment system for physician-led team-based care should:

- a. Reflect the value provided by the team and that any savings accrued by this value should be shared by the team;
- b. Reflect the time, effort and intellectual capital provided by individual team members;
- c. Be adequate to attract team members with the appropriate skills and training to maximize the success of the team; and
- d. Be sufficient to sustain the team over the time frame that it is needed.

Citation: CMS Rep. 1, I-13; Reaffirmed: CMS Rep. 1, I-15; Reaffirmed: CMS Rep. 08, A-16

Support for Physician Led, Team Based Care D-35.985

Our AMA:

1. Reaffirms, will proactively advance at the federal and state level, and will encourage state and national medical specialty societies to promote policies H-35.970, H-35.973, H-35.974, H-35.988, H-35.989, H-35.992, H-35.993, H-160.919, H-160.929, H-160.947, H-160.949, H-160.950, H-360.987, H 405.969 and D-35.988.
2. Will identify and review available data to analyze the effects on patients' access to care in the opt-out states (states whose governor has opted out of the federal Medicare physician supervision requirements for anesthesia services) to determine whether there has been any increased access to care in those states.
3. Will identify and review available data to analyze the type and complexity of care provided by all non-physician providers, including CRNAs in the opt-out states (states whose governor has opted out of the federal Medicare physician supervision requirements for anesthesia services), compared to the type and complexity of care provided by physicians and/or the anesthesia care team.
4. Will advocate to policymakers, insurers and other groups, as appropriate, that they should consider the available data to best determine how non-physicians can serve as a complement to address the nation's primary care workforce needs.
5. Will continue to recognize non-physician providers as valuable components of the physician-led health care team.
6. Will continue to advocate that physicians are best qualified by their education and training to lead the health care team.
7. Will call upon the Robert Wood Johnson Foundation to publicly announce that the report entitled, "Common Ground: An Agreement between Nurse and Physician Leaders on Interprofessional Collaboration for the Future of Patient Care" was premature; was not released officially; was not signed; and was not adopted by the participants.

Citation: BOT Rep. 9, I-11; Reaffirmed: CMS Rep. 1, A-12; Reaffirmed: CMS Rep. 07, A-17; Reaffirmed: CMS Rep. 10, A-19; Reaffirmed: CMS Rep. 6, A-21

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 221
(A-22)

Introduced by: Women Physicians Section

Subject: Strategies to Mitigate Racial and Ethnic Disparities in Maternal and Fetal Morbidity and Mortality at the Grassroots Level

Referred to: Reference Committee B

1 Whereas, The United States has the highest maternal and infant mortality rates among
2 comparable developed countries, specifically in survival rates of African American mothers and
3 their infants, ^{1,2}and the rates for maternal mortality and severe maternal morbidity are about
4 three times higher for women who received C-sections versus vaginal deliveries,³ and academic
5 consensus recommend an urgency in implementation and tracking of remedial actions;^{1,2} and
6

7 Whereas, In the United States, Black women are more likely to receive C-sections when
8 compared to other women of color groups and white women, when adjusted for variables, even
9 among low-risk cohorts;^{3,4,5} and
10

11 Whereas, Mothers who were Medicaid recipients and received prenatal education and childbirth
12 support from trained doulas had lower odds of Cesarean sections and preterm births compared
13 to mothers who did not receive doula services;⁶ and
14

15 Whereas, Improving access to care, inclusivity of people of color, health prevention, affordable
16 healthcare and insurance coverage, tracking of quality outcome measures linked to provider
17 incentives are methods suited for eliminating racial disparities;^{5,6,7,8,9} and
18

19 Whereas, Eliminating barriers to training and licensure of a workforce pipeline inclusive of
20 doulas, midwives,^{6,10} and family physicians^{11,12,13} who provide maternity services made available
21 in rural and urban areas to supplement support to women can potentially reduce C-section rates
22 that put women and infants at risk;^{10,11,12,13} therefore, be it
23

24 RESOLVED, That our American Medical Association advocate for institutional and departmental
25 policies that promote awareness and transparency in defining the criteria for identifying and
26 mitigating gaps in health equity in Maternal Fetal outcome measures affecting racial and
27 minority U.S. population (Directive to Take Action); and be it further
28

29 RESOLVED, That our AMA engage with relevant stakeholders to initiate a similar awareness
30 campaign for public health education and health prevention at the grassroots level in the
31 communities, and advocate Medicaid and affordable insurance coverage for ancillary support
32 services. (Directive to Take Action)

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

Received: 05/04/22

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RELEVANT AMA POLICY

Disparities in Maternal Mortality D-420.993

Our AMA: (1) will ask the Commission to End Health Care **Disparities** to evaluate the issue of health **disparities in maternal mortality** and offer recommendations to address existing **disparities in the rates of maternal mortality in the United States**; (2) will work with the CDC, HHS, state and county health departments to decrease **maternal mortality rates in the US**; (3) encourages and promotes to all state and county health departments to develop, implement, and sustain a **maternal mortality** surveillance system that centers around health equity; and (4) will work with stakeholders to encourage research on identifying barriers and developing strategies toward the implementation of evidence-based practices to prevent disease conditions that contribute to poor obstetric outcomes, **maternal morbidity and maternal mortality in racial and ethnic minorities**.

CSAPH Rep. 3, A-09 Appended: Res. 403, A-11 Appended: Res. 417, A-18 Reaffirmed: Res. 229, A-21 Modified: Joint CMS/CSAPH Rep. 1, I-21

Reducing Inequities and Improving Access to Insurance for Maternal Health Care H-185.917

1. Our AMA acknowledges that structural racism and bias negatively impact the ability to provide optimal health care, including maternity care, for people of color.
2. Our AMA encourages physicians to raise awareness among colleagues, residents and fellows, staff, and hospital administrators about the prevalence of racial and ethnic inequities and the effect on health outcomes, work to eliminate these inequities, and promote an environment of trust.
3. Our AMA encourages physicians to pursue educational opportunities focused on embedding equitable, patient-centered care for patients who are pregnant and/or within 12 months postpartum into their clinical practices and encourages physician leaders of health care teams to support similar appropriate professional education for all members of their teams.
4. Our AMA will continue to monitor and promote ongoing research regarding the impacts of societal (e.g., racism or unaffordable health insurance), geographical, facility-level (e.g., hospital quality), clinician-level (e.g., implicit bias), and patient-level (e.g., comorbidities, chronic stress

or lack of transportation) barriers to optimal care that contribute to adverse and disparate maternal health outcomes, as well as research testing the effectiveness of interventions to address each of these barriers.

5. Our AMA will promote the adoption of federal standards for clinician collection of patient-identified race and ethnicity information in clinical and administrative data to better identify inequities. The federal data collection standards should be: (a) informed by research (including real-world testing of technical standards and standardized definitions of race and ethnicity terms to ensure that the data collected accurately reflect diverse populations and highlight, rather than obscure, critical distinctions that may exist within broad racial or ethnic categories), (b) carefully crafted in conjunction with clinician and patient input to protect patient privacy and provide non-discrimination protections, and (c) lead to the dissemination of best practices to guide respectful and non-coercive collection of accurate, standardized data relevant to maternal health outcomes.

6. Our AMA supports the development of a standardized definition of maternal mortality and the allocation of resources to states and Tribes to collect and analyze maternal mortality data (i.e., Maternal Mortality Review Committees and vital statistics) to enable stakeholders to better understand the underlying causes of maternal deaths and to inform evidence-based policies to improve maternal health outcomes and promote health equity.

7. Our AMA encourages hospitals, health systems, and state medical associations and national medical specialty societies to collaborate with non-clinical community organizations with close ties to minoritized and other at-risk populations to identify opportunities to best support pregnant persons and new families.

8. Our AMA encourages the development and funding of resources and outreach initiatives to help pregnant individuals, their families, their communities, and their workplaces to recognize the value of comprehensive prepregnancy, prenatal, peripartum, and postpartum care. These resources and initiatives should encourage patients to pursue both physical and behavioral health care, strive to reduce barriers to pursuing care, and highlight care that is available at little or no cost to the patient.

9. Our AMA supports adequate payment from all payers for the full spectrum of evidence-based prepregnancy, prenatal, peripartum, and postpartum physical and behavioral health care.

10. Our AMA encourages hospitals, health systems, and states to participate in maternal safety and quality improvement initiatives such as the Alliance for Innovation on Maternal Health program and state perinatal quality collaboratives.

11. Our AMA will advocate for increased access to risk-appropriate care by encouraging hospitals, health systems, and states to adopt verified, evidence-based levels of maternal care.

Citation: Joint CMS/CSAPH Rep. 1, I-21

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 222
(A-22)

Introduced by: Mississippi, Florida, Arizona, Texas, New Jersey, California

Subject: To Study the Economic Impact of Mid-Level Provider Employment in the United States of America

Referred to: Reference Committee B

1 Whereas, 24 out of 50 states have granted full practice rights for registered nurse practitioners
2 (<https://www.aanp.org/advocacy/state/state-practice-environment>); and
3

4 Whereas, In a CDC funded study performed in 2016, it was discovered that patients were more
5 frequently prescribed antibiotics if evaluated and treated by a NP or PA vs a physician only. The
6 frequency of antibiotic prescriptions was 17% to 12% for overall visits and 61% to 54% for acute
7 respiratory infection visits, respectively
8 (<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5047413/>); and
9

10 Whereas, A study published in 2013 determined that the quality of referrals to an academic
11 medical center was higher for physicians than that of NPs and PAs regarding the clarity of the
12 referral question, understanding of pathophysiology, and adequate pre-referral evaluation and
13 documentation ([https://www.mayoclinicproceedings.org/article/S0025-6196\(13\)00732-5/fulltext](https://www.mayoclinicproceedings.org/article/S0025-6196(13)00732-5/fulltext));
14 and
15

16 Whereas, A study published in *JAMA* in 2015 concluded that mid-level providers ordered more
17 imaging studies during clinic visits
18 (<https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/1939374>); and
19

20 Whereas, A study published in *JAMA Dermatology* in 2015 determined that the number needed
21 to biopsy (NNB) for NP's/PA's was significantly higher compared to physicians. 2.9 v 5.9
22 respectively (<https://jamanetwork.com/journals/jamadermatology/fullarticle/2203840>); and
23

24 Whereas, A recent study published in the *Journal of the Mississippi State Medical Association*
25 found that the care for over 33,000 Medicare patients provided by nonphysician providers was
26 \$43 higher per patient per month than the care provided by physicians. This difference was
27 estimated to add \$10.3 million annually to the cost of providing care to these patients if all of the
28 care was provided by nonphysician providers. When adjusted for risk due to patient complexity,
29 the cost increased to \$119 per patient per month or \$28.5 million annually ([https://www.ama-
30 assn.org/print/pdf/node/82301](https://www.ama-assn.org/print/pdf/node/82301)); therefore be it
31

32 RESOLVED, That our American Medical Association encourage and support studies sponsored
33 by relevant state and federal agencies to determine the economic impact of mid-level
34 unsupervised practice on American consumers (Directive to Take Action); and further be it
35

36 RESOLVED, That our AMA develop model state legislation that opposes enactment of
37 legislation and reversal of such legislation, if present, that would authorize the independent
38 practice of medicine by any individual who is not a physician. (Directive to Take Action)

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

Received: 05/06/22

RELEVANT AMA POLICY

Independent Practice of Medicine by Advanced Practice Registered Nurses H-35.988

Our AMA, in the public interest, opposes enactment of legislation to authorize the independent practice of medicine by any individual who has not completed the states requirements for licensure to engage in the practice of medicine and surgery in all of its branches. Our AMA opposes enactment of the Advanced Practice Registered Nurse (APRN) Multistate Compact, due to the potential of the APRN Compact to supersede state laws that require APRNs to practice under physician supervision, collaboration or oversight.

Citation: Sub. Res. 53, I-82; Reaffirmed: A-84; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmed: BOT Rep. 28, A-03; Reaffirmed: BOT Rep. 9, I-11; Modified: Res. 214, I-17; Modified: BOT Rep. 15, A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 223
(A-22)

Introduced by: American Academy of Dermatology, American Society for Dermatologic Surgery Association, American Society of Dermatopathology, American College of Mohs Surgery, Society for Investigative Dermatology, American Society of Ophthalmic Plastic and Reconstructive Surgery, Louisiana, South Carolina, Missouri, Arizona, International Society of Hair Restoration Surgery, Iowa, Texas, Florida, Mississippi, Kansas, American Academy of Otolaryngology- Head and Neck Surgery, American Association of Neurological Surgeons, Congress of Neurological Surgeons, American College of Rheumatology

Subject: National Drug Shortages of Lidocaine and Saline Preparations

Referred to: Reference Committee B

1 Whereas, Despite repeated legislative attempts to alleviate national drug shortages, critical drug
2 shortages for many medications, including lidocaine, lidocaine with epinephrine, and saline
3 preparations remain; and
4

5 Whereas, There is need for greater transparency regarding what actions the Food and Drug
6 Administration (FDA) has taken or plans to take to help alleviate current drug shortages; and
7

8 Whereas, Small and independent physician practices have minimal if any bargaining power with
9 drug distributors and wholesalers, and thus are often disproportionately affected by drug
10 shortages. Additionally, products in short supply are frequently allocated based on previous
11 order history, which unfairly discriminates against new or growing medical practices; and
12

13 Whereas, National drug shortages negatively impact patients with the potential for delays in
14 care and patient harm; therefore be it
15

16 RESOLVED, That our American Medical Association work with national specialty societies and
17 other relevant stakeholders to draft a letter to the FDA calling for direct and prompt actions to
18 alleviate current national shortages of lidocaine and normal saline preparations (Directive to
19 Take Action); and be it further
20

21 RESOLVED, That our AMA amend existing HOD policy H-100.956 on National Drug Shortages
22 by addition and deletion to read as follows:
23

24 "8. Our AMA supports the view that wholesalers should routinely institute a transparent
25 allocation-based system for distribution of drugs in short supply that does not
26 discriminate against small, independent or new medical practices or those with less
27 purchasing power that attempts to fairly distribute drugs in short supply based on
28 remaining inventory and considering the customer's purchase history." (Modify Current
29 HOD Policy)

Fiscal Note: Modest - between \$1,000 - \$5,000
Received: 05/11/22

Reference:

US FDA: Current and Resolved Drug Shortages and Discontinuations Reported to the FDA,

<https://www.accessdata.fda.gov/scripts/drugshortages/>

Institute for Safe Medication Practices: Management of Drug Shortages with 0.9% Sodium Chloride, Sterile Water for Injection, and EPINEPHrine, <https://www.ismp.org/resources/management-drug-shortages-09-sodium-chloride-sterile-water-injection-and-epinephrine>

RELEVANT AMA POLICY

National Drug Shortages H-100.956

1. Our AMA considers drug shortages to be an urgent public health crisis, and recent shortages have had a dramatic and negative impact on the delivery and safety of appropriate health care to patients.
2. Our AMA supports recommendations that have been developed by multiple stakeholders to improve manufacturing quality systems, identify efficiencies in regulatory review that can mitigate drug shortages, and explore measures designed to drive greater investment in production capacity for products that are in short supply, and will work in a collaborative fashion with these and other stakeholders to implement these recommendations in an urgent fashion.
3. Our AMA supports authorizing the Secretary of the U.S. Department of Health and Human Services (DHHS) to expedite facility inspections and the review of manufacturing changes, drug applications and supplements that would help mitigate or prevent a drug shortage.
4. Our AMA will advocate that the US Food and Drug Administration (FDA) and/or Congress require drug manufacturers to establish a plan for continuity of supply of vital and life-sustaining medications and vaccines to avoid production shortages whenever possible. This plan should include establishing the necessary resiliency and redundancy in manufacturing capability to minimize disruptions of supplies in foreseeable circumstances including the possibility of a disaster affecting a plant.
5. The Council on Science and Public Health shall continue to evaluate the drug shortage issue, including the impact of group purchasing organizations on drug shortages, and report back at least annually to the House of Delegates on progress made in addressing drug shortages.
6. Our AMA urges continued analysis of the root causes of drug shortages that includes consideration of federal actions, evaluation of manufacturer, Group Purchasing Organization (GPO), and distributor practices, contracting practices by market participants on competition, access to drugs, pricing, and analysis of economic drivers.
7. Our AMA urges regulatory relief designed to improve the availability of prescription drugs by ensuring that such products are not removed from the market due to compliance issues unless such removal is clearly required for significant and obvious safety reasons.
8. Our AMA supports the view that wholesalers should routinely institute an allocation system that attempts to fairly distribute drugs in short supply based on remaining inventory and considering the customer's purchase history.
9. Our AMA will collaborate with medical specialty society partners and other stakeholders in identifying and supporting legislative remedies to allow for more reasonable and sustainable payment rates for prescription drugs.
10. Our AMA urges that during the evaluation of potential mergers and acquisitions involving pharmaceutical manufacturers, the Federal Trade Commission consult with the FDA to determine whether such an activity has the potential to worsen drug shortages.
11. Our AMA urges the FDA to require manufacturers to provide greater transparency regarding the pharmaceutical product supply chain, including production locations of drugs, and provide more detailed information regarding the causes and anticipated duration of drug shortages.
12. Our AMA supports the collection and standardization of pharmaceutical supply chain data in order to determine the data indicators to identify potential supply chain issues, such as drug shortages.
13. Our AMA encourages global implementation of guidelines related to pharmaceutical product supply chains, quality systems, and management of product lifecycles, as well as expansion of

global reporting requirements for indicators of drug shortages.

14. Our AMA urges drug manufacturers to accelerate the adoption of advanced manufacturing technologies such as continuous pharmaceutical manufacturing.

15. Our AMA supports the concept of creating a rating system to provide information about the quality management maturity, resiliency and redundancy, and shortage mitigation plans, of pharmaceutical manufacturing facilities to increase visibility and transparency and provide incentive to manufacturers. Additionally, our AMA encourages GPOs and purchasers to contractually require manufacturers to disclose their quality rating, when available, on product labeling.

16. Our AMA encourages electronic health records (EHR) vendors to make changes to their systems to ease the burden of making drug product changes.

17. Our AMA urges the FDA to evaluate and provide current information regarding the quality of outsourcer compounding facilities.

18. Our AMA urges DHHS and the U.S. Department of Homeland Security (DHS) to examine and consider drug shortages as a national security initiative and include vital drug production sites in the critical infrastructure plan.

Citation: CSAPH Rep. 2, I-11; Modified: CSAPH Rep. 7, A-12; Modified: CSAPH Rep. 2, I-12; Modified: CSAPH Rep. 8, A-13; Modified in lieu of Res. 912, I-13; Modified: CSAPH Rep. 3, A-14; Modified: CSAPH Rep. 2, I-15; Appended: CSAPH Rep. 04, I-17; Modified: CSAPH Rep. 02, A-18; Reaffirmed: CMS Rep. 08, A-19; Reaffirmed: Res. 105, A-19; Modified: CSAPH Rep. 1, I-20

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 224
(A-22)

Introduced by: AMDA – The Society for Post-Acute and Long-Term Care Medicine

Subject: HPSA and MUA Designation for SNFs

Referred to: Reference Committee B

1 Whereas, Health professional shortage areas (HPSAs) and medically underserved areas
2 (MUAs) are areas, population groups, and facilities designated by the United States
3 Department of Health and Human Services as having met criteria indicating a significant
4 need for additional primary health care resources, such that limited resources can be
5 prioritized and directed to those areas to assist in addressing that need; and
6

7 Whereas, An area, population group, or facility designated as a HPSA or MUA has specific
8 programs made available to it targeted at enhancing primary care infrastructure through
9 recruitment and retention of health care providers and support for primary health care
10 facilities. Federal and State programs utilizing shortage designations as criteria for eligibility
11 include: National Health Service Corps, State Loan Repayment Program, NURSE Corps,
12 Federally Qualified Health Center and Health Center Look-Alike Certification, Medicare
13 Incentive Payment Program, CMS Rural Health Clinics Program, J-1 Visa Waiver and the
14 National Interest Waiver Programs, as well as scoring preferences for various Title VII and
15 VIII grants; and
16

17 Whereas, Due to a rapidly aging population, lack of commensurate increase in medical
18 school and residency positions, early retirement of healthcare professionals from burnout
19 and effects of the pandemic, and a lack of direct incentives to practice in senior living
20 communities, there is an acute shortage of healthcare professionals including Physicians,
21 nurses, and clinical practitioners in skilled nursing facilities. [https://www.aamc.org/news-](https://www.aamc.org/news-insights/us-physician-shortage-growing)
22 [insights/us-physician-shortage-growing](https://www.aamc.org/news-insights/us-physician-shortage-growing); therefore be it
23

24 RESOLVED, That our American Medical Association advocate for legislative action directing the
25 United States Department of Health and Human Services to designate all skilled nursing
26 facilities, irrespective of their geographic location, as health professional shortage areas and/or
27 medically underserved areas to facilitate recruitment and retention of health professionals using
28 the usual and customary support made available for such designations. (Directive to Take
29 Action)

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

Received: 05/10/22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 225
(A-22)

Introduced by: AMDA – The Society for Post-Acute and Long-Term Care Medicine

Subject: Public Listing of Medical Directors for Nursing Facilities

Referred to: Reference Committee B

1 Whereas, In the early 1990s, the Centers for Medicare & Medicaid Services (CMS)
2 developed regulations and interpretive guidelines for the nursing facility (NF) medical
3 director's role: "to ensure that the facility provides appropriate care as required; monitors
4 and implements resident care policies; provides oversight and supervision of physician
5 services and the medical care of residents; plays a significant role in overseeing the overall
6 clinical care of residents to ensure to the extent possible that care is adequate; evaluates
7 situations as they arise and takes appropriate steps to try to correct the root cause, if
8 possible; consults with the resident and his or her physician concerning care and treatment,
9 if necessary; and ensures the support of essential medical consultants as needed;" and
10

11 Whereas, There is minimal public awareness of these guidelines, nor is there a public
12 listing of NF medical directors. Therefore, when there are deficiencies in clinical care of NF
13 residents or NFs' failure to implement resident care policies, the NF residents and their
14 families do not have ready access to NF medical director to request remediation of such
15 deficiencies by overseeing and coordinating clinical care of affected residents; and
16

17 Whereas, When such deficiencies in the clinical care of NF residents occur resulting in
18 adverse clinical outcomes, the residents and their families are forced to seek remediation
19 by complaining to their state public health departments bypassing the NF medical director,
20 thereby eliminating an opportunity for early interventions to 'correct the root cause' and to
21 improve quality of care for all NF residents; and
22

23 Whereas, Some NFs may elect to engage medical directors for the sole purpose of
24 referring admissions to their facilities, or medical directors without adequate training or
25 knowledge of geriatric medical principles, bioethics, and the complex regulatory framework
26 in which skilled nursing facilities operate, potentially resulting in bad outcomes and a lack of
27 quality control in these NFs; therefore be it
28

29 RESOLVED, That our American Medical Association advocate for the Centers for Medicare &
30 Medicaid Services to promote health care transparency and consumer access to quality
31 health care by hosting a public listing of medical directors of all nursing facilities (NFs) in the
32 country. (Directive to Take Action)

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

Received: 05/10/22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 226
(A-22)

Introduced by: Association for Clinical Oncology
Subject: Coverage for Clinical Trial Ancillary Costs
Referred to: Reference Committee B

- 1 Whereas, Clinical trials are key to advancing new standards of care that can improve survival
2 and quality of life for people with cancer and other conditions; and
3
4 Whereas, Many patient populations continue to be underrepresented in trials, especially certain
5 racial and ethnic groups, older adults, rural residents, and those with limited incomes; and
6
7 Whereas, Private payers, Medicare, and Medicaid are responsible for covering routine care
8 costs associated with clinical trials, but patients are often left responsible for ancillary costs,
9 such as transportation to a trial site, lodging, meals, and additional childcare; and
10
11 Whereas, Ancillary costs can lead to lower rates of participation for lower-income patients as
12 well as rural patients who might not have trial sites nearby¹; and
13
14 Whereas, Some trial sponsors provide financial support for ancillary costs but others cite
15 concerns about running afoul of federal research participant protections that could subject them
16 to civil monetary penalties; and
17
18 Whereas, Pilot financial assistance programs that provide compensation for ancillary costs have
19 demonstrated promise in improving clinical trial accrual and clinical outcomes²; therefore be it
20
21 RESOLVED, That our American Medical Association amend Policy H-460.965, Viability of
22 Clinical Research Coverages and Reimbursement, as follows “...(11) legislation and regulatory
23 reform should be supported that establish program integrity/fraud and abuse safe harbors that
24 permit sponsors to cover co-pays/coinsurance/ deductibles, ~~and~~ otherwise not covered clinical
25 care, and non-clinical ancillary costs in the context of nationally approved clinical trials (Modify
26 Current HOD Policy); and be it further
27
28 RESOLVED, That our AMA actively advocate for federal and state legislation that would allow
29 coverage of non-clinical ancillary costs by sponsors of clinical trials. (Directive to Take Action)

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

Received: 05/11/22

¹ Journal of Clinical Oncology. Addressing Financial Barriers to Patient Participation in Clinical Trials: ASCO Policy Statement. Journal of Clinical Oncology website. <https://ascopubs.org/doi/pdf/10.1200/JCO.18.01132>. Published September 13, 2018. Accessed April 28, 2022.

² Nipp RD, Powell E, Finkelstein D, et al. 2014. Alleviating financial burden for cancer patients in clinical trials. J Clin Oncol 32, 2014 (suppl; abstr 10).

RELEVANT AMA POLICY

Viability of Clinical Research Coverages and Reimbursement H-460.965

Our AMA believes that:

- (1) legislation and regulatory reform should be pursued to mandate third party payer coverage of patient care costs (including co-pays/co-insurance/deductibles) of nationally approved (e.g., NIH, VA, ADAMHA, FDA), scientifically based research protocols or those scientifically based protocols approved by nationally recognized peer review mechanisms;
- (2) third party payers should formally integrate the concept of risk/benefit analysis and the criterion of availability of effective alternative therapies into their decision making processes;
- (3) third party payers should be particularly sensitive to the difficulty and complexity of treatment decisions regarding the seriously ill and provide flexible, informed and expeditious case management when indicated;
- (4) its efforts to identify and evaluate promising new technologies and potentially obsolete technologies should be enhanced;
- (5) its current efforts to identify unproven or fraudulent technologies should be enhanced;
- (6) sponsors (e.g., NIH, pharmaceutical firms) of clinical research should finance fully the incremental costs added by research activities (e.g., data collection, investigators' salaries, data analysis) associated with the clinical trial. Investigators should help to identify such incremental costs of research;
- (7) supports monitoring present studies and demonstration projects, particularly as they relate to the magnitude (if any) of the differential costs of patient care associated with clinical trials and with general practice;
- (8) results of all trials should be communicated as soon as possible to the practicing medical community maintaining the peer reviewed process of publication in recognized medical journals as the preferred means of evaluation and communication of research results;
- (9) funding of biomedical research by the federal government should reflect the present opportunities and the proven benefits of such research to the health and economic well being of the American people;
- (10) the practicing medical community, the clinical research community, patient advocacy groups and third party payers should continue their ongoing dialogue regarding issues in payment for technologies that benefit seriously ill patients and evaluative efforts that will enhance the effectiveness and efficiency of our nation's health care system; and
- (11) legislation and regulatory reform should be supported that establish program integrity/fraud and abuse safe harbors that permit sponsors to cover co-pays/coinsurance/ deductibles and otherwise not covered clinical care in the context of nationally approved clinical trials.

Citation: CSA Rep. F, I-89; Reaffirmed: Joint CMS/CSA Rep., I-92; Reaffirmed: BOT Rep.40, I-93; Reaffirmed: CSA Rep. 13, I-99; Reaffirmation A-00; Reaffirmed: CMS Rep. 4, A-02; Reaffirmed: CMS Rep. 4, A-12; BOT Action in response to referred for decision: Res. 813, I-15; BOT Action in response to referred for decision: Res. 823, I-15; Reaffirmation: I-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 227
(A-22)

Introduced by: Louisiana

Subject: Supporting Improvements to Patient Data Privacy

Referred to: Reference Committee B

1 Whereas, Patients are increasingly using smartphones, connected consumer devices, and
2 cloud-based applications to monitor vital signs, fitness metrics, and biological cycles, as well
3 as to store and maintain medical information as a personal health record; and
4

5 Whereas, Data collected through these tools and stored in personal digital applications is not
6 currently protected under HIPAA because software and technology companies and vendors
7 are not classified as covered entities; and
8

9 Whereas, It has been documented that certain health care providers have allowed Google, –
10 which owns large fitness tracker company Fitbit – access to sensitive medical records,
11 including visit location and time data, as part of a corporate partnership, without patient
12 permission or physician notification; and
13

14 Whereas, Sen. Bill Cassidy of Louisiana introduced the Stop Marketing and Revealing the
15 Wearables and Trackers Consumer Health Data Act (“Smartwatch Data Act”) – new federal
16 legislation to expand health data protections to include these types of device-collected
17 information; therefore be it
18

19 RESOLVED, That our American Medical Association support legislation to strengthen patient
20 data privacy protections by making health information collected or stored on smartphones and
21 similar consumer devices subject to the same privacy protections as standard medical records.
22 (New HOD Policy)

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

Received: 05/11/22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 228
(A-22)

Introduced by: Michigan
Subject: Expanded Child Tax Credit
Referred to: Reference Committee B

1 Whereas, Poverty rates for individuals under the age of 18 increased from 14.4 percent in 2019
2 to 16.1 percent in 2020; and
3
4 Whereas, Children across most other racial categories are more likely to experience poverty
5 than their white counterparts and they are disproportionately represented among children in
6 poverty; and
7
8 Whereas, Child poverty negatively impacts children’s physical, mental, and emotional health
9 and development, and this effect continues into adulthood; and
10
11 Whereas, The American Heart Association notes mounting evidence that mitigation of child
12 poverty improves cardiovascular outcomes in adulthood and recommends tax credits as one
13 means of mitigation; and
14
15 Whereas, The existing child tax credit legislation detailed in the American Recovery and
16 Reinvestment Plan of 2009 excludes roughly half of Latino and Black children because their
17 parents earn too little income to receive full benefit of that policy; and
18
19 Whereas, The expanded child tax credit included in the American Rescue Plan Act of 2021
20 dramatically and quickly reduced child poverty rates in the United States, including significant
21 reductions in poverty rates for Black and Latino children; and
22
23 Whereas, 91 percent of families with low incomes utilized funds provided through the expanded
24 child tax credit for necessities, including food, clothing, shelter, utilities, or education; and
25
26 Whereas, The expanded child tax credit included in the American Rescue Plan Act of 2021
27 ended in December 2021; and
28
29 Whereas, Seven states to date have successfully implemented a child tax credit to supplement
30 and strengthen that offered by federal legislation; therefore be it
31
32 RESOLVED, That our American Medical Association actively support the American Families
33 Plan of 2021 and/or similar policies that aim to institute a permanent, expanded child tax credit
34 at the federal level. (Directive to Take Action)

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

Received: 05/11/22

Sources:

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 229
(A-22)

Introduced by: Michigan

Subject: Expedited Immigrant Green Card for J-1 Visa Waiver Physicians Serving in Underserved Areas

Referred to: Reference Committee B

1 Whereas, International medical graduates (IMG) resident physicians with J-1 visas can waive
2 the mandatory return to their native country as required per J-1 regulation and become eligible
3 to stay in the United States as a permanent resident by serving in underserved areas for three
4 years; and
5
6 Whereas, Their service is extremely helpful in improving the health of U.S. citizens, especially
7 low income and rural communities; and
8
9 Whereas, Substantial care to COVID-19 patients was provided by these J-1 visa waiver
10 physicians and they saved lives; and
11
12 Whereas, The waiting period for getting the green card visa for physicians of certain countries is
13 longer than 10 years at present due to the seven percent per country cap of visa conversions to
14 green cards, and the J-1 visa waiver physicians have to join the end of the very long queue of
15 1.2 million applicants for certain countries, and meanwhile their children are becoming status
16 less at age 18; and
17
18 Whereas, These J-1 visa waiver physicians provided great national service to US citizens, and
19 deserve priority in visa allotment; therefore be it
20
21 RESOLVED, That our American Medical Association lobby U.S. Congress and the U.S.
22 Administration that the J-1 visa waiver physicians serving in underserved areas be given highest
23 priority in visa conversion to green cards upon completion of their service commitment
24 obligation and be exempted from the per country limitation of H-1B to green card visa
25 conversion. (Directive to Take Action)

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

Received: 05/11/22

Sources:

1. <https://www.cato.org/publications/immigration-research-policy-brief/backlog-skilled-immigrants-tops-1-million-over#employment-based-green-card-backlog>
2. [1.4 Million Skilled Immigrants in Employment-Based Green Card Backlogs in 2021 | Cato at Liberty Blog](#)
3. [Letter to USCIS on Impact of Green Card Backlog on IMGs](#)
4. [Backlog for Skilled Immigrants Tops 1 Million: Over 200,000 Indians Could Die of Old Age While Awaiting Green Cards | Cato Institute](#)

RELEVANT AMA POLICY

J-1 Visas and Waivers D-255.993

1. Our AMA shall encourage HHS and other interested government agencies to continue sponsorship of the J-1 visa waiver program.
2. If the USDA does not continue in its role as an interested government agency (IGA), the AMA encourage HHS to expand its J-1 visa waiver program.
3. Our AMA will work with federal agencies to ensure better coordination of federal, state, and local agencies in monitoring the placement and enforcement of physicians' service requirements through the J-1 waiver and Conrad-30 programs with a report back at A-03.
4. Our AMA will work towards regulation and/or legislation to allow physicians on H-1B visas for their J-1 visa waiver, who are limited to serving in medically underserved areas, to continue to care for their patients who require hospitalization in the closest appropriate medical facility which may not be in the underserved area.
5. Our AMA will work with state medical societies to study and report back on the feasibility of having a national data repository of J-1 Visa Waiver statistics so that J-1 Visa Waiver unoffered positions can be transferred to states as needed to treat underserved communities and to monitor the success of this program.

Citation: (BOT Rep. 11, I-02; Appended: Res. 324, A-11; Appended: Res. 904, I-11; Reaffirmation A-14)

Conrad 30 - J-1 Visa Waivers D-255.985

1. Our AMA will: (A) lobby for the reauthorization of the Conrad 30 J-1 Visa Waiver Program; (B) advocate that the J-1 Visa waiver slots be increased from 30 to 50 per state; (C) advocate for expansion of the J-1 Visa Waiver Program to allow IMGs to serve on the faculty of medical schools and residency programs in geographic areas or specialties with workforce shortages; (D) publish on its website J-1 visa waiver (Conrad 30) statistics and information provided by state Conrad 30 administrators along with a frequently asked questions (FAQs) document about the Conrad 30 program; (E) advocate for solutions to expand the J-1 Visa Waiver Program to increase the overall number of waiver positions in the US in order to increase the number of IMGs who are willing to work in underserved areas to alleviate the physician workforce shortage; (F) work with the Educational Commission for Foreign Medical Graduates and other stakeholders to facilitate better communication and information sharing among Conrad 30 administrators, IMGs, US Citizenship and Immigration Services and the State Department; and (G) continue to communicate with the Conrad 30 administrators and IMGs members to share information and best practices in order to fully utilize and expand the Conrad 30 program.
2. Our AMA will continue to monitor legislation and provide support for improvements to the J-1 Visa Waiver program.
3. Our AMA will continue to promote its educational or other relevant resources to IMGs participating or considering participating in J-1 Visa waiver programs.
4. As a benefit of membership, our AMA will provide advice and information on Federation and other resources (but not legal opinions or representation), as appropriate to IMGs in matters pertaining to work-related abuses.
5. Our AMA encourages IMGs to consult with their state medical society and consider requesting that their state society ask for assistance by the AMA Litigation Center, if it meets the Litigation Center's established case selection criteria.

Citation: (Res. 233, A-06; Appended: CME Rep. 10, A-11; Appended: Res. 303, A-11; Reaffirmation I-11; Modified: BOT Rep. 5, I-12; Appended: BOT Rep. 27, A-13; Reaffirmation A-14)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 230
(A-22)

Introduced by: Medical Student Section

Subject: Advancing the Role of Outdoor Recreation in Public Health

Referred to: Reference Committee B

1 Whereas, Mental illness and chronic diseases are extremely prevalent in the United States with
2 suicide, heart disease, and diabetes among the leading causes of death¹⁻³; and
3

4 Whereas, Outdoor recreation, defined as outdoor leisure time that occurs in urban, human-
5 made, and/or natural environments involving elements of nature such as terrain, plants, wildlife,
6 and water bodies, has been shown to positively impact physical, mental, and social health⁴⁻¹⁷;
7 and
8

9 Whereas, Outdoor recreation is associated with decreased risk of cardiovascular mortality and
10 myopia^{7,8}; and
11

12 Whereas, Compared to recreation in a non-natural environment, recreation in a natural outdoor
13 environment resulted in a 13.4-15.8% decrease in salivary cortisol levels and a 1.7-1.9%
14 reduction in systolic blood pressure⁹; and
15

16 Whereas, A 2018 Oregon study estimated that participation in outdoor recreation produces
17 between \$735 million and \$1.4 billion in savings per year related to chronic disease¹⁰; and
18

19 Whereas, Outdoor recreation can enhance well-being, happiness, and quality of life and
20 improve symptoms related to depression, stress, and post-traumatic stress disorder (PTSD),
21 particularly amongst veterans¹¹⁻¹⁷; and
22

23 Whereas, The National Recreation and Park Association and the CDC recognize the
24 importance of outdoor recreation to public health and support improving access to recreation
25 opportunities and continuing research efforts^{18,19}; and
26

27 Whereas, Public spaces available for outdoor recreation are increasingly threatened by
28 decreased public availability due to oil and gas leases and the impacts of climate change²⁰⁻²²;
29 and
30

31 Whereas, National Park visits increased 16% between 2013 and 2018 and continue to rise,
32 while discretionary and maintenance appropriations have remained stagnant, with nearly \$12
33 billion of deferred maintenance accumulated, a trend consistent across public recreation
34 agencies^{23,24}; and
35

36 Whereas, State parks are also affected by decreased spending with parks across Alabama,
37 Montana, Connecticut, Massachusetts, Wyoming, Minnesota, Texas, Utah and other states
38 facing threats of closure and maintenance backlogs²⁴⁻²⁹; and

1 Whereas, Decreased appropriations for recreation spaces may uniquely impact low-
2 socioeconomic and minority communities that already have lower quality public spaces for
3 recreation, decreased accessibility, and increased rates of space loss, despite these groups
4 disproportionately benefiting from outdoor recreation²⁹⁻³⁵; and
5

6 Whereas, With proven health benefits, outdoor recreation is now being considered as a
7 potential clinical tool via park prescriptions and outdoor organization referrals³⁶; and
8

9 Whereas, Outdoor recreation as therapy has had limited development in clinical application due
10 to insufficient program reach and resources, lack of available recreation spaces, and limited
11 research on the underlying mechanisms, and effective dose and duration^{12,37}; and
12

13 Whereas, Current AMA policies, including H-470.997 and H-135.973, encourage physical
14 activity and environmental stewardship but do not specifically address outdoor recreation, nor
15 do they include the unique exercise independent benefits and activities attributed to outdoor
16 recreation; and
17

18 Whereas, While AMA policy D-470.993 encourages creation of a set type of exercise venues at
19 the local level, this policy does not include many forms of outdoor recreation spaces and
20 activities, nor does it consider federal and state management of outdoor recreation spaces; and
21

22 Whereas, Our AMA would benefit from clear guidance on how to act on legislation related to
23 outdoor recreation such as H.R. 2435 and S.500/H.R. 1225 which were introduced in the 2019
24 cycle to expand opportunities for treatment and healing of military veterans through outdoor
25 recreation on public lands and to alleviate the maintenance backlog in National Parks and
26 Public Lands, respectively³⁸⁻⁴⁰; therefore be it
27

28 RESOLVED, That our American Medical Association encourage federal, state and local
29 governments to create new and maintain existing public lands and outdoor spaces for the
30 purposes of outdoor recreation; (Directive to Take Action) and be it further
31

32 RESOLVED, That our AMA work with the Centers for Disease Control and Prevention, National
33 Institute of Environmental Health Science, National Recreation and Park Association, and other
34 relevant stakeholders to encourage continued research on the clinical uses of outdoor
35 recreation therapy. (Directive to Take Action)

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

Received: 05/11/22

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RELEVANT AMA POLICY

Government to Support Community Exercise Venues D-470.993

Our AMA will encourage: (1) towns, cities and counties across the country to make recreational exercise more available by utilizing existing or building walking paths, bicycle trails, swimming pools, beaches and community recreational fitness facilities; and (2) governmental incentives such as tax breaks and grants for the development of community recreational fitness facilities. Res. 423, A-04; Reaffirmed in lieu of Res. 434, A-12

Exercise and Physical Fitness H-470.997

The AMA encourages all physicians to utilize the health potentialities of exercise for their patients as a most important part of health promotion and rehabilitation and urges state and local medical societies to emphasize through all available channels the need for physical activity for all age groups and both sexes. The AMA encourages other organizations and agencies to join with the Association in promoting physical fitness through all appropriate means.

BOT Rep. K, A-66; Reaffirmed: CLRPD Rep. C, A-88; Reaffirmed: Sunset Report, I-98; Modified and Reaffirmed: CSAPH Rep. 2, A-08; Reaffirmed: BOT Rep. 10, A-14

American's Health H-440.859

Our AMA will: (1) make improving health through increased activity and proper diet a priority; (2) propose legislation calling on the federal government and state governments to develop new and innovative programs in partnership with the private sector that encourage personal responsibility for proper dietary habits and physical activity of individual Americans; and (3) continue to work in conjunction with the American College of Sports Medicine, American Heart Association, US Department of Health and Human Services and any other concerned organizations to provide educational materials that encourage a healthier America through increased physical activity and improved dietary habits.

Res. 201, A-09; Reaffirmation, A-12

Physical Activity Guidelines H-60.979

Our AMA supports the continued expert review and development of national guidelines regarding physical activity for all ages and the dissemination of such guidelines to physicians. Res. 186, I-90; Reaffirmed: Sunset Report, I-00; Modified: BOT Rep. 10, A-14

Promotion of Exercise Within Medicine and Society H-470.990

Our AMA supports (1) education of the profession on exercise, including instruction on the role of exercise prescription in medical practice in its continuing education courses and conferences, whenever feasible and appropriate;(2) medical student instruction on the prescription of exercise;(3) physical education instruction in the school system; and (4) education of the public on the benefits of exercise, through its public relations program.

Res. 56, I-78; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmation: I-98; Reaffirmation: A-07; Reaffirmed: BOT Rep. 21, A-12

Promotion of Exercise H-470.991

1. Our AMA: (A) supports the promotion of exercise, particularly exercise of significant cardiovascular benefit; and (B) encourages physicians to prescribe exercise to their patients and to shape programs to meet each patient's capabilities and level of interest.

2. Our AMA supports National Bike to Work Day and encourages active transportation whenever possible.

Res. 83, parts 1 and 2, I-77; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CSAPH Rep. 1, A-10; Appended: Res. 604, A-11; Reaffirmed: CSAPH Rep. 1, A-21

Increasing Outdoor Activity to Prevent Myopia Onset and Progression in School Children H-60.913

Our AMA supports efforts to increase outdoor time and promote other activities that have been demonstrated to reduce the progression of myopia in children.

Res. 405, A-17

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.

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

Environmental Preservation H-135.972

It is the policy of the AMA to support state society environmental activities by:

(1) identifying areas of concern and encouraging productive research designed to provide authoritative data regarding health risks of environmental pollutants;

(2) encouraging continued efforts by the CSAPH to prepare focused environmental studies, where these studies can be decisive in the public consideration of such problems;

(3) maintaining a global perspective on environmental problems;

(4) considering preparation of public service announcements or other materials appropriate for public/patient education; and (5) encouraging state and component societies that have not already done so to create environmental committees.

Res. 52, A-90; Reaffirmed: Sunset Report, I-00; Modified: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 01, A-20

Research into the Environmental Contributors to Disease D-135.997

Our AMA will (1) advocate for greater public and private funding for research into the environmental causes of disease, and urge the National Academy of Sciences to undertake an authoritative analysis of environmental causes of disease; (2) ask the steering committee of the Medicine and Public Health Initiative Coalition to consider environmental contributors to disease as a priority public health issue; and (3) lobby Congress to support ongoing initiatives that include reproductive health outcomes and development particularly in minority populations in Environmental Protection Agency Environmental Justice policies.

Res. 402, A-03; Appended: Res. 927, I-11; Reaffirmed in lieu of Res. 505, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 231
(A-22)

Introduced by: Medical Student Section

Subject: Amending Policy H-155.955: Increasing Accessibility to Incontinence
Products to include Diaper Tax Exemption

Referred to: Reference Committee B

1 Whereas, Diapers are used by different population groups, including but not limited to young
2 children and those with a variety of medical conditions¹; and
3

4 Whereas, The populations that utilize diapers often overlap with vulnerable patient groups, such
5 as infants/toddlers, the elderly, adults with physical disabilities, and adults with intellectual
6 disabilities, who are unable to independently perform activities of daily living including toilet
7 use¹; and
8

9 Whereas, Diapers that are not changed in a timely manner increase the risk of urinary tract
10 infections and diaper dermatitis, especially for extended hours spent in a diaper overnight; this
11 also creates an environment for the formation of pressure ulcers²⁻³; and
12

13 Whereas, Up to 36% of families struggle to afford child diapers, and diaper need (defined as the
14 lack of an adequate supply of clean diapers) can limit parents' ability to work, given that many
15 childcare centers require parents to supply diapers as a condition of enrollment³⁻⁶; and
16

17 Whereas, An American Academy of Pediatrics (AAP) study found that the average cost of
18 diapers is \$936 per year, per child, which is over 6% of a federal minimum wage salary of \$7.25
19 per hour^{3,7}; and
20

21 Whereas, An adult can expect to spend \$80-240 per month on diapers, depending on the
22 degree of incontinence and extent of need^{8,9}; and
23

24 Whereas, According to the National Diaper Bank Network, some families pay more in taxes for
25 diapers over a year than the cost of a one-month supply of diapers and, in 2014, the lowest
26 income quintile (with an average after-tax income of \$11,000) spent an estimated 14% of its
27 income on diapers^{10,11}; and
28

29 Whereas, Mothers reporting mental health needs were more likely to also report diaper need,
30 and in a population of low-income families in an urban setting, 30% of mothers who reported
31 diaper need were more likely to be Hispanic and older^{3,6}; and
32

33 Whereas, A study of the Vermont WIC (Women, Infants, and Children) Program, a low-income
34 based nutrition program, showed that 32.5% of families in the program reported diaper need¹²;
35 and
36

37 Whereas, Although the National Diaper Bank Network diaper distribution program assisted
38 280,000 children, it reached only 4% of the 7 million children living in families with incomes at or
39 below 200% of the federal poverty level¹³; and

1 Whereas, Medicaid coverage of child diapers deemed medically necessary for incontinence
2 varies among states, with Utah, New Hampshire, and the District of Columbia having no age
3 limit for beginning diaper coverage, while Maine, Kansas, and California begin coverage at 5
4 years¹⁴; and

5
6 Whereas, Thirty-six states charge sales tax on diapers; California, Connecticut, Massachusetts,
7 Minnesota, New Jersey, New York, Pennsylvania, Rhode Island, and Vermont exempt diapers
8 from taxation; and Maryland and North Dakota exempt adult incontinence products alone^{13,15};
9 and

10
11 Whereas, In a study of 50,000 households in low-income areas with a change in diaper tax
12 status, implementation of sales tax exemptions for diapers was associated with a 5.4% increase
13 in diaper spending and a 6.2% decrease in spending on children's pain medication, suggesting
14 health benefits as a result of tax exemptions¹⁶; and

15
16 Whereas, As of 2021, thirteen states have adopted specific tax exemptions on menstrual
17 products, illustrating the legislative and economic feasibility of exempting necessary hygiene
18 products from taxable goods¹⁷; and

19
20 Whereas, Cost savings from the repeal of sales tax on menstrual products have been shown to
21 directly benefit consumers, particularly those of lower-income backgrounds, by shifting the tax
22 break mostly to consumers and away from manufacturers¹⁸; and

23
24 Whereas, Congress is currently considering multiple bills to both remove sales tax on diapers as
25 well as make child diapers qualified medical expenses eligible for spending from pre-tax HSAs,
26 HRAs, and FSAs¹⁹⁻²¹; and

27
28 Whereas, AMA Policy H-270.953 recognizes access to feminine hygiene products used for
29 menstruation and other genital tract secretions as a public health issue and supports the
30 removal of sales tax on all feminine hygiene products; and

31
32 Whereas, AMA Policy H-155.955 supports increased access to affordable incontinence
33 products, but does not contain specific measures for implementation; therefore be it

34
35 RESOLVED, That our American Medical Association amend Policy H-155.955, "Increasing
36 Accessibility to Incontinence Products," by addition and deletion as follows:

37
38 **Increasing Accessibility to Incontinence Products H-155.955**

39 Our AMA supports increased access to affordable incontinence products, the
40 removal of sales tax on child and adult diapers, including single-use and reusable
41 diapers, and the inclusion of child diapers as qualified medical expenses for Health
42 Savings Accounts (HSAs), Health Reimbursement Arrangements (HRAs), and
43 Flexible Spending Accounts (FSAs). (Modify Current HOD Policy)

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

Received: 05/11/22

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RELEVANT AMA POLICY

Tax Exemptions for Feminine Hygiene Products H-270.953

Our AMA supports legislation to remove all sales tax on feminine hygiene products.
Res. 215, A-16

Infant Mortality in the United States H-245.986

It is the policy of the AMA: (1) to continue to address the problems that contribute to infant mortality within its ongoing health of the public activities. In particular, the special needs of adolescents and the problem of teen pregnancy should continue to be addressed by the adolescent health initiative; and (2) to be particularly aware of the special

health access needs of pregnant women and infants, especially racial and ethnic minority group populations, in its advocacy on behalf of its patients.

BOT Rep. U, I-91; Modified by BOT Rep. 8, A-97; Reaffirmed: CSAPH Rep. 3, A-07; Reaffirmation A-07; Modified: CSAPH Rep. 01, A-17

Adequate Funding of the WIC Program H-245.989

Our AMA urges the U.S. Congress to investigate recent increases in the cost of infant formula, as well as insure that WIC programs receive adequate funds to provide infant formula and foods for eligible children.

Res. 269, A-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 01, A-20

Opposition to Proposed Budget Cuts in WIC and Head Start H-245.979

The AMA opposes reductions in funding for WIC and Head Start and other programs that significantly impact child and infant health and education.

Res. 246, I-94; Reaffirmed: BOT Rep. 29, A-04; Reaffirmed: BOT Rep. 19, A-14

Increasing Accessibility to Incontinence Products H-155.955

Our AMA supports increased access to affordable incontinence products.

Res. 908, I-18

Health Savings Accounts H-165.852

It is the policy of the AMA that: (1) high-deductible health insurance plans issued to families in conjunction with Health Savings Accounts (HSAs) be allowed to apply lower, per-person deductibles to individual family members with the permitted levels for per-person deductibles being the same as permitted levels for individual deductibles, and with the annual HSA account contribution limit being determined by the full family deductible or the dollar-limit for family policies; (2) contributions to HSAs should be allowed to continue to be tax deductible until legislation is enacted to replace the present exclusion from employees' taxable income of employer-provided health expense coverage with tax credits for individuals and families; (3) advocacy of HSAs continues to be incorporated prominently in its campaign for health insurance market reform; (4) activities to educate patients about the advantages and opportunities of HSAs be enhanced; (5) efforts by companies to develop, package, and market innovative products built around HSAs continue to be monitored and encouraged; (6) HSAs continue to be promoted and offered to AMA physicians through its own medical insurance programs; and (7) legislation promoting the establishment and use of HSAs and allowing the tax-free use of such accounts for health care expenses, including health and long-term care insurance premiums and other costs of long-term care, be strongly supported as an integral component of AMA efforts to achieve universal access and coverage and freedom of choice in health insurance.

CMS Rep. 11 - I-94; Reaffirmed by Sub. Res. 125 and Sub. Res. 109, A-95; Reaffirmed by CMS Rep. 7, A-97; Reaffirmation A-97; Reaffirmed: CMS Rep. 5, I-97; Reaffirmation I-98; Reaffirmed: CMS Rep. 5 and 7, I-99; CMS Rep. 10, I-99; Appended by Res. 220, A-00; Reaffirmation I-00; Reaffirmed Res. 109 & Reaffirmation A-01; Reaffirmed: CMS Rep. 2, I-01; Reaffirmation A-02; CMS Rep. 3, I-02; Reaffirmed: CMS Rep. 3, A-03; Reaffirmation I-03; CMS Rep. 6, A-04; Reaffirmation A-04; Consolidated: CMS Rep. 7, I-05; Reaffirmation A-07; Reaffirmation A-10; Reaffirmed: CMS Rep. 2, A-11; Reaffirmed: CMS Rep. 9, A-11; Reaffirmed: Res. 239, A-12; Reaffirmed: CMS Rep. 5, I-12; Reaffirmed: CMS Rep. 9, A-14; Reaffirmed: CMS Rep. 05, A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 232
(A-22)

Introduced by: Medical Student Section

Subject: Expansion of Epinephrine Entity Stocking Legislation

Referred to: Reference Committee B

- 1 Whereas, Up to 5% of the US population has suffered anaphylaxis¹; and
2
3 Whereas, Common triggers of anaphylaxis are food, drugs, venom, and blood products²; and
4
5 Whereas, 5% to 8% of US children and 2% to 3% of US adults are at risk for anaphylaxis due to
6 food allergy¹; and
7
8 Whereas, Only 40.7% of children and 25% of adults with food allergies have an epinephrine
9 auto-injector prescription^{3,4}; and
10
11 Whereas, Low rates of epinephrine possession are particularly concerning given that nearly
12 40% of food-allergic adults reported at least one lifetime food allergy-related emergency
13 department visit, and more than half reported a history of one or more severe food-allergic
14 reactions⁴; and
15
16 Whereas, The prevalence of penicillin allergy in the US is 10%, with 6.8% suffering from
17 anaphylaxis⁵; and
18
19 Whereas, Most deaths from anaphylaxis have been associated with delayed administration of
20 epinephrine⁶; and
21
22 Whereas, A study showed that patients who received epinephrine earlier were less likely to be
23 hospitalized compared to those who received it later at the emergency room (17% vs 43%)⁷;
24 and
25
26 Whereas, Accidental injections can occur in a variety of circumstances, such as placing the
27 thumb on the tip of the epinephrine auto-injector during administration or children playing with
28 the devices⁸; and
29
30 Whereas, While recent data suggests that accidental epinephrine injections and lacerations are
31 a serious concern, these appear to be rare adverse events and usually require limited medical
32 intervention⁸; and
33
34 Whereas, To ensure proper treatment of anaphylaxis, epinephrine auto-injectors should always
35 be replaced before they expire⁸; and
36
37 Whereas, In situations concerning the safety and efficacy of expired epinephrine, overall, the
38 benefits of using epinephrine auto-injectors outweigh the potential risks⁸; and

1 Whereas, As of July 2019, 36 states have passed epinephrine entity stocking laws that allow
2 authorized entities defined by each state to obtain and administer epinephrine auto-injectors to
3 individuals undergoing an anaphylactic reaction⁹; and
4

5 Whereas, All authorized entities with possession of epinephrine auto-injectors are required to
6 complete any certification and training requirements set forth by their state health department¹⁰;
7 and
8

9 Whereas, Completion of certification requirements for epinephrine auto-injectors typically
10 protects the entity, employees of the entity, and healthcare providers prescribing epinephrine
11 from any subsequent liabilities¹⁰; and
12

13 Whereas, The passage of an epinephrine entity stocking law in Michigan was cited as a reason
14 for the University of Michigan to have onsite auto-injectable epinephrine in their dining halls
15 starting in fall 2019¹¹; and
16

17 Whereas, Following the passage of the Emergency Allergy Treatment Act in Florida, multiple
18 Disney resorts implemented the stocking of epinephrine auto-injectors in 2014^{12,13}; and
19

20 Whereas, Individual states have defined authorized entities differently with many states
21 employing broad definitions, such as the state of Florida that has defined one as “an entity or
22 organization at which allergens capable of causing anaphylaxis may be present”^{10,12}; therefore
23 be it
24

25 RESOLVED, That our American Medical Association support the adoption of laws that allow
26 state-authorized entities to permit the storage of auto-injectable epinephrine for use in case of
27 an emergency. (New HOD Policy)

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

Received: 05/11/22

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RELEVANT AMA POLICY

Decreasing Epinephrine Auto-Injector Accidents and Misuse H-115.968

Our AMA: 1) encourages physicians to review standard epinephrine auto-injector administration protocol with patients upon initial prescription and on follow-up visits; and 2) encourages improved product design and labeling of epinephrine auto-injectors.

Res. 513, A-11; Reaffirmed: CSAPH Rep. 1, A-21

Food Allergic Reactions in Schools and Airplanes H-440.884

Our AMA recommends that all:

- (1) schools provide increased student and teacher education on the danger of food allergies;
- (2) schools have a set of emergency food allergy guidelines and emergency anaphylaxis kits on the premises, and that at least one member of the school administration be trained and certified in the indications for and techniques of their use; and
- (3) commercial airlines have a set of emergency food allergy guidelines and emergency anaphylaxis kits on the premises, and that at least one member of the flight staff, such as the head flight attendant, be trained and certified in the indications for and techniques of their use. Res. 415, A-04; Reaffirmed: CSAPH Rep. 1, A-14

Preventing Allergic Reactions in Food Service Establishments D-440.932

Our American Medical Association will pursue federal legislation requiring restaurants and food establishments to: (1) include a notice in menus reminding customers to let the staff know of any food allergies; (2) educate their staff regarding common food allergens and the need to remind customers to inform wait staff of any allergies; and (3) identify menu items which contain any of the major food allergens identified by the FDA (in the Food Allergen Labeling and Consumer Protection Act of 2004) and which allergens the menu item contains.

Res. 416, A-15

Over-the-Counter Inhalers in Asthma H-115.972

Our AMA will send a letter to the US Food and Drug Administration (FDA) expressing: 1) our strong opposition to FDA making the decision to allow inhaled epinephrine to be sold as an over-the counter medication without first soliciting public input; and 2) our opposition to the approval of over-the-counter sale of inhaled epinephrine as it is currently not a recommended treatment for asthma.

CSA Rep. 2, A-99; Reaffirmed: CSAPH Rep. 1, A-09; Modified: Res. 927, I-18; Reaffirmation: A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 233
(A-22)

Introduced by: Medical Student Section

Subject: Support for Warning Labels on Firearm Ammunition Packaging

Referred to: Reference Committee B

- 1 Whereas, Over 45,200 firearm-related deaths occurred in the United States in 2020, equating to
2 13.7 firearm-related deaths per 100,000 population and 124 deaths each day, making it the
3 worst year on record for firearm-related deaths¹; and
4
- 5 Whereas, Firearms are the second-leading cause of death of children in the U.S.²; and
6
- 7 Whereas, Over half of the firearm-related deaths in the U.S. are due to suicide and access to a
8 firearm increases suicide risk by seven times³; and
9
- 10 Whereas, Access to a firearm doubles the risk of death by homicide⁴; and
11
- 12 Whereas, Women in the U.S. are 25 times more likely to be killed with firearms than in other
13 high-income countries and in homes where domestic violence occurs, a firearm increases the
14 risk of women being killed by five times⁵; and
15
- 16 Whereas, Over 40% of Americans live in a household with at least one firearm, but fewer than
17 44% store their firearms unloaded and separate from the ammunition, which is recognized as a
18 best practice to reduce the risk of firearm-related suicide and injury⁶⁻¹⁰; and
19
- 20 Whereas, Relatively few federal or state regulations on ammunition exist, despite evidence that
21 reduced availability of ammunition has been associated with reduced firearm-related mortality⁷⁻
22 ¹²; and
23
- 24 Whereas, Text-based warning labels have been shown to and may be effective in reducing
25 harmful health behaviors such as consumption of high-sugar or nutritionally poor foods,
26 consumption of alcohol, and misuse of medications¹³⁻²⁰; and
27
- 28 Whereas, A large body of evidence shows graphic warning labels on tobacco packaging
29 consistently reduce tobacco use, are more effective at changing behaviors and cognitive
30 patterns than text-only warnings, and are equally effective for many diverse population
31 subgroups^{14,21-34,37,38}; and
32
- 33 Whereas, Graphic pictorial warning labels have also been shown to have greater potential
34 benefits than text-based warnings in reducing alcohol use, sugary drink consumption, and
35 gambling^{14,21-34,37,38}; and
36
- 37 Whereas, In May 2019, the #DontLookAway campaign proposed requiring graphic warning
38 labels depicting potential harms on firearm ammunition packaging in the U.S. alongside public
39 health statistics concerning firearm-related harms^{39,40}; and

1 Whereas, No published studies currently exist concerning warning labels or graphic warning
2 labels on ammunition or firearms packaging; in the U.S., this may be attributable to restrictions
3 on firearms research while in other developed nations it is likely due to strong restrictions on
4 firearm ownership and purchasing, which results in markedly lower firearm ownership and
5 ammunition consumption⁴¹⁻⁴⁸; and
6

7 Whereas, In 2019, California began implementing Assembly Bill 1525, which requires warning
8 labels detailing firearm risks and firearm regulation laws be included on all packaging of firearms
9 and located on the premises of licensed firearms dealers, illustrating such requirements can be
10 enacted, though no research has yet been published on their effectiveness⁴⁹; and
11

12 Whereas, Our AMA supports warning labels on packaging of foods high in added sugars (D-
13 150.974), foods containing high fructose corn syrup (D-150.981), wire-bristle grill brushes (D-
14 10.991), detergents (D-60.967), waterbeds and beanbag furniture (H-245.985), indoor tanning
15 equipment (H-440.839), noise-producing toys (H-440.897), energy beverages (D-150.976),
16 latex-containing products (H-480.970), hand-held devices (H-15.952), and nicotine and tobacco
17 products (H-495.973), and our AMA supports graphic warning labels on tobacco packaging (H-
18 495.989); and
19

20 Whereas, Our AMA recognizes firearms as a public health problem (H-145.997) and gun
21 violence as a public health crisis (D-145.995); therefore be it
22

23 RESOLVED, That our American Medical Association support legislation requiring that
24 packaging for any firearm ammunition produced in, sold in, or exported from the United States
25 carry a legible, boxed warning that includes, at a minimum, (a) text-based statistics and/or
26 graphic picture-based warning labels related to the risks, harms, and mortality associated with
27 firearm ownership and use, and (b) explicit recommendations that ammunition be stored
28 securely and separately from firearms. (Directive to Take Action)

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

Received: 05/11/22

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RELEVANT AMA POLICY

Tobacco Product Labeling H-495.989

Our AMA: (1) supports requiring more explicit and effective health warnings, such as graphic warning labels, regarding the use of tobacco (and alcohol) products (including but not limited to, cigarettes, smokeless tobacco, chewing tobacco, and hookah/water pipe tobacco, and ingredients of tobacco products sold in the United States); (2) encourages the Food and Drug Administration, as required under Federal law, to revise its rules to require color graphic warning labels on all cigarette packages depicting the negative health consequences of smoking; (3) supports legislation or regulations that require (a) tobacco companies to accurately label their products, including electronic nicotine delivery systems (ENDS), indicating nicotine content in easily understandable and meaningful terms that have plausible biological significance; (b) picture-based warning labels on tobacco products produced in, sold in, or exported from the United States; (c) an increase in the size of warning labels to include the statement that smoking is ADDICTIVE and may result in DEATH; and (d) all advertisements for cigarettes and each pack of cigarettes to carry a legible, boxed warning such as: "Warning: Cigarette Smoking causes CANCER OF THE MOUTH, LARYNX, AND LUNG, is a major cause of HEART DISEASE AND EMPHYSEMA, is ADDICTIVE, and may result in DEATH. Infants and children living with smokers have an increased risk of respiratory infections and cancer;" (4) urges the Congress to require that: (a) warning labels on cigarette packs should appear on the front and the back and occupy twenty-five percent of the total surface area on each side and be set out in black-and-white block; (b) in the case of cigarette advertisements, warning labels of cigarette packs should be moved to the top of the ad and should be enlarged to twenty-five percent of total ad space; and (c) warning labels following these specifications should be included on cigarette packs of U.S. companies being distributed for sale in foreign markets; and (5) supports requiring warning labels on all ENDS products, starting with the warning that nicotine is addictive.
CSA Rep. 3, A-04, Modified: Res. 402, A-13, Modified: Res. 925, I-16, Modified: Res. 428, A-19

Support for Nutrition Label Revision and FDA Review of Added Sugars D-150.974

1. Our AMA will issue a statement of support for the newly proposed nutrition labeling by the Food and Drug Administration (FDA) during the public comment period.
2. Our AMA will recommend that the FDA further establish a recommended daily value (%DV) for the new added sugars listing on the revised nutrition labels based on previous recommendations from the WHO and AHA).

3. Our AMA will encourage further research into studies of sugars as addictive through epidemiological, observational, and clinical studies in humans.

4. Our AMA encourages the FDA to: (a) develop front-of-package warning labels for foods that are high in added sugars based on the established recommended daily value; and (b) limit the amount of added sugars permitted in a food product containing front-of-package health or nutrient content claims.

Res. 422, A-14, Appended: Res. 903, I-18

The Health Effects of High Fructose Syrup D-150.981

Our AMA:

(1) recognizes that at the present time, insufficient evidence exists to specifically restrict use of high fructose corn syrup (HFCS) or other fructose-containing sweeteners in the food supply or to require the use of warning labels on products containing HFCS;

(2) encourages independent research (including epidemiological studies) on the health effects of HFCS and other sweeteners, and evaluation of the mechanism of action and relationship between fructose dose and response; and

(3) in concert with the Dietary Guidelines for Americans, recommends that consumers limit the amount of added caloric sweeteners in their diet.

CSAPH Rep. 3, A-08, Reaffirmation: A-13

Grill Brush Warning D-10.991

Our AMA will request that the appropriate federal agency require the placement of a warning label on all wire-bristle grill brushes informing consumers about the possibility of wire bristles breaking off and being accidentally ingested.

Res. 423, A-18

Support for Detergent Poisoning and Child Safety Act D-60.967

1. Our AMA will advocate to the state and federal authorities for laws that would protect children from poisoning by detergent packet products by requiring that these products meet child-resistant packaging requirements and that these products are manufactured to be less attractive to children in color and in design and to include conspicuous warning labels.

2. Our AMA will advocate that the detergent product package labeling be constructed in a clear and obvious method, so children know that the product is dangerous to ingest.

3. Our AMA encourages the Consumer Product Safety Commission in conjunction with the American Association of Poison Control Centers to study the impact of "F3159-15 - Consumer Safety Specification for Liquid Laundry Packets" to ensure that the voluntary ASTM standard adequately protects children from injury, including eye injury.

Res. 430, A-16, Appended: Res. 413, A-17

Mandatory Labeling for Waterbeds and Beanbag Furniture H-245.985

The AMA urges the Consumer Product Safety Commission to require waterbed manufacturers and manufacturers of similar type furnishings to affix a permanent label and to distribute warning materials on each waterbed and other furnishings sold concerning the risks of leaving an infant or handicapped child, who lacks the ability to roll over, unattended on a waterbed or beanbag.

Res. 414, A-92, Reaffirmed: CSA Rep. 8, A-03, Modified: CSAPH Rep. 1, A-13

Protecting the Public from Dangers of Ultraviolet Radiation H-440.839

1. Our AMA encourages physicians to counsel their patients on sun-protective behavior.

Tanning Parlors: Our AMA supports: (1) educational campaigns on the hazards of tanning parlors, as well as the development of local tanning parlor ordinances to protect our patients and the general public from improper and dangerous exposure to ultraviolet radiation; (2) legislation to strengthen state laws to make the consumer as informed and safe as possible; (3) dissemination of information to physicians and the public about the dangers of ultraviolet light from sun exposure and the possible harmful effects of the ultraviolet light used in commercial tanning centers; (4) collaboration between medical societies and schools to achieve the inclusion of information in the health curricula on the hazards of exposure to tanning rays; (5) the enactment of federal legislation to: (a) prohibit access to the use of indoor tanning equipment (as defined in 21 CFR ?1040.20 [a][9]) by anyone under the age of 18; and (b) require a United States Surgeon General warning be prominently posted, detailing the positive correlation between ultraviolet radiation, the use of indoor tanning equipment, and the incidence of skin cancer; (6) warning the public of the risks of ultraviolet A radiation (UVA) exposure by skin tanning units, particularly the FDA's findings warning Americans that the use of UVA tanning booths and sun beds pose potentially significant health risks to users and should be discouraged; (7) working with the FDA to ensure that state and local authorities implement legislation, rules, and regulations regarding UVA exposure, including posted warnings in commercial tanning salons and spas; (8) an educational campaign in conjunction with various concerned national specialty societies to secure appropriate state regulatory and oversight activities for tanning parlor facilities, to reduce improper and dangerous exposure to ultraviolet light by patients and general public consumers; and (9) intensified efforts to enforce current regulations.

Sunscreens. Our AMA supports: (1) the development of sunscreens that will protect the skin from a broad spectrum of ultraviolet radiation, including both UVA and UVB; and (2) the labeling of sunscreen products with a standardized ultraviolet (UV) logo, inclusive of ratings for UVA and UVB, so that consumers will know whether these products protect against both types of UV radiation. Terms such as low, medium, high and very high protection should be defined depending on standardized sun protection factor level.

2. Our AMA supports sunshade structures (such as trees, awnings, gazebos and other structures providing shade) in the planning of public and private spaces, as well as in zoning matters and variances in recognition of the critical important of sun protection as a public health measure.

3. Our AMA, as part of a successful skin cancer prevention strategy, supports free public sunscreen programs that: (a) provide sunscreen that is SPF 15 or higher and broad spectrum; (b) supply the sunscreen in public spaces where the population would have a high risk of sun exposure; and (c) protect the product from excessive heat and direct sun.
CCB/CLRPD Rep. 3, A-14, Appended: Res. 403, A-14, Appended: Res. 404, A-19, Appended: Res. 905, I-19

Noise Induced Hearing Loss in Children And Adolescents H-440.897

1. Our AMA: (a) encourages public education about the dangers of noise-induced hearing loss especially from toys and electronic devices; and (b) encourages the Consumer Product Safety Commission and other appropriate agencies to study the impact of toys and electronic devices on noise-induced hearing loss among children and adolescents.
2. Our AMA adopts pediatric noise exposure standards recommending that children avoid toys that produce greater than 85 dB of SPL, or greater than 90 dB SPL for more than one hour.
3. Our AMA will work with other stakeholders to ensure toy manufacturers' adherence to pediatric noise exposure standards that children avoid toys that produce 85 dB of SPL, or greater than 90 dB SPL.
4. Our AMA will work with other stakeholders to require that manufacturers label toys with the level of sound produced and/or a warning that sound production exceeds safety standards (85 dB of SPL) and may result in hearing loss.
Res. 407, I-00, Reaffirmed: CSAPH Rep. 6, A-08, Appended: Res. 411, A-16

Hazards of Energy Beverages - Their Abuse and Regulation D-150.976

1. Our AMA will seek necessary regulatory action through the US Food and Drug Administration to regulate potentially hazardous energy beverages (like Red Bull (TM), Rockstar (TM), Monster (TM), Full Throttle (TM)).
2. Our AMA will seek federal regulation to implement warning labels about the side effects of the contents of energy drinks, particularly when combined with alcohol.
3. Our AMA supports a ban on the marketing of "high stimulant/caffeine drinks" to children/adolescents under the age of 18.
Res. 909, I-11, Appended: Res. 409, A-13

Latex Allergy Warning H-480.970

The AMA supports the appropriate labeling of latex-containing medical devices with warnings about possible allergic reactions. The AMA strongly encourages health care facilities to provide non-latex alternatives of at least comparable efficacy alongside their latex counterparts in all areas of patient care.
Sub. Res. 503, A-96, Appended: Res. 504, I-97, Reaffirmed: CSAPH Rep. 3, A-07, Reaffirmed: CSAPH Rep. 1, A-17

The Dangers of Distraction While Operating Hand-Held Devices H-15.952

1. Our AMA encourages physicians to educate their patients regarding the public health risks of distracted driving, which includes the risks of visual distraction – taking one's eyes off the road, manual distraction – taking one's hands off the wheel, and cognitive distraction – taking one's mind off what they are doing.
2. Our AMA will: (a) support legislation that would ban the use of hand-held devices while driving, as a step in the right direction towards preventing distracted driving and (b) encourage additional research to identify the most effective strategies to reduce distracted driving-related crash risks.
3. Our AMA: (a) recognizes distracted walking as a preventable hazard and encourages awareness of the hazard by physicians and the public; and (b) encourages research into the severity of distracted walking as a public health hazard as well as ways in which to prevent it.
4. Our AMA supports public education efforts regarding the dangers of distracted driving, particularly activities that take drivers' eyes off the road, and that the use of earbuds or headphones while driving is dangerous and illegal in some states.
5. Our AMA: (a) supports education on the use of earbuds or headphones in both ears during outdoor activities requiring auditory attention, including but not limited to biking, jogging, rollerblading, skateboarding and walking; and (b) supports the use of warning labels on the packaging of hand-held devices utilized with earbuds or headphones, indicating the dangers of using earbuds or headphones in both ears during outdoor activities requiring auditory attention, including but not limited to biking, jogging, rollerblading, skateboarding and walking.
6. Our AMA will make it a priority to create a national education and advocacy campaign on distracted driving in collaboration with interested stakeholders.
Res. 217, I-08, Appended: Res. 905, I-09, Appended: BOT Rep. 10, A-13, Appended: Res. 416, A-13, Modified in lieu of Res. 414, A-15, Appended: Res. 425, A-19, Appended: BOT Rep. 12, I-19, Modified: BOT Rep. 17, I-21

FDA to Extend Regulatory Jurisdiction Over All Non-Pharmaceutical Nicotine and Tobacco Products H-495.973

Our AMA: (1) supports the U.S. Food and Drug Administration's (FDA) proposed rule that would implement its deeming authority allowing the agency to extend FDA regulation of tobacco products to pipes, cigars, hookahs, e-cigarettes and all other non-pharmaceutical tobacco/nicotine products not currently covered by the Federal Food, Drug, and Cosmetic Act, as amended by the Family Smoking Prevention and Tobacco Control Act; (2) supports legislation and/or regulation of electronic cigarettes and all other non-pharmaceutical tobacco/nicotine products that: (a) establishes a minimum legal purchasing age of 21; (b) prohibits use in all places that tobacco cigarette use is prohibited, including in hospitals and other places in which health care is delivered; (c) applies the same marketing and sales restrictions that are applied to tobacco cigarettes, including prohibitions on television advertising, product placement in television and films, and the use of celebrity spokespeople; (d) prohibits product claims of reduced risk or effectiveness as tobacco cessation tools, until such time that credible evidence is available, evaluated, and supported by the FDA; (e) requires the use of secure, child- and tamper-proof packaging and design, and safety labeling on containers of replacement fluids (e-liquids) used in e-cigarettes; (f) establishes manufacturing and product (including e-liquids) standards for identity, strength, purity, packaging, and labeling with instructions and contraindications for use; (g) requires transparency and disclosure concerning product design, contents,

and emissions; and (h) prohibits the use of characterizing flavors that may enhance the appeal of such products to youth; and (3) urges federal officials, including but not limited to the U.S. Food and Drug Administration to: (a) prohibit the sale of any e-cigarette cartridges and e-liquid refills that do not include a complete list of ingredients on its packaging, in the order of prevalence (similar to food labeling); and (b) require that an accurate nicotine content of e-cigarettes, e-cigarette cartridges, and e-liquid refills be prominently displayed on the product alongside a warning of the addictive quality of nicotine.

Res. 206, I-13, Modified in lieu of: Res. 511, A-14, Modified in lieu of: Res. 518, A-14, Modified in lieu of: Res. 519, A-14, Modified: CSAPH Rep. 2, I-14, Reaffirmation, A-15, Reaffirmed in lieu of: Res. 412, A-15, Reaffirmed in lieu of Res. 419, A-15, Reaffirmed: Res. 421, A-15, Reaffirmation A-16, Appended: Res. 429, A-18, Modified: CSAPH Rep. 05, A-18, Reaffirmation: I-19

Ban on Handguns and Automatic Repeating Weapons H-145.985

It is the policy of the AMA to:

- (1) Support interventions pertaining to firearm control, especially those that occur early in the life of the weapon (e.g., at the time of manufacture or importation, as opposed to those involving possession or use). Such interventions should include but not be limited to:
 - (a) mandatory inclusion of safety devices on all firearms, whether manufactured or imported into the United States, including built-in locks, loading indicators, safety locks on triggers, and increases in the minimum pressure required to pull triggers;
 - (b) bans on the possession and use of firearms and ammunition by unsupervised youths under the age of 21;
 - (c) bans of sales of firearms and ammunition from licensed and unlicensed dealers to those under the age of 21 (excluding certain categories of individuals, such as military and law enforcement personnel);
 - (d) the imposition of significant licensing fees for firearms dealers;
 - (e) the imposition of federal and state surtaxes on manufacturers, dealers and purchasers of handguns and semiautomatic repeating weapons along with the ammunition used in such firearms, with the attending revenue earmarked as additional revenue for health and law enforcement activities that are directly related to the prevention and control of violence in U.S. society; and
 - (f) mandatory destruction of any weapons obtained in local buy-back programs.
 - (2) Support legislation outlawing the Black Talon and other similarly constructed bullets.
 - (3) Support the right of local jurisdictions to enact firearm regulations that are stricter than those that exist in state statutes and encourage state and local medical societies to evaluate and support local efforts to enact useful controls.
 - (4) Oppose "concealed carry reciprocity" federal legislation that would require all states to recognize concealed carry firearm permits granted by other states and that would allow citizens with concealed gun carry permits in one state to carry guns across state lines into states that have stricter laws.
 - (5) Support the concept of gun buyback programs as well as research to determine the effectiveness of the programs in reducing firearm injuries and deaths.
- BOT Rep. 50, I-93, Reaffirmed: CSA Rep. 8, A-05, Reaffirmation, A-14, Appended: Res. 427, A-18, Reaffirmation: A-18, Modified: Res. 244, A-18

Gun Violence as a Public Health Crisis D-145.995

Our AMA: (1) will immediately make a public statement that gun violence represents a public health crisis which requires a comprehensive public health response and solution; and (2) will actively lobby Congress to lift the gun violence research ban. Citation: Res. 1011, A-16; Reaffirmation: A-18; Reaffirmation: I-18

Firearms as a Public Health Problem in the United States - Injuries and Death H-145.997

1. Our AMA recognizes that uncontrolled ownership and use of firearms, especially handguns, is a serious threat to the public's health inasmuch as the weapons are one of the main causes of intentional and unintentional injuries and deaths. Therefore, the AMA:

- (A) encourages and endorses the development and presentation of safety education programs that will engender more responsible use and storage of firearms;
 - (B) urges that government agencies, the CDC in particular, enlarge their efforts in the study of firearm-related injuries and in the development of ways and means of reducing such injuries and deaths;
 - (C) urges Congress to enact needed legislation to regulate more effectively the importation and interstate traffic of all handguns;
 - (D) urges the Congress to support recent legislative efforts to ban the manufacture and importation of nonmetallic, not readily detectable weapons, which also resemble toy guns; (5) encourages the improvement or modification of firearms so as to make them as safe as humanly possible;
 - (E) encourages nongovernmental organizations to develop and test new, less hazardous designs for firearms;
 - (F) urges that a significant portion of any funds recovered from firearms manufacturers and dealers through legal proceedings be used for gun safety education and gun-violence prevention; and
 - (G) strongly urges US legislators to fund further research into the epidemiology of risks related to gun violence on a national level.
2. Our AMA will advocate for firearm safety features, including but not limited to mechanical or smart technology, to reduce accidental discharge of a firearm or misappropriation of the weapon by a non-registered user; and support legislation and regulation to standardize the use of these firearm safety features on weapons sold for non-military and non-peace officer use within the U.S.; with the aim of establishing manufacturer liability for the absence of safety features on newly manufactured firearms.

CSA Rep. A, I-87, Reaffirmed: BOT Rep. 50, I-93, Appended: Res. 403, I-99, Reaffirmation A-07, Reaffirmation, A-13, Appended: Res. 921, I-13, Reaffirmed: CSAPH Rep. 04, A-18, Reaffirmation, A-18, Reaffirmation: I-18, Appended: Res. 405, A-19

Gun Safety H-145.978

Our AMA: (1) recommends and promotes the use of trigger locks and locked gun cabinets as safety precautions; and (2) endorses standards for firearm construction reducing the likelihood of accidental discharge when a gun is dropped and that standardized drop tests be developed. Res. 425, I-98, Reaffirmed: Res. 409, A-00, Reaffirmed: CSAPH Rep. 1, A-10, Reaffirmation A-13

Firearm Availability H-145.996

1. Our AMA: (a) advocates a waiting period and background check for all firearm purchasers; (b) encourages legislation that enforces a waiting period and background check for all firearm purchasers; and (c) urges legislation to prohibit the manufacture, sale or import of lethal and non-lethal guns made of plastic, ceramics, or other non-metallic materials that cannot be detected by airport and weapon detection devices.
2. Our AMA supports requiring the licensing/permitting of firearms-owners and purchasers, including the completion of a required safety course, and registration of all firearms.
3. Our AMA supports "gun violence restraining orders" for individuals arrested or convicted of domestic violence or stalking, and supports extreme risk protection orders, commonly known as "red-flag" laws, for individuals who have demonstrated significant signs of potential violence. In supporting restraining orders and "red-flag" laws, we also support the importance of due process so that individuals can petition for their rights to be restored.

Res. 140, I-87, Reaffirmed: BOT Rep. 8, I-93, Reaffirmed: BOT Rep. 50, I-93, Reaffirmed: CSA Rep. 8, A-05, Reaffirmed: CSAPH Rep. 1, A-15, Modified: BOT Rep. 12, A-16, Appended: Res. 433, A-18, Reaffirmation, I-18, Modified: BOT Rep. 11, I-18

School Violence H-145.983

Our AMA: (1) encourages states to adopt legislation enabling schools to limit and control the possession and storage of weapons or potential weapons on school property; (2) advocates for schools to remain gun-free zones except for school-sanctioned activities and professional law enforcement officers; and (3) opposes requirements or incentives of teachers to carry weapons.

Sub. Res. 402, I-95; Reaffirmed: CSA Rep. 8, A-05; Reaffirmed: CSAPH Rep. 1, A-15; Appended: Res. 402, A-18

Control of Non-Detectable Firearms H-145.994

Our AMA supports a ban on the (1) manufacture, importation, and sale of any firearm which cannot be detected by ordinary airport screening devices, including 3D printed firearms and (2) production and distribution of 3D firearm digital blueprints.

Sub. Res. 79, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmed: CSAPH Rep. 01, A-18; Modified: BOT Rep. 11, I-18

Firearm Related Injury and Death: Adopt a Call to Action H-145.973

Our AMA endorses the specific recommendations made by an interdisciplinary, inter-professional group of leaders from the American Academy of Family Physicians, American Academy of Pediatrics, American College of Emergency Physicians, American College of Obstetricians and Gynecologists, American College of Physicians, American College of Surgeons, American Psychiatric Association, American Public Health Association, and the American Bar Association in the publication "Firearm-Related Injury and Death in the United States: A Call to Action From 8 Health Professional Organizations and the American Bar Association," which is aimed at reducing the health and public health consequences of firearms and lobby for their adoption.

Res. 214, I-16

Gun Regulation H-145.999

Our AMA supports stricter enforcement of present federal and state gun legislation and the imposition of mandated penalties by the judiciary for crimes committed with the use of a firearm, including the illegal possession of a firearm.

Sub. Res. 31, I-81, Reaffirmed: CLRPD Rep. F, I-91, Amended: BOT Rep. 50, I-93, Reaffirmed: Res. 409, A-00, Reaffirmation: A-07, Reaffirmed: BOT Rep. 22, A-17, Modified: Res. 401, A-17, Reaffirmation: I-18

Waiting Period Before Gun Purchase H-145.992

The AMA supports legislation calling for a waiting period of at least one week before purchasing any form of firearm in the U.S.

Res. 171, A-89, Reaffirmed: BOT Rep. 50, I-93, Reaffirmed: CSAPH Rep. 8, A-05, Reaffirmation: A-07, Reaffirmed: BOT Rep. 22, A-17, Reaffirmation A-18

Waiting Periods for Firearm Purchases H-145.991

The AMA supports using its influence in matters of health to effect passage of legislation in the Congress of the U.S. mandating a national waiting period that allows for a police background and positive identification check for anyone who wants to purchase a handgun from a gun dealer anywhere in our country.

Sub. Res. 34, I-89, Reaffirmed: BOT Rep. 8, I-93, Reaffirmed: BOT Rep. 50, I-93, Reaffirmed: CSA Rep. 8, A-05, Reaffirmation: A-07, Reaffirmed: BOT Rep. 22, A-17, Reaffirmation: A-18, Reaffirmation: I-18

Restriction of Assault Weapons H-145.993

Our AMA supports appropriate legislation that would restrict the sale and private ownership of inexpensive handguns commonly referred to as "Saturday night specials," and large clip, high-rate-of-fire automatic and semi-automatic firearms, or any weapon that is modified or redesigned to operate as a large clip, high-rate-of-fire automatic or semi-automatic weapon and ban the sale and ownership to the public of all assault-type weapons, bump stocks and related devices, high capacity magazines and armor piercing bullets.

Sub. Res. 264, A-89; Reaffirmed: BOT Rep. 50, I-93; Amended: Res.215, I-94; Reaffirmed: CSA Rep. 6, A-04; Reaffirmation A-07; Reaffirmed: BOT Rep. 22, A-17; Modified: Res. 433, A-18; Reaffirmation: A-18

Prevention of Unintentional Shooting Deaths Among Children H-145.979

Our AMA supports legislation at the federal and state levels making gun owners legally responsible for injury or death caused by a child gaining unsupervised access to a gun, unless it can be shown that reasonable measures to prevent child access to the gun were taken by the gun owner, and that the specifics, including the nature of "reasonable measures," be determined by the individual constituencies affected by the law.

Res. 204, I-98; Reaffirmed: BOT Rep. 23, A-09; Reaffirmed: CSAPH Rep. 01, A-19

Guns in Hospitals H-215.977

1. The policy of the AMA is to encourage hospitals to incorporate, within their security policies, specific provisions on the presence of firearms in the hospital. The AMA believes the following points merit attention:

A. Given that security needs stem from local conditions, firearm policies must be developed with the cooperation and collaboration of the medical staff, the hospital security staff, the hospital administration, other hospital staff representatives, legal counsel, and local law enforcement officials. Consultation with outside experts, including state and federal law enforcement agencies, or patient advocates may be warranted.

B. The development of these policies should begin with a careful needs assessment that addresses past issues as well as future needs.

C. Policies should, at minimum, address the following issues: a means of identification for all staff and visitors; restrictions on access to the hospital or units within the hospital, including the means of ingress and egress; changes in the physical layout of the facility that would improve security; the possible use of metal detectors; the use of monitoring equipment such as closed circuit television; the development of an emergency signaling system; signage for the facility regarding the possession of weapons; procedures to be followed when a weapon is discovered; and the means for securing or controlling weapons that may be brought into the facility, particularly those considered contraband but also those carried in by law enforcement personnel.

D. Once policies are developed, training should be provided to all members of the staff, with the level and type of training being related to the perceived risks of various units within the facility. Training to recognize and defuse potentially violent situations should be included.

E. Policies should undergo periodic reassessment and evaluation.

F. Firearm policies should incorporate a clear protocol for situations in which weapons are brought into the hospital.

2. Our AMA will advocate that hospitals and other healthcare delivery settings limit guns and conducted electrical weapons in units where patients suffering from mental illness are present. BOT Rep. 23, I-94, Reaffirmation: I-03, Reaffirmed: CSA Rep. 6, A-04, Reaffirmed: CSAPH Rep. 2, I-10, Appended: Res. 426, A-16

Prevention of Firearm Accidents in Children H-145.990

Our AMA (1) supports increasing efforts to reduce pediatric firearm morbidity and mortality by encouraging its members to (a) inquire as to the presence of household firearms as a part of childproofing the home; (b) educate patients to the dangers of firearms to children; (c) encourage patients to educate their children and neighbors as to the dangers of firearms; and (d) routinely remind patients to obtain firearm safety locks, to store firearms under lock and key, and to store ammunition separately from firearms;(2) encourages state medical societies to work with other organizations to increase public education about firearm safety; (3) encourages organized medical staffs and other physician organizations, including state and local medical societies, to recommend programs for teaching firearm safety to children; and (4) supports enactment of Child Access Prevention laws that are consistent with AMA policy.

Res. 165, I-89, Reaffirmed: Sunset Report and Appended: Sub. Res. 401, A-00, Reaffirmed: CSAPH Rep. 1, A-10, Reaffirmation: A-13, Reaffirmed: CSAPH Rep. 04, A-18, Reaffirmation: I-18, Modified: BOT Rep. 11, I-18

Firearm Safety and Research, Reduction in Firearm Violence, and Enhancing Access to Mental Health Care H-145.975

1. Our AMA supports: a) federal and state research on firearm-related injuries and deaths; b) increased funding for and the use of state and national firearms injury databases, including the expansion of the National Violent Death Reporting System to all 50 states and U.S. territories, to inform state and federal health policy; c) encouraging physicians to access evidence-based data regarding firearm safety to educate and counsel patients about firearm safety; d) the rights of physicians to have free and open communication with their patients regarding firearm safety and the use of gun locks in their homes; e) encouraging local projects to facilitate the low-cost distribution of gun locks in homes; f) encouraging physicians to become involved in local firearm safety classes as a means of promoting injury prevention and the public health; and g) encouraging CME providers to consider, as appropriate, inclusion of presentations about the prevention of gun violence in national, state, and local continuing medical education programs.

2. Our AMA supports initiatives to enhance access to mental and cognitive health care, with greater focus on the diagnosis and management of mental illness and concurrent substance use disorders, and work with state and specialty medical societies and other interested stakeholders to identify and develop standardized approaches to mental health assessment for potential violent behavior.

3. Our AMA (a) recognizes the role of firearms in suicides, (b) encourages the development of curricula and training for physicians with a focus on suicide risk assessment and prevention as well as lethal means safety counseling, and (c) encourages physicians, as a part of their suicide prevention strategy, to discuss lethal means safety and work with families to reduce access to lethal means of suicide.

Sub. Res. 221, A-13, Appended: Res. 416, A-14, Reaffirmed: Res. 426, A-16, Reaffirmed: BOT Rep. 28, A-18, Reaffirmation: A-18, Modified: CSAPH Rep. 04, A-18, Reaffirmation, I-18; Reaffirmed: CSAPH Rep. 3, A-21

Firearm Safety Counseling in Physician-Led Health Care Teams H-145.976

1. Our AMA: (a) will oppose any restrictions on physicians' and other members of the physician-led health care team's ability to inquire and talk about firearm safety issues and risks with their patients; (b) will oppose any law restricting physicians' and other members of the physician-led health care team's discussions with patients and their families about firearms as an intrusion into medical privacy; and (c) encourages dissemination of educational materials related to firearm safety to be used in undergraduate medical education.

2. Our AMA will work with appropriate stakeholders to develop state-specific guidance for physicians on how to counsel patients to reduce their risk for firearm-related injury or death, including guidance on when and how to ask sensitive questions about firearm ownership, access, and use, and clarification on the circumstances under which physicians are permitted or may be required to disclose the content of such conversations to family members, law enforcement, or other third parties. Res. 219, I-11, Reaffirmation: A-13, Modified: Res. 903, I-13, Appended: Res. 419, A-17, Reaffirmed: CSAPH Rep. 4, A-18; Reaffirmed: CSAPH Rep. 3, I-21

Preventing Firearm-Related Injury and Morbidity in Youth D-145.996

Our American Medical Association will identify and support the distribution of firearm safety materials that are appropriate for the clinical setting.

Res. 216, A-15

Safety of Non-powder (Gas-Loaded/Spring-Loaded) Guns H-145.989

It is the policy of the AMA to encourage the development of appropriate educational materials designed to enhance physician and general public awareness of the safe use of as well as the dangers inherent in the unsafe use of non-powder (gas-loaded/spring-loaded) guns.

Res. 423, I-91; Modified: Sunset Report, I-01; Modified: CSAPH Rep. 1, A-11; Reaffirmed: CSAPH Rep. 1, A-21

Data on Firearm Deaths and Injuries H-145.984

The AMA supports legislation or regulatory action that: (1) requires questions in the National Health Interview Survey about firearm related injury as was done prior to 1972; (2) mandates that the Centers for Disease Control and Prevention develop a national firearm fatality reporting system; and (3) expands activities to begin tracking by the National Electronic Injury Surveillance System.

Res. 811, I-94, Reaffirmed: CSA Rep. 6, A-04, Reaffirmation: A-13

Epidemiology of Firearm Injuries D-145.999

Our AMA will: (1) strongly urge the Administration and Congress to encourage the Centers for Disease Control and Prevention to conduct an epidemiological analysis of the data of firearm-related injuries and deaths; and (2) urge Congress to provide sufficient resources to enable the CDC to collect and analyze firearm-related injury data and report to Congress and the nation via a broadly disseminated document, so that physicians and other health care providers, law enforcement and society at large may be able to prevent injury, death and the other costs to society resulting from firearms. Res. 424, A-03; Reaffirmation A-13; Modified: CSAPH Rep. 1, A-13; Reaffirmation: A-18

Removing Restrictions on Federal Funding for Firearm Violence Research D-145.994

Our AMA will provide an informational report on recent and current organizational actions taken on our existing AMA policies (e.g. H-145.997) regarding removing the restrictions on federal funding for firearms violence research, with additional recommendations on any ongoing or proposed upcoming actions.

Res. 201, I-16

AMA Campaign to Reduce Firearm Deaths H-145.988

The AMA supports educating the public regarding methods to reduce death and injury due to keeping guns, ammunition and other explosives in the home.

Res. 410, A-93, Reaffirmed: CLRPD Rep. 5, A-03, Reaffirmation: A-13, Modified: CSAPH Rep. 1, A-13

Physicians and the Public Health Issues of Gun Safety D-145.997

Our AMA will request that the US Surgeon General develop a report and campaign aimed at reducing gun-related injuries and deaths. Res. 410, A-13

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 234
(A-22)

Introduced by: Medical Student Section

Subject: Updating Policy on Immigration Laws, Rules, Legislation, and Health Disparities

Referred to: Reference Committee B

- 1 Whereas, The 2018 American Community Survey (ACS) reported that about 10.6 million
2 undocumented immigrants were living the United States¹; and
3
- 4 Whereas, Throughout the COVID-19 pandemic, there were at least 48 immigration policy
5 changes that not only affected international travel, student visas, immigration, and asylum
6 processes, but also caused significant confusion for immigration lawyers²⁻⁴; and
7
- 8 Whereas, The suspension of the United States Custom and Immigration Services (USCIS)
9 during the early stages of the COVID-19 pandemic led to a back-up in the processing of
10 necessary documentation, which left many unable to access certain benefits necessary for
11 work, receiving healthcare, and accessing public benefits⁵; and
12
- 13 Whereas, The Executive Office for Immigration Review (EOIR) suspended all hearings for non-
14 detained individuals on March 18, 2020, which delayed the processing of asylum seekers
15 enrolled in the Migrant Protection Protocols and left them to remain in Mexico in unsanitary
16 conditions that promotes the spread of the virus⁵; and
17
- 18 Whereas, The federal government used statutes and the Tariff Act of 1930 in order to create
19 rules from the Centers for Disease Control and Prevention (CDC) and CBP that restricted entry
20 at the northern and southern borders and barred asylum seekers from entering the country due
21 to public health threats, despite evidence suggesting that such restrictions are ineffective and
22 may even divert resources from other interventions⁵; and
23
- 24 Whereas, Immigration courts closed at the beginning of the COVID-19 pandemic and postponed
25 hearings for detained people, prolonging their stay in detention centers^{4,5}; and
26
- 27 Whereas, The relief packages that were provided by the government during the pandemic either
28 provided little or no coverage to immigrants and their families, leaving them with few options for
29 testing and treatment⁵⁻⁷; and
30
- 31 Whereas, The Families First Coronavirus Response Act (FFCRA) failed to make COVID-19
32 related services available under emergency Medicaid, which means that immigrants are unable
33 to access these services since they cannot apply for non-emergency Medicaid due to
34 immigration eligibility criteria^{1,5,8}; and
35
- 36 Whereas, The Coronavirus Aid, Relief, and Economic Security (CARES) act limited the ability to
37 receive a stimulus payment to individuals with a social security number, which limits many
38 immigrants who file taxes using Individual Taxpayer Identification Numbers (ITIN)^{1,5,8}; and

1 Whereas, Lapses in work authorization due to slowed processing times and suspension of
2 required processing services may result in immigrants being unemployed or losing benefits
3 offered by their employer; further, undocumented immigrants typically work low-earning jobs
4 and are unable to receive unemployment insurance or government stimulus checks during
5 national crises^{5,8,9}; and

6
7 Whereas, Both the FFCRA and the CARES act expanded Unemployment Insurance (UI)
8 programs, but due to lapses in work authorizations, many immigrants may either not qualify or
9 lose access to this vital benefit¹; and

10
11 Whereas, Skeletal and dental maturity are assessed from hand-wrist radiographs and dental x-
12 rays, which together are compared to growth charts to determine the age of an individual¹⁰; and

13
14 Whereas, Estimated chronological age determined from growth charts, hand-wrist radiographs,
15 and dental x-rays may not correlate with the true chronological age of an individual due to
16 population and geography-specific factors, including nutritional intake, environmental exposure,
17 and genetics to such an extent that the Centers for Disease Control (CDC) recommends against
18 using hand-wrist radiographs to determine the age of refugees¹⁰⁻¹⁴; and

19
20 Whereas, International records highlight the wide variety in growth charts used in different
21 countries, in part due to different genetics, nutrition, medical conditions, and environmental
22 exposures¹⁵⁻¹⁷; and

23
24 Whereas, The Department of Homeland Security (DHS) and the Department of Health and
25 Human Services (HHS) can request new skeletal and dental x-ray imaging to establish the age
26 of an individual crossing the border, though the DHS handbook states that medical images may
27 be used only when no other means of verifying chronological age (records from birth, baptism,
28 school, healthcare, statements by the person in question or family members) exist¹⁸⁻²⁰; and

29
30 Whereas, According to Food and Drug Administration recommendations, performing x-rays on
31 children comes with greater risk of radiation-related illness and should only be used to answer a
32 clinical question or to guide treatment¹⁹; and

33
34 Whereas, As part of the 2009 Appropriations Bill, Congress stated its concern that Immigration
35 and Customs Enforcement (ICE) had not stopped using fallible bone and dental forensics for
36 child age determination and has since decreased their use of age determination exams^{21,22};
37 and

38
39 Whereas, In 2018, ICE decreased its number of age determination exams to less than 50;
40 meanwhile, HHS increased its utilization of the exams for those in the care of the Office of
41 Refugee Resettlement (ORR) to almost 700, almost double the number granted to both
42 agencies in each of the prior two years²²; and

43
44 Whereas, Minors who are incorrectly classified as adults due to dental and x-ray imaging are
45 held in adult detention centers while waiting for their cases to be heard and therefore are not
46 held in the least restrictive setting, in violation of the Flores settlement agreement^{23,24}; and

47
48 Whereas, Attorneys representing minors report that their clients' supporting documentation was
49 not used and were instead placed in adult detention centers solely based on x-ray images for
50 months until federal judges ruled that ICE and HHS could not classify their immigrant clients as
51 adults based solely on imaging²⁵; and

1 Whereas, AMA policy recognizes unique health needs of immigrants and refugees (H-350.957)
2 and opposes rules deter immigrants from utilizing non-cash public benefits (D-440.927) but
3 does not address protections for immigrants during national crises; and
4

5 Whereas, AMA policy advocates that healthcare for minors in detention centers should be
6 directed solely towards bettering health (H-65.958) and that medical records should not be used
7 for immigration enforcement (H-315.966); therefore be it
8

9 RESOLVED, That our American Medical Association, in order to prioritize the unique health
10 needs of immigrants, asylees, refugees, and migrant workers during national crises, such as a
11 pandemic:

12 (1) oppose the slowing or halting of the release of individuals and families that are currently part
13 of the immigration process;

14 (2) oppose continual detention when the health of these groups is at risk and supports releasing
15 immigrants on recognizance, community support, bonding, or a formal monitoring program
16 during national crises that impose a health risk;

17 (3) support the extension or reauthorization of visas that were valid prior to a national crisis if the
18 crisis causes the halting of immigration processing; and

19 (4) oppose utilizing public health concerns to deny or significantly hinder eligibility for asylum
20 status to immigrants, refugees, or migrant workers without a viable, medically sound alternative
21 solution; (New HOD Policy) and be it further
22

23 RESOLVED, That our AMA support discontinuation of the use of non-medically necessary
24 dental and bone forensics to assess an immigrant's age. (New HOD Policy)

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

Received: 05/11/22

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RELEVANT AMA POLICY

Impact of Immigration Barriers on the Nation's Health D-255.980

1. Our AMA recognizes the valuable contributions and affirms our support of international medical students and international medical graduates and their participation in U.S. medical schools, residency and fellowship training programs and in the practice of medicine.
2. Our AMA will oppose laws and regulations that would broadly deny entry or re-entry to the United States of persons who currently have legal visas, including permanent resident status (green card) and student visas, based on their country of origin and/or religion.
3. Our AMA will oppose policies that would broadly deny issuance of legal visas to persons based on their country of origin and/or religion.
4. Our AMA will advocate for the immediate reinstatement of premium processing of H-1B visas for physicians and trainees to prevent any negative impact on patient care.
5. Our AMA will advocate for the timely processing of visas for all physicians, including residents, fellows, and physicians in independent practice.
6. Our AMA will work with other stakeholders to study the current impact of immigration reform efforts on residency and fellowship programs, physician supply, and timely access of patients to health care throughout the U.S.

Alt. Res. 308, A-17; Modified: CME Rep. 01, A-18; Reaffirmation: A-19; Reaffirmed: CME Rep. 4, A-21

Patient and Physician Rights Regarding Immigration Status H-315.966

Our AMA supports protections that prohibit U.S. Immigration and Customs Enforcement, U.S. Customs and Border Protection, or other law enforcement agencies from utilizing information from medical records to pursue immigration enforcement actions against patients who are undocumented.

Res. 018, A-17

Opposing the Detention of Migrant Children H-60.906

Our AMA: (1) opposes the separation of migrant children from their families and any effort to end or weaken the Flores Settlement that requires the United States Government to release undocumented children "without unnecessary delay" when detention is not required for the protection or safety of that child and that those children that remain in custody must be placed in the "least restrictive setting" possible, such as emergency foster care; (2) supports the humane treatment of all undocumented children, whether with families or not, by advocating for regular, unannounced, auditing of the medical conditions and services provided at all detention facilities by a non-governmental, third party with medical expertise in the care of vulnerable children; and (3) urges continuity of care for migrant children released from detention facilities.

Res. 004, I-18

Addressing Immigrant Health Disparities H-350.957

1. Our American Medical Association recognizes the unique health needs of refugees, and encourages the exploration of issues related to refugee health and support legislation and policies that address the unique health needs of refugees.
2. Our AMA: (A) urges federal and state government agencies to ensure standard public health screening and indicated prevention and treatment for immigrant children, regardless of legal status, based on medical evidence and disease epidemiology; (B) advocates for and publicizes medically accurate information to reduce anxiety, fear, and marginalization of specific populations; and (C) advocates for policies to make available and effectively deploy resources needed to eliminate health disparities affecting immigrants, refugees or asylees.
3. Our AMA will call for asylum seekers to receive all medically-appropriate care, including vaccinations in a patient centered, language and culturally appropriate way upon presentation for asylum regardless of country of origin.

Res. 804, I-09 Appended: Res. 409, A-15; Reaffirmation: A-19; Appended: Res. 423, A-19; Reaffirmation: I-19

HIV, Immigration, and Travel Restrictions H-20.901

Our AMA recommends that: (1) decisions on testing and exclusion of immigrants to the United States be made only by the U.S. Public Health Service, based on the best available medical, scientific, and public health information; (2) non-immigrant travel into the United States not be restricted because of HIV status; and (3) confidential medical information, such as HIV status, not be indicated on a passport or visa document without a valid medical purpose.

CSA Rep. 4, A-03; Modified: Res. 2, I-10; Modified: Res. 254, A-18

Opposing Office of Refugee Resettlement's Use of Medical and Psychiatric Records for Evidence in Immigration Court H-65.958

Our AMA will: (1) advocate that healthcare services provided to minors in immigrant detention and border patrol stations focus solely on the health and well-being of the children; and (2) condemn the use of confidential medical and psychological records and social work case files as evidence in immigration courts without patient consent.

Res. 013, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 235
(A-22)

Introduced by: Ohio

Subject: Improving the Veterans Health Administration Referrals for Veterans for Care outside the VA System

Referred to: Reference Committee B

- 1 Whereas, Scandal at the Department of Veterans Affairs regarding wait times and access to
2 referral for specialty care resulted in reforms permitting expedited referral of VA patients to
3 doctors outside the VA system if prompt care could not be provided within the system; and
4
5 Whereas, A whistleblower-prompted VA internal investigation confirmed that in 2017 alone, for
6 2,538 veterans, doctors outside the VA system were terminating services to the veterans and/or
7 referring them to collection agencies, and impacting their credit profiles, because the VA was
8 not providing the indicated pay for services provided; and
9
10 Whereas, Investigation also determined that the software system for managing travel
11 reimbursement for the veterans referred outside the VA for care is obsolete, resulting in
12 \$224 million in improper travel reimbursements in 2017 alone; and
13
14 Whereas, The House Committee on Veterans' Affairs plans a hearing this spring to address
15 these issues; therefore be it
16
17 RESOLVED, The our American Medical Association advocate for reform of the veterans' health
18 administration to provide timely and complete payment for veterans' care received outside the
19 VA system and accurate and efficient management of travel reimbursement for that care.
20 (Directive to Take Action)

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

Received: 05/10/22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 236
(A-22)

Introduced by: Ohio
Subject: Out-of-Network Care
Referred to: Reference Committee B

1 Whereas, Many patients receive care from physicians who are not in their insurance company's
2 restrictive network for multiple reasons; and
3
4 Whereas, This leads to out-of-network bills that are unexpected both to patients and physicians,
5 especially in Emergency situations; and
6
7 Whereas, There are multiple potential legislative solutions being considered both at the national
8 and state levels to address this problem; and
9
10 Whereas, AMA Policy H-285.904 only addresses permitting mediation in those instances where
11 a physician's unique background or skills (e.g. the Gould Criteria) are not accounted for within a
12 minimum coverage standard; therefore be it
13
14 RESOLVED, That our American Medical Association amend, by substitution, AMA Policy
15 H-285.904, "Out-of-Network Care," item H, to read as follows:
16
17 ~~H. Mediation should be permitted in those instances where a physician's unique~~
18 ~~background or skills (e.g. the Gould Criteria) are not accounted for within a~~
19 ~~minimum coverage standard.~~
20
21 H. Mediation and/or Independent Dispute Resolution (IDR) should be permitted in
22 all circumstances as an option or alternative to come to payment resolution
23 between insurers and providers. (Modify Current HOD Policy)

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

Received: 05/10/22

RELEVANT AMA POLICY

Out-of-Network Care H-285.904

1. Our AMA adopts the following principles related to unanticipated out-of-network care:
 - A. Patients must not be financially penalized for receiving unanticipated care from an out-of-network provider.
 - B. Insurers must meet appropriate network adequacy standards that include adequate patient access to care, including access to hospital-based physician specialties. State regulators should enforce such standards through active regulation of health insurance company plans.
 - C. Insurers must be transparent and proactive in informing enrollees about all deductibles, copayments and other out-of-pocket costs that enrollees may incur.
 - D. Prior to scheduled procedures, insurers must provide enrollees with reasonable and timely access to in-network physicians.

E. Patients who are seeking emergency care should be protected under the "prudent layperson" legal standard as established in state and federal law, without regard to prior authorization or retrospective denial for services after emergency care is rendered.

F. Out-of-network payments must not be based on a contrived percentage of the Medicare rate or rates determined by the insurance company.

G. Minimum coverage standards for unanticipated out-of-network services should be identified. Minimum coverage standards should pay out-of-network providers at the usual and customary out-of-network charges for services, with the definition of usual and customary based upon a percentile of all out-of-network charges for the particular health care service performed by a provider in the same or similar specialty and provided in the same geographical area as reported by a benchmarking database. Such a benchmarking database must be independently recognized and verifiable, completely transparent, independent of the control of either payers or providers and maintained by a non-profit organization. The non-profit organization shall not be affiliated with an insurer, a municipal cooperative health benefit plan or health management organization.

H. Mediation should be permitted in those instances where a physician's unique background or skills (e.g. the Gould Criteria) are not accounted for within a minimum coverage standard.

2. Our AMA will advocate for the principles delineated in Policy H-285.904 for all health plans, including ERISA plans.

3. Our AMA will advocate that any legislation addressing surprise out of network medical bills use an independent, non-conflicted database of commercial charges.

Citation: Res. 108, A-17; Reaffirmation: A-18; Appended: Res. 104, A-18; Reaffirmed in lieu of: Res. 225, I-18; Reaffirmation: A-19; Reaffirmed: Res. 210, A-19; Appended: Res. 211, A-19; Reaffirmed: CMS Rep. 5, A-21

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 237
(A-22)

Introduced by: Ohio
Subject: Prescription Drug Dispensing Policies
Referred to: Reference Committee B

- 1 Whereas, In some states a pharmacist may dispense a 90-day supply of medication, when a
2 30-day supply with 2 or more refills is ordered, without approval by the physician, unless the
3 prescription specifically states DAW; and
4
5 Whereas, Suicides may involve an overdose of certain prescription medications; and
6
7 Whereas, Physician may not be aware of a patients suicide potential; and
8
9 Whereas, There are major restrictions on the prescribing of opiates and other controlled
10 substances, other prescription medications may be used by patients to end their lives; and
11
12 Whereas, It may be unsafe to leave the decision of whether to dispense a 90-day supply of
13 medication, when a 30-day supply with 2 refills has been ordered by the prescriber, up to "the
14 Pharmacist's Professional discretion after consulting with the patient;" therefore be it
15
16 RESOLVED, That our American Medical Association work with pharmacy benefit managers to
17 eliminate financial incentives for patients to receive a supply of medication greater than
18 prescribed (Directive to Take Action); and be it further
19
20 RESOLVED, That our AMA create model state legislation that would restrict dispensing
21 medication quantities greater than prescribed (Directive to Take Action); and be it further
22
23 RESOLVED, That our AMA support any legislation that would remove financial barriers favoring
24 dispensing quantities of medication greater than prescribed. (New HOD Policy)

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

Received: 05/10/22

RELEVANT AMA POLICY

Adequate Prescription Medication Supply H-120.943

1. Our AMA urges health plans to: (a) define a month's supply as a minimum of 31 days and three month's supply as a minimum of 93 days, so that patients are not shorted on their one-month or three-month supply of prescription drugs; and (b) allow prescription refills to provide the appropriate number of doses for the time period specified by the physician.
 2. Our AMA will advocate and support advocacy at the state and federal levels against arbitrary prescription limits that restrict access to medically necessary treatment by limiting the dose, amount or days of the first or subsequent prescription for patients with pain related to a cancer or terminal diagnosis.
- Citation: Res. 510, A-07; Reaffirmed: CMS Rep. 04, A-16; Appended: Res. 918, I-16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 238
(A-22)

Introduced by: Texas

Subject: COVID-19 Economic Injury Disaster Loan (EIDL) Forgiveness for Physician Groups of Five or Fewer Physicians

Referred to: Reference Committee B

1 Whereas, During the initial phases of the COVID-19 pandemic, many physician practices relied
2 on the Economic Injury Disaster Loan (EIDL) federal small business loan program; and
3

4 Whereas, EIDL supports recovery from the COVID-19 disaster's economic impacts by providing
5 accessible and borrower-friendly capital; and
6

7 Whereas, The EIDL has a loan term of 30 years at 3.75% fixed interest rate for for-profits and
8 2.75% fixed interest rate for nonprofits; and
9

10 Whereas, The Small Business Administration (SBA) is taking real estate as collateral for loans
11 more than \$500,000, and personal guarantee for loans more than \$200,000; and
12

13 Whereas, Two forms of EIDL loans, those fully forgiven and those with low interest rates, are
14 available; and
15

16 Whereas, More than half the money from the U.S Department of the Treasury's Coronavirus
17 Relief Fund for small businesses went to only 5% of recipients, according to data on more than
18 5 million loans issued via the Payroll Protection Program, and only 28% of the money was
19 distributed in amounts of less than \$150,000; and
20

21 Whereas, Payroll costs for health care employees have risen exponentially since the pandemic
22 began (and continue to rise); and
23

24 Whereas, No increase in Medicare, Medicaid, or commercial insurance fee schedules has
25 occurred despite this hardship; and
26

27 Whereas, Given this inequity of available government assistance, many small businesses either
28 failed, took out non-forgiven loans to remain open, increased their workload, or underwent other
29 hardships to stay in operation; and
30

31 Whereas, Small businesses that successfully maximized their productivity and intentionally
32 reduced operating costs (through actions that cannot be maintained long-term, such as
33 postponing staff training and delaying equipment upgrades) were unfairly penalized by
34 government assistance programs and denied the same level of relief afforded to large
35 businesses that did not reduce their expenditures and were therefore able to demonstrate
36 financial losses; therefore be it

- 1 RESOLVED, That our American Medical Association advocate for Economic Injury Disaster
- 2 Loan (EIDL) forgiveness for physician groups of five or fewer physicians for loans of less than
- 3 \$150,000 granted by the Small Business Administration by whatever mechanism is available,
- 4 with no stipulations based on productivity or profit/loss reports to receive this forgiveness.
- 5 (Directive to Take Action)

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

Received: 05/09/22

References:

1. O'Connell J, Van Dam A, Gregg A, Fowers A. More than half of emergency small-business funds went to larger businesses, new data shows. www.washingtonpost.com/business/2020/12/01/ppp-sba-data. *The Washington Post*. Published Dec. 2, 2020. Accessed Dec. 14, 2021.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 239
(A-22)

Introduced by: Idaho

Subject: Virtual Services When Patients Are Away From Their Medical Home

Referred to: Reference Committee B

- 1 Whereas, Virtual telemedicine care is a tool that can increase access, lower cost, and improve
2 the quality of healthcare; and
3
- 4 Whereas, Due to rapid changes in virtual technology, and increasing patient mobility, the
5 practice of medicine may need to occur across state lines to facilitate continuity of care for Idaho
6 patients who are receiving care from an Idaho licensed physician; and
7
- 8 Whereas, Continuity of care is defined by the American Academy of Family Physicians as, “the
9 process by which the patient and his/her physician-led care team are cooperatively involved in
10 ongoing health care management toward the shared goal of high-quality, cost-effective medical
11 care;” and
12
- 13 Whereas, Two elements have been shown to predict the best healthcare outcomes - health
14 insurance coverage and a usual source of continuity of care; and
15
- 16 Whereas, Idaho law requires a physician to be licensed in Idaho and establish a physician-
17 patient relationship in accordance with Idaho law in order to treat patients located in Idaho using
18 telehealth technology; and
19
- 20 Whereas, The practitioner who the patient has an established relationship with at their medical
21 home is in the best position to provide continuity of care, particularly if enabling technology is
22 available; and
23
- 24 Whereas, Health insurance coverage, including Medicare Advantage part C, is often restricted
25 to networks defined by regional or state boundaries; therefore be it
26
- 27 RESOLVED, That our American Medical Association support Medicare coverage of virtual
28 continuity of care follow-up services for patients within the physician’s established medical home
29 when the patient has an established relationship with the provider and such care is not
30 prohibited by the state in which the patient is geographically situated at the time of service
31 (Directive to Take Action); and be it further
32
- 33 RESOLVED, That our AMA advocate with the Centers for Medicare and Medicaid Services
34 (CMS), and Congress if necessary, to cover virtual continuity follow-up care services provided
35 by a patient’s established medical home or usual source of care, as if they were in person, even
36 if the patient is temporarily located outside of the region or state of their medical home.
37 (Directive to Take Action)

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

Received: 05/11/22

RELEVANT AMA POLICY

Coverage of and Payment for Telemedicine H-480.946

1. Our AMA believes that telemedicine services should be covered and paid for if they abide by the following principles:

- a) A valid patient-physician relationship must be established before the provision of telemedicine services, through:
 - A face-to-face examination, if a face-to-face encounter would otherwise be required in the provision of the same service not delivered via telemedicine; or
 - A consultation with another physician who has an ongoing patient-physician relationship with the patient. The physician who has established a valid physician-patient relationship must agree to supervise the patient's care; or
 - Meeting standards of establishing a patient-physician relationship included as part of evidence-based clinical practice guidelines on telemedicine developed by major medical specialty societies, such as those of radiology and pathology.Exceptions to the foregoing include on-call, cross coverage situations; emergency medical treatment; and other exceptions that become recognized as meeting or improving the standard of care. If a medical home does not exist, telemedicine providers should facilitate the identification of medical homes and treating physicians where in-person services can be delivered in coordination with the telemedicine services.
- b) Physicians and other health practitioners delivering telemedicine services must abide by state licensure laws and state medical practice laws and requirements in the state in which the patient receives services.
- c) Physicians and other health practitioners delivering telemedicine services must be licensed in the state where the patient receives services, or be providing these services as otherwise authorized by that state's medical board.
- d) Patients seeking care delivered via telemedicine must have a choice of provider, as required for all medical services.
- e) The delivery of telemedicine services must be consistent with state scope of practice laws.
- f) Patients receiving telemedicine services must have access to the licensure and board certification qualifications of the health care practitioners who are providing the care in advance of their visit.
- g) The standards and scope of telemedicine services should be consistent with related in-person services.
- h) The delivery of telemedicine services must follow evidence-based practice guidelines, to the degree they are available, to ensure patient safety, quality of care and positive health outcomes.
- i) The telemedicine service must be delivered in a transparent manner, to include but not be limited to, the identification of the patient and physician in advance of the delivery of the service, as well as patient cost-sharing responsibilities and any limitations in drugs that can be prescribed via telemedicine.
- j) The patient's medical history must be collected as part of the provision of any telemedicine service.
- k) The provision of telemedicine services must be properly documented and should include providing a visit summary to the patient.
- l) The provision of telemedicine services must include care coordination with the patient's medical home and/or existing treating physicians, which includes at a minimum identifying the patient's existing medical home and treating physicians and providing to the latter a copy of the medical record.

m) Physicians, health professionals and entities that deliver telemedicine services must establish protocols for referrals for emergency services.

2. Our AMA believes that delivery of telemedicine services must abide by laws addressing the privacy and security of patients' medical information.

3. Our AMA encourages additional research to develop a stronger evidence base for telemedicine.

4. Our AMA supports additional pilot programs in the Medicare program to enable coverage of telemedicine services, including, but not limited to store-and-forward telemedicine.

5. Our AMA supports demonstration projects under the auspices of the Center for Medicare and Medicaid Innovation to address how telemedicine can be integrated into new payment and delivery models.

6. Our AMA encourages physicians to verify that their medical liability insurance policy covers telemedicine services, including telemedicine services provided across state lines if applicable, prior to the delivery of any telemedicine service.

7. Our AMA encourages national medical specialty societies to leverage and potentially collaborate in the work of national telemedicine organizations, such as the American Telemedicine Association, in the area of telemedicine technical standards, to the extent practicable, and to take the lead in the development of telemedicine clinical practice guidelines.

Citation: CMS Rep. 7, A-14; Reaffirmed: BOT Rep. 3, I-14; Reaffirmed in lieu of Res. 815, I-15; Reaffirmed: CME Rep. 06, A-16; Reaffirmed: CMS Rep. 06, I-16; Reaffirmed: Res. 111, A-17; Reaffirmation: A-18; Reaffirmed: CMS Rep. 1, I-19; Reaffirmed: CMS Rep. 8, A-21

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 240
(A-22)

Introduced by: Carl S. Wehri, MD, Delegate

Subject: Physician Payment Reform & Equity (PPR & E)

Referred to: Reference Committee B

- 1 Whereas, Physicians in independent practice are running small businesses and employ tens of
2 thousands of American workers; and
3
- 4 Whereas, According to the Medicare Economic Index, the cost of running a medical practice
5 increased 39 percent from 2001 to 2021; and
6
- 7 Whereas, The U.S. economy has entered a new inflationary cycle and the cost of retaining staff
8 for a physician's office continues to increase with inflation; and
9
- 10 Whereas, According to data from the Medicare Trustees, Medicare physician pay has increased
11 just 11 percent over the last 20 years while Medicare hospital payments increased by 60% from
12 2001 to 2021; and
13
- 14 Whereas, Adjusted for inflation, Medicare physician pay *declined* 20 percent from 2001 to 2021,
15 while hospital payment far surpassed inflation in this period; and
16
- 17 Whereas, Cost/price pressures have reduced the number of independent practice physicians,
18 and have threatened the viability of independent medical practice; and
19
- 20 Whereas, The loss of the private practice of medicine will have a profound impact on the
21 availability of high-quality, cost-effective medical care for many patients across this nation; and
22
- 23 Whereas, Improved payments for physician work will aid all physicians, both independent and
24 employed, as increased payment for physician services will also improve the value of RVUs that
25 our employed physician colleagues depend on for their compensation; and
26
- 27 Whereas, Our AMA has long had policy on improving payments for physician work, but it has
28 little to show in terms of concrete actions and results to accomplish said policy; therefore be it
29
- 30 RESOLVED, That our American Medical Association define Physician Payment Reform and
31 Equity (PPR & E) as "improvement in physician payment by Medicare and other third-party
32 payers so that physician reimbursement covers current office practice expenses at rates that
33 are fair and equitable, and that said equity include annual updates in payment rates" (Directive
34 to Take Action); and be it further
35
- 36 RESOLVED, That our AMA place Physician Payment Reform and Equity as the single highest
37 advocacy priority of our organization (Directive to Take Action); and be it further

1 RESOLVED, That our AMA use every resource at its disposal (including but not limited to
2 elective, legislative, regulatory, and lobbying efforts) to advocate for an immediate increase in
3 Medicare physician payments to help cover the expense of office practice (Directive to Take
4 Action); and be it further

5
6 RESOLVED, That in addition to an immediate increase in Medicare physician payments, our
7 AMA advocate for a statutory annual update in such payments that would equal or exceed the
8 Medicare Economic Index or the Consumer Price Index, whichever is most advantageous in
9 covering the continuously inflating costs of running an office practice (Directive to Take Action);
10 and be it further

11
12 RESOLVED, That our AMA establish a Task Force appointed by the Board of Trustees to
13 outline a specific set of steps that are needed to accomplish the goals of Physician Payment
14 Reform and Equity and report back to the HOD at the 2022 Interim Meeting regarding that plan
15 (Directive to Take Action); and be it further

16
17 RESOLVED, That our report back to the HOD at each subsequent meeting regarding their
18 progress on meeting the goals of Physician Payment Reform and Equity, until Physician
19 Payment Reform and Equity is accomplished. (Directive to Take Action)

Fiscal Note: Estimated cost of \$320K to implement resolution.

Received: 05/11/22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 241
(A-22)

Introduced by: Missouri

Subject: Unmatched Graduate Physician Workforce

Referred to: Reference Committee B

- 1 Whereas, The United States is expected to have an alarming shortage of physicians in primary
2 and specialty care; and
3
- 4 Whereas, The number of practicing physicians is decreasing due to burnout, retirement, and
5 other causes; and
6
- 7 Whereas, The current number of medical students, residents, and fellows will not prevent such
8 a shortage; and
9
- 10 Whereas, Congress has repeatedly failed to provide funding to educate the necessary number
11 of physicians to provide needed care of our aging and expanding population; and
12
- 13 Whereas, Physician Assistants (PAs) and Nurse Practitioners (NPs) have increasingly replaced
14 licensed physicians in providing primary and some specialty care due to geographic and
15 economic shortage of physicians; and
16
- 17 Whereas, Many States have allowed non-physician extenders to practice medicine
18 independently rather than under the supervision of and/or in collaboration with licensed
19 physicians; and
20
- 21 Whereas, A large number of physicians graduate from medical schools, take and pass USMLE
22 part one and two, then apply for residency, but fail to get one of the limited number of post-
23 graduate training spots in the US; and
24
- 25 Whereas, These graduating physicians spend six to eight years in undergraduate and graduate
26 studies before graduating, and some of them serve a year of internship required to graduate.
27 They spend huge sums of money to complete their studies, sit for and pass the rigorous USMLE
28 tests, spend thousands of dollars on their applications for the matching programs and
29 interviews; and
30
- 31 Whereas, These unfortunate physicians face the very hard reality of a sudden irreversible
32 interruption of their careers, outstanding debts they cannot repay, and the grim fact that others
33 who are less qualified, less educated, and less financially burdened individuals such as PAs and
34 NPs can practice medicine with or without collaborating with a licensed physician; and
35
- 36 Whereas, Missouri passed a law several years ago allowing these unfortunate graduating
37 physicians to obtain a license called Assistant Physician (AP) which allow these physicians
38 without residency to work in underserved areas in primary care in collaboration with a licensed
39 Missouri physician; and

1 Whereas, Several other States passed similar laws, under different titles such as Graduate
2 Physician and Associate Physician; and

3
4 Whereas, These graduating physicians working in collaboration with licensed physicians face in
5 their daily collaborative practices the denial of reimbursement by Medicare while Medicaid and
6 private insurers recognize their billings; and

7
8 Whereas, The AMA House of Delegates opposed, several years ago, the creation of this class
9 of licensees mainly because its creation may weaken our case in Congress for increased
10 funding for GME; and

11
12 Whereas, The number of these unfortunate graduating physicians has grown by the thousands
13 each year, yet Congress did not provide the needed funding to create enough residency slots to
14 train these physicians, while more non-physicians providing medical care increased dramatically
15 and many of them are now allowed to practice independently; and

16
17 Whereas, Many of these graduating physicians, after practicing in collaboration with licensed
18 physicians and acquiring additional skills and experience, were able to match into a residency
19 program; therefore, be it

20
21 RESOLVED, That our American Medical Association work with state societies to support these
22 unmatched graduate physicians through their legislators and regulators to allow these
23 physicians to work in underserved areas, in primary care, only in collaboration with a licensed
24 physician (Directive to Take Action); and be it further

25
26 RESOLVED, That our AMA work with appropriate parties and the Centers for Medicare and
27 Medicaid Services to reimburse for services rendered by these graduating physicians working in
28 their collaborative practices as do private insurers and state Medicaid programs (Directive to
29 Take Action); and be it further

30
31 RESOLVED, That the AMA allow these graduating physicians, working in collaboration with a
32 licensed physician, to become members of an AMA subgroup (Directive to Take Action); and be
33 it further

34
35 RESOLVED, That our AMA oppose any effort by these graduating physicians working in
36 collaboration with licensed physicians, to become independent licensed physicians without
37 satisfactorily completing formal residency training. (Directive to Take Action)

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

Received: 05/11/22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 242
(A-22)

Introduced by: American Association of Neurological Surgeons, Congress of Neurological Surgeons, American Academy of Dermatology, American Academy of Facial Plastic and Reconstructive Surgery, American Academy of Otolaryngology-Head and Neck Surgery, American Academy of Physical Medicine and Rehabilitation, American College of Surgeons, American Gastroenterological Association, American Orthopaedic Foot & Ankle Society, American Society for Dermatologic Surgery, American Society for Gastrointestinal Endoscopy; American Society for Surgery of the Hand, American Society of Cataract and Refractive Surgery, American Society of Echocardiography, American Society of Interventional Pain Physicians, International Society for the Advancement of Spine Surgery, North American Spine Society, California, Florida, Texas

Subject: Public Awareness and Advocacy Campaign to Reform the Medicare Physician Payment System

Referred to: Reference Committee B

- 1 Whereas, Physicians have been enduring financial instability in the Medicare physician payment
- 2 system due to a confluence of fiscal uncertainties related to the COVID-19 pandemic, ongoing
- 3 payment cuts, a lack of inflationary updates and increased administrative barriers; and
- 4
- 5 Whereas, Because of this uncertainty and instability, less than one-half of physicians (and for
- 6 some specialties, the percentage is even higher) now work in private practice, and as private
- 7 equity, hospitals systems and others acquire physician practices, this consolidation will continue
- 8 to drive up health care costs; and
- 9
- 10 Whereas, According to data from the Medicare Trustees, physician payments have barely
- 11 changed for nearly two decades, increasing just 7 percent from 2001 to 2020; in comparison,
- 12 hospital and skilled nursing facility updates totaled approximately 60 percent during this same
- 13 time frame; and
- 14
- 15 Whereas, Based on the Medicare Economic Index, the cost of running a medical practice
- 16 increased 37 percent between 2001 and 2020, and economy-wide inflation, as measured by the
- 17 Consumer Price Index, increased 46 percent over this period; and
- 18
- 19 Whereas, Physicians are bracing for another round of steep Medicare Physician Fee Schedule
- 20 (PFS) payment cuts in 2023 due to the continuation of the 2% Medicare sequestration, 4% pay-
- 21 as-you-go cuts, elimination of the 3% payment adjustment and other PFS changes triggering
- 22 the budget-neutrality adjustment; and
- 23
- 24 Whereas, Medicare's efforts to move from fee-for-service to value-based care are stalled, due to
- 25 flaws in the Merit-based Incentive Payment System and a lack of Advanced-Alternative
- 26 Payment Models in which physicians of all specialties can participate; and

1 Whereas, Steep payment cuts could jeopardize patients' timely access to care, particularly if
2 physicians are forced to limit the number of Medicare patients they treat due to low
3 reimbursement rates; and
4

5 Whereas, Preventing Medicare physician payment cuts in 2023 and passing broader Medicare
6 payment reform legislation will require a comprehensive, well-funded, sustained public
7 education and advocacy campaign on behalf of all physicians; and
8

9 Whereas, According to the 2021 Annual Report, the AMA has \$1.2 billion in assets with \$887.6
10 million in reserves, of which \$386.5 million is available above the minimum reserve portfolio,
11 and these funds provide the AMA with the ability to fund major strategic spending initiatives that
12 are not within the AMA's operating budget; and
13

14 Whereas, A highly visible public awareness and advocacy campaign would demonstrate the
15 AMA's leadership on this issue, which would be well received by physicians and help drive
16 membership in the AMA; therefore be it
17

18 RESOLVED, That our American Medical Association immediately launch and sustain a well-
19 funded comprehensive public awareness and advocacy campaign, that includes paid
20 advertising, social and earned media, and patient and physician grassroots, to prevent/mitigate
21 future Medicare payment cuts and lay the groundwork to pass federal legislation that reforms
22 the current Medicare physician payment system by incorporating annual inflation updates,
23 eliminating/replacing or revising budget neutrality requirements, offering a variety of payment
24 models and incentives to promote value-based care and safeguarding access to high-quality
25 care by advancing health equity and reducing disparities. (Directive to Take Action)

Fiscal Note: Estimated cost to implement this resolution is between \$1,010,000 to \$25,060,000.

Received: 05/11/22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 243
(A-22)

Introduced by: Ohio

Subject: Appropriate Physician Payment for Office-Based Services

Referred to: Reference Committee B

1 Whereas, Physicians in independent practice are running small businesses and employ tens of
2 thousands of American workers; and
3

4 Whereas, According to the Medicare Economic Index, the cost of running a medical practice
5 increased 39 percent from 2001 to 2021; and
6

7 Whereas, The U.S. economy has entered a new inflationary cycle and the cost of retaining staff
8 for a physician's office continues to increase with inflation; and
9

10 Whereas, According to data from the Medicare Trustees, Medicare physician pay has increased
11 just 11 percent over the last 20 years while Medicare hospital payments increased by 60% from
12 2001 to 2021; and
13

14 Whereas, Adjusted for inflation, Medicare physician pay declined 20 percent from 2001 to 2021,
15 while hospital payment far surpassed inflation in this period; and
16

17 Whereas, Cost/price pressures have reduced the number of independent practice physicians,
18 and have threatened the viability of independent medical practice; and
19

20 Whereas, The loss of the private practice of medicine will have a profound impact on the
21 availability of high-quality, cost-effective medical care for many patients across this nation; and
22

23 Whereas, Improved payments for physician work will aid all physicians, both independent and
24 employed, as increased payment for physician services will also improve the value of RVUs that
25 our employed physician colleagues depend on for their compensation; and
26

27 Whereas, Our AMA has long had policy on improving payments for physician work, but it has
28 little to show in terms of concrete actions and results to accomplish said policy; therefore be it
29

30 RESOLVED, That our American Medical Association advocate for improvement in physician
31 payment by Medicare and other third-party payers so that physician reimbursement covers
32 current office practice expenses at rates that are fair and equitable, and that said equity include
33 annual updates in payment rates to account for increased costs of running a medical practice.
34 (Directive to Take Action)

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

Received: 05/10/22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 244
(A-22)

Introduced by: Ohio

Subject: Prohibit Reversal of Prior Authorization

Referred to: Reference Committee B

1 Whereas, The process of obtaining prior authorization requires several steps that take
2 significant physician and staff time; and
3

4 Whereas, After prior authorization is obtained, the insurance company sends a letter or other
5 communication stating that the test, procedure, or medication is approved; and
6

7 Whereas, After receiving such communication, the physician will proceed with ordering the
8 approved testing, scheduling the procedure, or giving the approved medication; and
9

10 Whereas, After the testing or procedure is scheduled or done or the medication is given,
11 physicians and patients have received a second communication from the insurance company
12 reversing the prior authorization and denying payment; and
13

14 Whereas, Many of the prior authorization letters have a statement such as: "This notification is
15 not an approval for claim payment. This is confirmation of referral/authorization only;" and
16

17 Whereas, This is unfair to the patient and physician who proceed in good faith to do the testing
18 or procedure or provide the medication; therefore be it
19

20 RESOLVED, That once the physician's office has received prior authorization for testing, a
21 procedure, or a medication, the insurance company should not be permitted to refuse payment
22 for that test or procedure or medication unless the patient is no longer insured by that company
23 at the time the test or procedure is done or the medication is given; and be it further
24

25 RESOLVED, That a health insuring corporation or utilization review organization that authorizes
26 a proposed admission, treatment, or health care service by a participating provider based upon
27 the complete and accurate submission of all necessary information relative to an eligible
28 enrollee should not retroactively deny this authorization if the provider renders the health care
29 service in good faith and pursuant to the authorization and all of the terms and conditions of the
30 provider's contract with the health insuring corporation, and be it further
31

32 RESOLVED, That our American Medical Association seek federal legislation/rules to prohibit
33 denial of payment by a Medicare Advantage plan for a previously prior approved medication,
34 procedure, or test unless the patient is no longer insured by that company at the time of service
35 (Directive to Take Action); and be it further
36

37 RESOLVED, That our AMA redistribute its model legislation on retrospective denial of payment
38 to all state societies, especially those who have not already passed such legislation. (Directive
39 to Take Action)

Fiscal Note: Modest - between \$1,000 - \$5,000
Received: 05/10/22