

Reference Committee B

Report(s) of the Board of Trustees

- 06 Universal Good Samaritan Statute
- 07 Obtaining Professional Recognition for Medical Service Professionals

Resolution(s)

- 201 Opposition to the Restriction and Criminalization of Appropriate Use of Psychotropics in Long Term Care
- 202 Protecting the Health of Patients Incarcerated in For-Profit Prisons
- 203 Anti-Discrimination Protections for Housing Vouchers
- 204 Improving PrEP & PEP Access
- 205 Cannabis Product Safety
- 206 The Influence of Large Language Models (LLMs) on Health Policy Formation and Scope of Practice
- 207 On-Site Physician Requirement for Emergency Departments
- 208 Non-Physician Practitioners Oversight and Training
- 210 Immigration Status in Medicaid and CHIP
- 213 Health Technology Accessibility for Aging Patients
- 215 A Public Health-Centered Criminal Justice System
- 216 Saving Traditional Medicare
- 217 Addressing Work Requirements for J-1 Visa Waiver Physicians
- 218 Youth Residential Treatment Program Regulation
- 219 Improving Access to Post-Acute Medical Care for Patients with Substance Use Disorder (SUD)
- 220 Merit-Based Process for the Selection of all Federal Administrative Law Judges
- 222 Expansion of Remote Digital Laboratory Access Under CLIA
- 223 Initial Consultation for Clinical Trials Under Medicare Advantage
- 224 ERISA Preemption of State Laws Regulating Pharmacy Benefit Managers

REPORT OF THE BOARD OF TRUSTEES

B of T Report 06-I-23

Subject: Universal Good Samaritan Statute
(Res. 214-I-22)

Presented by: Willie Underwood, III, MD, MSc, MPH, Chair

Referred to: Reference Committee B

At the 2022 Interim Meeting, the House of Delegates referred Resolution 214-I-22, sponsored by the Georgia Delegation. Resolution 214-I-22 asks the American Medical Association (AMA) to: 1) help protect patients in need of emergency care and protect physicians and other responders by advocating for a national “universal” Good Samaritan Statute; and 2) advocate for the unification of the disparate statutes by creation of a national standard via either federal legislation or through policy directed by the Department of Health and Human Services to specify terms that would protect rescuers from legal repercussion as long as the act by the rescuer meets the specified universal minimal standard of conduct and the good faith requirement, regardless of the event location; thus, effectively eliminating variations in the state statutes to facilitate the intent of the Good Samaritan statutes removing barriers that could impede the prompt rendering of emergency care.

The Reference Committee heard mixed testimony concerning Resolution 214, which noted that more needs to be done to support strong protections of physicians responding as Good Samaritans, regardless of location within the United States and regardless of the type of medical emergency they are called upon to address. Testimony highlighted that our AMA already has policy that promotes shielding physician Good Samaritans from liability while rendering treatment in response to emergencies, the opioid overdose epidemic, and in-flight medical emergencies. However, testimony also stated that our AMA should not create policy that would preempt existing state laws that are more protective than that of a national minimum standard. For these reasons, the House of Delegates (HOD) referred Resolution 214 for a report to be considered at the 2023 Interim Meeting.

BACKGROUND

Origin of Good Samaritan Laws

All 50 states and the District of Columbia have a Good Samaritan law, in addition to federal laws for specific circumstances.¹ However, the protection that Good Samaritan laws provide is not unlimited and varies from state to state,² including who is protected (e.g., physicians, emergency medical technicians, and other first responders) from liability and under what circumstances (e.g., rendering voluntary care). In general, these laws do not protect medical personnel from liability if acting in the course of their usual profession.³

Good Samaritan laws provide liability protection against claims of “ordinary negligence.” Ordinary negligence is the failure to act as a reasonably prudent person; that is, the failure to exercise such

care as a reasonably acting person would ordinarily apply under the same or similar circumstances.⁴ These laws typically do not protect against “gross negligence” or willful actions. Gross negligence is a conscious and voluntary disregard of the need to use reasonable care that is likely to cause foreseeable grave injury or harm to persons, property, or both.⁵

Applicability of Good Samaritan Laws to Physicians

Good Samaritan laws apply to physicians (and other health care professionals) only when certain conditions are met:

- (1) There must exist no duty to treat (for this reason, Good Samaritan protection does not typically apply to on-call physicians). Any physician with a pre-existing relationship with the patient will generally not be considered a Good Samaritan.
- (2) The physician or other health care provider providing aid cannot receive compensation for their care.⁶

AMA POLICY

The AMA has several policies that have guided AMA advocacy in support of Good Samaritan protections for physicians, including responding to the COVID-19 public health emergency and the opioid overdose epidemic.⁷

AMA policy supports Good Samaritan protections for medical professionals responding to emergencies as “bystander physicians” (Policy H-130.937, Delivery of Health Care by Good Samaritans), and to medical professionals during in-flight medical emergencies (Policy H-45.997, In-Flight Emergency Care). In addition, AMA policy supports protections for callers or witnesses seeking medical help for overdose victims (Policy H-45.997, 911 Good Samaritan Laws). Thus, while the AMA has strong policy supporting the protection of physicians acting as a Good Samaritan in certain circumstances, and has advocated that Good Samaritan protections be extended to health care professionals when volunteering during a federally declared disaster,⁸ such policy does not directly ask for the alignment and harmonization of disparate state laws into a universal minimum standard of conduct.

AMA policy also reflects the concern that a federal or universal effort could undermine state liability laws—see H-130.937, Delivery of Health Care by Good Samaritans, which states that, “...3. Where there is no conflict with state or local jurisdiction protocol, policy, or regulation on this topic, the AMA supports the following basic [Good Samaritan] guidelines to apply in those instances where a bystander physician happens upon the scene of an emergency and desires to assist and render medical assistance.” Also, AMA policy on national and federal medical liability reform and protections is conditioned on not preempting effective or stronger state liability protection laws—see H-435.978, Federal Medical Liability Reform, which states that, “... (3) [AMA support] for any federal initiative incorporating provisions of this type [of liability reform] would be expressly conditional. Under no circumstances would support for federal preemptive legislation be extended or maintained if it would undermine effective tort reform provisions already in place in the states or the ability of the states in the future to enact tort reform tailored to local needs.”

DISCUSSION

The AMA has strong policy in support of general Good Samaritan liability protections, primarily at the state level, as well as strong policy in support of medical liability reform. AMA policy in

support of federal legislation, such as the Good Samaritan Health Professionals Act, is limited in scope or applies to limited circumstances. In particular, the AMA has well established policy to ensure that any federal liability law does not preempt effective state laws. In addition to the policies mentioned above, this limitation is reflected in policies H-435.967, Report of the Special Task Force and the Advisory Panel on Professional Liability, and H-435.964, Federal Preemption of State Professional Liability Laws. These policies reflect the concerns raised during past HOD deliberations on liability protections that there is the potential for unintended consequences in creating federal standards, which may jeopardize more protective state laws, and that advocating for federal standards or the unification of disparate state laws may not be uniformly supported by all state and specialty Federation members.

As noted above, AMA policy on Good Samaritans is limited to certain circumstances that are federal in nature—aviation (Policy H-45.997, In-Flight Emergency Care) and national emergencies, such as the overdose epidemic (Policy D-95.977, 911 Good Samaritan Laws). The AMA strongly supports the Good Samaritan Health Professionals Act (see footnote 8), which protects health care professionals from liability exposure when volunteering during a federally declared disaster and would help to ensure that needed medical volunteers are not turned away due to confusion and uncertainty about the application of Good Samaritan laws. However, the bill includes provisions to ensure that it would not preempt stronger state laws (“This section preempts the laws of a State or any political subdivision of a State to the extent that such laws are inconsistent with this section, unless such laws provide greater protection from liability.”⁹)

The Board agrees with the intent of the Resolution to help protect patients in need of emergency care by protecting physicians and other first responders with a Good Samaritan statute. The Board also agrees with the general concept of encouraging the development of effective Good Samaritan protection standards. The Board is concerned, however, that advocating for a federal standard or the unification of state Good Samaritan protections into a federal standard may jeopardize more protective state laws and may not be uniformly supported by all state and specialty Federation members. A more impactful approach would be to review current federal and state Good Samaritan laws and develop a set of principles on the most effective protections that would encourage physicians to render emergency care (as well as remove any barriers that impede the prompt rendering of emergency care). This approach would demonstrate what uniform standards would look like and could be used to assist states with less protective statutes to seek more protective legislation based on the principles as well as provide guidance on where federal laws could apply in the absence of a state law. Therefore, in lieu of adopting Resolution 214-I-22, the Board recommends that AMA Policy H-130.937, Delivery of Health Care by Good Samaritans, be amended by a new clause that directs the AMA to develop model principles on Good Samaritan protections for physicians under state and federal laws that would encourage the prompt rendering of emergency care.

Policy H-130.937, Delivery of Health Care by Good Samaritans

1. Our AMA will work with state medical societies to educate physicians about the Good Samaritan laws in their states and the extent of liability immunity for physicians when they act as Good Samaritans.
2. Our AMA encourages state medical societies in states without “Good Samaritan laws,” which protect qualified medical personnel, to develop and support such legislation.
3. Where there is no conflict with state or local jurisdiction protocol, policy, or regulation on this topic, the AMA supports the following basic guidelines to apply in those instances where a bystander physician happens upon the scene of an emergency and desires to assist and render medical assistance. For the purpose of this policy, “bystander physicians” shall refer to those physicians rendering assistance voluntarily, in the absence of pre-existing patient-physician

relationships, to those in need of medical assistance, in a service area in which the physician would not ordinarily respond to requests for emergency assistance. (a) Bystander physicians should recognize that prehospital EMS systems operate under the authority and direction of a licensed EMS physician, who has both ultimate medical and legal responsibility for the system. (b) A reasonable policy should be established whereby a bystander physician may assist in an emergency situation, while working within area-wide EMS protocols. Since EMS providers (non-physicians) are responsible for the patient, bystander physicians should work collaboratively, and not attempt to wrest control of the situation from EMS providers. (c) It is the obligation of the bystander physician to provide reasonable self-identification. (d) Where voice communication with the medical oversight facility is available, and the EMS provider and the bystander physician are collaborating to provide care on the scene, both should interact with the local medical oversight authority, where practicable. (e) Where voice communication is not available, the bystander physician may sign appropriate documentation indicating that he/she will take responsibility for the patient(s), including provision of care during transportation to a medical facility. Medical oversight systems lacking voice communications capability should consider the addition of such communication linkages to further strengthen their potential in this area. (f) The bystander physician should avoid involvement in resuscitative measures that exceed his or her level of training or experience. (g) Except in extraordinary circumstances or where requested by the EMS providers, the bystander physician should refrain from providing medical oversight of EMS that results in deviation from existing EMS protocols and standing orders.

4. Our AMA urges the International Civil Aviation Organization to make explicit recommendations to its member countries for the enactment of regulations providing “Good Samaritan” relief for those rendering emergency medical assistance aboard air carriers and in the immediate vicinity of air carrier operations.

RECOMMENDATION

The Board of Trustees recommends that the following recommendation be adopted in lieu of Resolution 214-I-22 and that the remainder of the report be filed.

That Policy H-130.937, Delivery of Health Care by Good Samaritans be amended by addition:

5. Our AMA will develop model principles on Good Samaritan protections for physicians under state and federal laws that would encourage the prompt rendering of emergency care.
(Modify Current HOD Policy)

Fiscal Note: \$10,000.

¹[Good Samaritan Laws](#), B. West and M. Varacallo National Institutes of Health National Library of Medicine, National Center for Biotechnology Information, September 2022.

²[Good Samaritan Law States \[Updated March 2023\]](#), WorldPopulationReview.com; See also, [What does the law say to Good Samaritans?: A review of Good Samaritan statutes in 50 states and on US airlines](#), Stewart PH, W.S. Agin WS and S.P. Douglas, 2013: cited in VeryWellHealth, R. Brouhard, September 2020, <https://www.verywellhealth.com/do-all-states-have-good-samaritan-laws-1298836#citation-2>.

³ See footnote 1, *supra*.

⁴ *Ibid*

⁵ *Ibid*

⁶ *Ibid*

⁷ See, (1) Statement of the American Medical Association to the Committee on Energy & Commerce Subcommittee on Oversight and Investigations, United States House of Representatives, Re: “Combating the Opioid Abuse Epidemic: Professional and Academic Perspectives,” Presented by Patrice A. Harris, MD,

MA, Secretary, Board of Trustees April 23, 2015, available at: <https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2Fopioid-abuse-testimony-23april2015.pdf>;

(2) Testimony of the American Medical Association before the U.S. House of Representatives Committee on Energy and Commerce Subcommittee on Health, Re: Examining Legislative Proposals to Combat our Nation's Drug Abuse Crisis, October 8, 2015, available at: <https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2Fopioid-house-energy-commerce-testimony-08oct2015.pdf>;

(3) Letter to Speaker Pelosi, Leader McConnell, Leader McCarthy, and Leader Schumer, March 19, 2020, available at: <https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2020-3-19-Letter-to-Congress-re-Financial-Assistance.pdf>;

(4) Letter to Representative Garner, February 7, 2016, available at: <https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2FAMA-letter-supporting-MT-Naloxone-Bill-FINAL.pdf>

(5) *Strengthening partnerships to end the nation's opioid crisis*, National Governors Association Health and Human Services Committee February 20, 2016 Statement for the record Patrice A. Harris, MD, MA Chair-elect American Medical Association Board of Trustees, available at: <https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2Fharris-statement-nga-feb2016.pdf>;

(6) Letter to the Honorable Chris Christie, Chair, President's Commission on Combating Drug Addiction and the Opioid Crisis, Office of National Drug Control Policy, May 18, 2017, available at: <https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2017-5-18-Letter-to-Christie-re-White-House-Commission-on-Opioids.pdf>;

(7) Letter to National Governors Association on State policies to preserve and expand the COVID-19 workforce by adopting civil immunity protections, April 20, 2020, available at: <https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2020-4-20-McBride-Letter-to-NGA-FINAL.pdf>.

⁸ Letters in support of the Good Samaritan Health Professionals Act: <https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2FGSHPA-support-ltr-to-Ruiz-Bucshon-final-9-28-21.pdf>; <https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2020-3-19-Letter-to-Congress-re-Financial-Assistance.pdf>; <https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2018-7-2-Letter-to-Walden-Pallone-re-Good-Samaritan.pdf>.

⁹ H.R. 2819, Good Samaritan Health Professionals Act of 2023, §224A.(c)(1).

REPORT OF THE BOARD OF TRUSTEES

B of T Report 07-I-23

Subject: Obtaining Professional Recognition for Medical Service Professionals
(Res. 232-I-22)

Presented by: Willie Underwood, III, MD, MSc, MPH, Chair

Referred to: Reference Committee B

At the 2022 Interim Meeting, the House of Delegates (HOD) referred Resolution 232-I-22, sponsored by the Organized Medical Staff Section. Resolution 232-I-22 asks the American Medical Association (AMA) to collaborate with leadership of the National Association of Medical Staff Services' Advocacy and Government Relations teams to advocate to the U.S. Bureau of Labor Statistics (BLS) for obtaining a unique standard occupational classification code during the next revision for medical service professionals to maintain robust medical credentialing for patient safety.

Testimony regarding this resolution was generally positive, recognizing the support that medical service professionals (MSPs) provide to medical staff by performing core functions such as credentialing. It was noted that the work that MSPs perform helps make the credentialing process more efficient and less administratively burdensome for physicians. Testimony further indicated that MSPs have previously been denied a standard occupation classification by the BLS but are unsure of the reason for this denial. Moreover, testimony expressed concerns that the resolution raised several questions that required further information and consideration before determining what, if any, advocacy strategy might be most effective in order to support MSPs and to achieve the goals of Resolution 232. This report focuses on the role of MSPs, their pursuit of a Standard Occupational Classification from the BLS, and the propriety of AMA support for these efforts.

BACKGROUND

A Standard Occupational Classification (SOC) is a system used to categorize and classify occupations within an economy. It is a standardized numerical code that groups similar jobs together based on the tasks, duties, and responsibilities performed by workers in those occupations. The SOC system is typically used by government agencies, labor market analysts, and researchers to collect and analyze occupational data for various purposes, such as workforce analysis, labor market information, and statistical reporting. The SOC system helps provide consistency and comparability when discussing and analyzing different occupations across various industries and sectors. It helps ensure that similar jobs are grouped together and that there is a common language for describing and classifying occupations, which is particularly important for statistical and policy-related purposes. The BLS is responsible for maintaining the SOC system and revises the SOC Manual approximately every 10 years. During the revision period, entities can petition to obtain a unique classification code for a profession. The revision process takes approximately four years. The BLS last revised its SOC Manual in 2018. It is likely that the BLS will announce the next revision process within the next few years.

Currently, there is no unique SOC for MSPs. The BLS instead categorizes MSPs as human resources professionals. The National Association Medical Staff Services (NAMSS)—which is a membership organization that includes medical staff and credentialing services professionals from medical group

practices, hospitals, managed care organizations, and credentials verification organizations—petitioned the BLS to obtain a unique SOC for MSPs during the last revision period, but their petition was denied. NAMSS intends to submit a revised petition to the BLS and is seeking stakeholder support.

DISCUSSION

If there is a growing demand for a specific occupation, such as MSPs, it is possible that the BLS may consider creating a specific SOC to better capture and categorize the role of MSPs. The decision to establish a new SOC code or include an occupation within an existing code ultimately depends on various factors, including the demand for data, industry recognition, and the BLS' assessment of the occupation's uniqueness and significance in the labor market.

As mentioned above, BLS does not currently have an SOC for MSPs as a distinct category. Instead, BLS provides SOC codes for various specific occupations within the health care industry. Some of the occupations that may encompass roles related to MSPs include medical records and human information technicians, medical secretaries and administrative assistants, medical transcriptionists, and billing and posting clerks. MSPs, however, perform more specialized duties. For example, the Centers for Medicare & Medicaid Services (CMS) requirements to onboard medical staff members are distinct from other hospital employees because of the direct effects on patient safety. CMS sets rigorous standards for medical staff that MSPs oversee to minimize patient and hospital risks. Credentialing and privileging physicians and other clinicians require MSPs' unique skillset to ensure compliance with policies and procedures that are not required of human resources personnel. The following chart (provided by NAMSS) lists some of the differences between MSPs and human resources personnel.

MSPs	HR Personnel
Supports Medical Staff Services Office Members	Supports Hospital Employees
<ul style="list-style-type: none"> Exclusively serves the Medical Staff, a self-governing body separate from HR. Does not participate in hiring processes. Focuses on practitioners, who are often contracted, not employed. Enrolls practitioners in payer networks, provides documentation to treat patients, and tracks approvals for claims reimbursement. Provides Medical Staff leadership support (e.g., meeting, financial, election, committee, credentialing-software management). Manages development of bylaws, process and procedures, federal/state/organizational rules and regulations, privileging forms, peer review, and fair hearings/appeals. <p><i>Responsibilities:</i> Primary-source verification, credentialing, privileging, provider enrollment, continuous practitioner monitoring, reappointment, committee management, CME coordination, accreditation/regulatory compliance, Medical Staff governance, and National Provider Data Bank reports.</p>	<ul style="list-style-type: none"> Posts and fills open employee positions. Oversees payroll, I-9 verification, tax information, employment rules, compensation, and benefits. Manages private personnel information and employee-related issues. Enforces federal and state employment laws. Focuses on organizational employee policies. Counsels employees. Ensures facility safety, security, and compliance. Implements and facilitates employee professional-growth programs. <p><i>Responsibilities:</i> Staffing, employee support, employee policies, compensation/benefits, retention, safety/security, training/development, legal and worker protection.</p>

Credentials and Privileges	Recruits, Hires, Onboards
<ul style="list-style-type: none"> • Credentials and privileges practitioners that HR hires. • Obtains and primary-source verifies practitioner education, training, affiliation history, malpractice claims, peer references, certifications, licensure, DEA registration, federal/state sanctions. 	<ul style="list-style-type: none"> • Develops and oversees employed-staff structure, posts job descriptions, recruits, matches candidates with positions, develops benefits packages, onboards employees. • Reviews self-reported applicant data. • Does not assess clinical competencies.
Continuously Evaluates Performance	Oversees Staffing and Working Conditions
<ul style="list-style-type: none"> • Continuously monitors medical staff. • Uses understanding of medical procedures to match qualifications with privileges. • Reappoints practitioners every 2-3 years through vigorous recredentialing process. 	<ul style="list-style-type: none"> • Focuses on staffing, interpersonal relations, and workplace conditions. • Oversees growth and retention initiatives. • Does not review Medical Staff members quality performance.
Medical Staff Compliance Experts	Employment Law Experts
<ul style="list-style-type: none"> • Experts in bylaws, policies, and procedures, regulatory standards related to practitioners. • Ensures compliance with, and awareness of, accrediting-body standards; federal and state regulatory standards. 	<ul style="list-style-type: none"> • Abides by labor laws, regulations relating to employment, and HR-specific accreditation regulations. • Reports and maintains federal employment information.
Credentials	Credentials
<ul style="list-style-type: none"> • Certified Provider Credentialing Specialist (CPCS) • Certified Professional Medical Services Management (CPMSM) 	<ul style="list-style-type: none"> • Certified in Healthcare Human Resources (CHHR) • Certified Professional in Healthcare Risk Management (CPHRM)

1 AMA POLICY

2
3 AMA policy supports the compilation of accurate data on all components of physician practice costs and
4 the changes in such costs over time, as the basis for informed and effective advocacy (Policy H-400.966,
5 Medicare Payment Schedule Conversion Factor). The same policy supports the AMA working
6 aggressively with CMS, BLS, and other appropriate federal agencies to improve the accuracy of such
7 indices of market activity as the Medicare Economic Index and the medical component of the Consumer
8 Price Index.

9
10 AMA policy also supports workforce planning efforts, done by the AMA or others, that utilize data on all
11 aspects of the health care system, including projected demographics of the number and roles of other
12 health professionals in providing care (Policy H-200.955, Revisions to AMA Policy on the Physician
13 Workforce). The same policy supports the integral involvement of the medical profession in any
14 workforce planning efforts sponsored by federal or state governments, or by the private sector.

15 CONCLUSION

16
17
18 Based on the discussion above, the Board believes that the duties performed by MSPs are more unique
19 than what can be captured under SOC for human resources. Also, AMA policy generally aligns with
20 NAMSS' initiative to obtain a SOC for MSPs during the next revision of the BLS SOC Manual. While
21 the Board recommends support for a SOC for MSPs, the AMA's active advocacy resources and efforts
22 should remain focused on the AMA Recovery Plan for America's Physicians. Therefore, the Board

1 recommends that an Alternate Resolution 232-I-22 be adopted that would establish policy in support of an
2 SOC for MSPs in lieu of an active collaboration with the leadership of NAMSS.

3
4 RECOMMENDATION

5
6 The Board of Trustees recommends that Alternate Resolution 232-I-22 be adopted to read as follows, and
7 the remainder of the report be filed:

8
9 RESOLVED, That our American Medical Association support a unique standard occupational
10 classification from the U.S. Bureau of Labor Statistics for medical services professionals. (New HOD
11 Policy)

Fiscal Note: Less than \$500.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 201
(I-23)

Introduced by: American Association for Geriatric Psychiatry, American Academy of Addiction Psychiatry, American Academy of Child and Adolescent Psychiatry, American Academy of Psychiatry and the Law, American Psychiatric Association

Subject: Opposition to the Restriction and Criminalization of Appropriate Use of Psychotropics in Long Term Care

Referred to: Reference Committee B

1 Whereas, major neurocognitive disorders, including Alzheimer's disease and other dementias,
2 have become increasingly common as our population is aging; and
3

4 Whereas, behavioral and psychological symptoms of dementia are behavioral changes (i.e.
5 paranoia, delusions, auditory/visual hallucinations, physical and verbal aggression) that impact
6 the majority of patients with major neurocognitive disorders and are typically treated with a
7 combination of medications (i.e., antidepressants and antipsychotic medications) and behavioral
8 interventions; and
9

10 Whereas, despite the 2007 FDA warning advising increased risk of death in older adults with
11 dementia taking antipsychotics, these medications are still used following discussion of the risks
12 and benefits as supported by the American Psychiatric Association clinical practice guidelines
13 (2020) which noted: "Aggression, agitation, and psychosis are highly prevalent in patients with
14 Major Neurocognitive Disorder and cause great suffering. Their presence is associated with a
15 worse prognosis. While non-pharmacological approaches are generally recommended as first-
16 line treatments, they are often ineffective in the treatment of aggression, agitation and
17 psychosis, and the judicious use of antipsychotic medications may be appropriate"¹; and
18

19 Whereas, the Centers for Medicaid and Medicare Services (CMS) initiated a 2012 policy
20 reducing all psychotropic treatments with a focus on antipsychotic medications² and
21 imposing strict penalties for antipsychotic use without a diagnosis of schizophrenia, Tourette's,
22 or Huntington's disease³. As a result of this policy, psychiatrists report medically
23 inappropriate tapers and discontinuation of long-term stable antipsychotic regimens often
24 leading to behavioral decompensation, unanticipated nursing home discharge to community
25 hospitals where the patient is boarded for weeks to months before a new placement is
26 identified; and
27

28 Whereas, despite efforts since 2013 to encourage CMS measure adjustment and in light of the
29 2021 OIG report highlighting measure deficiencies⁴, CMS has not agreed to policy
30 changes that would differentiate appropriate and inappropriate antipsychotic prescribing based
31 on accepted clinical guidelines; and
32

33 Whereas, state legislatures have taken up the mantle of this overly restrictive CMS policy by
34 proposing laws⁵ that further incentivize nursing homes to discriminate against people living
35 with mental illness by promoting reduced access to psychotropics and criminalizing potential
36 errors in the medical record documentation specific to the use of psychotropics; and

RESOLVED, that our AMA amend policy H-160.954 by insertion as follows: (1) Our AMA continues to take all reasonable and necessary steps to ensure that errors in medical decision-making and medical records documentation, exercised in good faith, do not become a violation of criminal law. (2) Henceforth our AMA opposes any future legislation which gives the federal, state, and local government the responsibility to define appropriate medical practice and regulate such practice through the use of criminal penalties. (Modify Current HOD Policy)

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

Received: 9/25/2023

REFERENCES

1. American Psychiatric Association. (2020, July). APA Official Action: Position Statement on the Use of Antipsychotic Medication in Patients with Major Neurocognitive Disorder. [Position-Antipsychotic-Medication-Major-Neurocognitive-Disorder.pdf \(psychiatry.org\)](#)
2. Lucas JA and Bowblis JR. (2017) "CMS Strategies To Reduce Antipsychotic Drug Use In Nursing Home Patients With Dementia Show Some Progress" Health Affairs 36(7). <https://doi.org/10.1377/hlthaff.2016.1439>
3. Centers for Medicare and Medicaid Services. (2023, Jan 18). *Updates to the Nursing Home Care Compare Website and Five Star Quality Rating System: Adjusting Quality Measure Ratings Based on Erroneous Schizophrenia Coding, and Posting Citations Under Dispute*. US Department of Health and Human Services. [QSO-23-05-NH \(cms.gov\)](#)
4. Office of Inspector General (2021 May). *OEI-07-19-00490 - CMS Could Improve the Data It Uses To Monitor Antipsychotic Drugs in Nursing Homes*. U.S. Department of Health and Human Services
5. California Legislative Information (2023 March 16). *AB-48 Nursing Facility Resident Informed Consent Protection Act of 2023*. [Bill Text - AB-48 Nursing Facility Resident Informed Consent Protection Act of 2023. \(ca.gov\)](#)

RELEVANT AMA POLICY

Criminalization of Medical Judgment H-160.954

(1) Our AMA continues to take all reasonable and necessary steps to ensure that errors in medical decision-making and medical records documentation, exercised in good faith, do not become a violation of criminal law. (2) Henceforth our AMA opposes any future legislation which gives the federal government the responsibility to define appropriate medical practice and regulate such practice through the use of criminal penalties. [Sub. Res. 223, I-93; Reaffirmed: Res. 227, I-98; Reaffirmed: Res. 237, A-99; Reaffirmed and Appended: Sub. Res. 215, I-99; Reaffirmation A-09; Reaffirmed: CEJA Rep. 8, A-09; Reaffirmation: I-12 Modified: Sub. Res. 716, A-13; Reaffirmed in lieu of Res. 605, I-13; Reaffirmed: Res. 250, A-22; Reaffirmed: Res. 252, A-22]

The Criminalization of Health Care Decision Making H-160.946

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. [Sub. Res. 202, A-95; Reaffirmed: Res. 227, I-98; Reaffirmed: BOT Rep. 2, A-07; Reaffirmation A-09; Reaffirmation: I-12; Reaffirmed: BOT Rep. 9, A-22; Reaffirmed: Res. 250, A-22; Reaffirmed: Res. 252, A-22; Reaffirmed: Res. 224, I-22]

Opposition to Criminalizing Health Care Decisions D-160.999

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; Reaffirmed: BOT Rep. 9, A-22]

Report Regarding the Criminalization of Providing Medical Care H-80.992

Our American Medical Association will study the changing environment in which some medical practices have been criminalized including: the degree to which such criminalization is based or not based upon valid scientific findings, the degree to which this is altering the actual practice of medicine due to physician concerns and personal risk assessment, and the degree to which hospitals and health care systems are responding to this rapidly changing environment, with report back to the HOD no later than the November 2023 Interim meeting. [Res. 015, A-23]

Appropriate Use of Antipsychotic Medications in Nursing Home Patients D-120.951

Our AMA will: (1) meet with the Centers for Medicare & Medicaid Services (CMS) for a determination that acknowledges that antipsychotics can be an appropriate treatment for dementia-related psychosis if non-pharmacologic approaches have failed and will ask CMS to cease and desist in issuing citations or financial penalties for medically necessary and appropriate use of antipsychotics for the treatment of dementia-related psychosis; and (2) ask CMS to discontinue the use of antipsychotic medication as a factor contributing to the Nursing Home Compare rankings, unless the data utilized is limited to medically inappropriate administration of these medications. [Res. 523, A-12; Appended: Res. 708, A-19]

Long-Term Care Prescribing of Atypical Antipsychotic Medications H-25.989

Our AMA: (1) will collaborate with appropriate national medical specialty societies to create educational tools and programs to promote the broad and appropriate implementation of non-pharmacological techniques to manage behavioral and psychological symptoms of dementia in nursing home residents and the cautious use of medications; (2) supports efforts to provide additional research on other medications and non-drug alternatives to address behavioral problems and other issues with patients with dementia; and (3) opposes the proposed requirement that physicians who prescribe medications with “black box warnings on an off-label basis certify in writing that the drug meets the minimum criteria for coverage and reimbursement by virtue of being listed in at least one of the authorized drug compendia used by Medicare.” [Res. 819, I-11; Reaffirmed: CMS Rep. 1, A-21]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 202
(I-23)

Introduced by: Medical Student Section

Subject: Protecting the Health of Patients Incarcerated in For-Profit Prisons

Referred to: Reference Committee B

Whereas, the federal government and 26 states currently contract with for-profit prisons owned by private third-party companies, with the population incarcerated in for-profit prisons disproportionately rising at least 5 to 10 times faster than the overall incarcerated population from 2000 to 2016¹⁻³; and

Whereas, contracts with for-profit prisons raise ethical concerns, since facilities profit from larger incarcerated populations and longer sentences^{1,4}; and

Whereas, for-profit prisons maximize profits by cutting funding for payment, training, and retention of staff, resulting in inexperienced personnel with high turnover and increased risk to the safety and quality of life of incarcerated individuals^{3,7-8}; and

Whereas, for-profit prisons spend under 10% of their funds on healthcare compared to 15% in public prisons, offer less access to mental health, addiction, and HIV care, and demonstrate greater rates of delayed interventions for serious mental illness, denial or delay of medically necessary hospitalization, inappropriate use of non-physicians, overcrowding, assaults, injuries due to riots, use of force and solitary confinement, and due process violations⁷⁻¹¹; and

Whereas, while public prisons are obligated to release data on operations, safety conditions, healthcare use, and parole and probation services and can be held publicly accountable, for-profit prisons are not subject to this level of oversight^{1,6,13-14}; and

Whereas, in 2021, the Biden-Harris Administration announced that they would not renew federal contracts with for-profit prisons, but these corporations continue to contract with counties who in turn contract with the federal government for criminal and immigration detention¹⁵⁻¹⁶; and

Whereas, California, Nevada, New York, Illinois, and Washington state all ban or limit state use of for-profit prisons, and 22 states do not use for-profit prisons at all¹⁷⁻¹⁸; therefore be it

RESOLVED, that our American Medical Association advocate against the use of for-profit prisons (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for for-profit prisons, public prisons with privatized medical services, and detention centers to be held to the same standards as prisons with public medical services, especially with respect to oversight, reporting of health-related outcomes, and quality of healthcare. (Directive to Take Action)

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

Received: 09/11/2023

REFERENCES

1. Private prisons vs. public prisons. Criminal Justice Programs. <https://www.criminaljusticeprograms.com/articles/private-prisons-vs-public-prisons/>. Published May 4, 2021. Accessed March 20, 2022.
2. Fetting A, Nellis A. Private prisons in the United States. The Sentencing Project. <https://www.sentencingproject.org/publications/private-prisons-united-states/>. Published March 30, 2021. Accessed April 8, 2023.
3. Gotsch K, Basti V. Capitalizing on mass incarceration: U.S. growth in private prisons. The Sentencing Project. <https://www.sentencingproject.org/publications/capitalizing-on-mass-incarceration-u-s-growth-in-private-prisons/>. Published August 2, 2018. Accessed March 20, 2022.
4. Cert examples. Human Resources. <https://in.nau.edu/human-resources/cert-examples/>. Accessed March 20, 2022.
5. Burkhardt BC. Who is in private prisons? demographic profiles of prisoners and workers in American private prisons. *Int Journal of Law, Crime and Justice*. 2017;51:24-33. doi:10.1016/j.ijlcrj.2017.04.004
6. Kim C. Private prisons face an uncertain future as states turn their backs on the industry. Vox. <https://www.vox.com/policy-and-politics/2019/12/1/20989336/private-prisons-states-bans-california-nevada-colorado>. Published December 1, 2019. Accessed March 20, 2022.
7. Wagner P, Rabuy B. Following the money of mass incarceration. Prison Policy Initiative. <https://www.prisonpolicy.org/reports/money.html>. Published January 25, 2017. Accessed March 20, 2022.
8. Risko R. Budget Briefing: Corrections. House Fiscal Agency. https://www.house.mi.gov/hfa/PDF/Briefings/Corrections_BudgetBriefing_fy22-23.pdf. Published December 2022. Accessed April 9, 2023.
9. Review of Federal Bureau of Prisons' monitoring of ... Office of the Inspector General. <https://oig.justice.gov/reports/2016/e1606.pdf>. Published August 2016. Accessed March 20, 2022.
10. Thompson C. Everything you ever wanted to know about private prisons... <https://www.themarshallproject.org/2014/12/18/everything-you-ever-wanted-to-know-about-private-prisons>. Published December 18, 2014. Accessed March 20, 2022.
11. Wessler S. Federal officials ignored years of internal warnings about deaths at private prisons. The Nation. <https://www.thenation.com/article/archive/federal-officials-ignored-years-of-internal-warnings-about-deaths-at-private-prisons/>. Published December 14, 2017. Accessed March 20, 2022.
12. Nowotny KM, Rogers RG, Boardman JD. Racial disparities in health conditions among prisoners compared with the general population. *SSM - Population Health*. <https://www.sciencedirect.com/science/article/pii/S235282731730037X?via%3Dihub>. Published May 22, 2017. Accessed March 20, 2022.
13. Montes AN, Mears DP, Stewart EA. Racial and ethnic divides in privatized punishment: Examining disparities in private prison placements. *Justice Quarterly*. 2019;37(5):930-954. doi:10.1080/07418825.2019.1675747
14. Kim D-Y. Prison privatization: An Empirical Literature Review and path forward. *Int Crim Justice Rev*. 2019;32(1):24-47. doi:10.1177/1057567719875791
15. Executive order on reforming our incarceration system to eliminate the use of privately operated criminal detention facilities. The White House. <https://www.whitehouse.gov/briefing-room/presidential-actions/2021/01/26/executive-order-reforming-our-incarceration-system-to-eliminate-the-use-of-privately-operated-criminal-detention-facilities/>. Published January 26, 2021. Accessed March 20, 2022.
16. Eisen L-B. Breaking down Biden's order to eliminate DOJ private prison contracts. Brennan Center for Justice. <https://www.brennancenter.org/our-work/research-reports/breaking-down-bidens-order-eliminate-doj-private-prison-contracts>. Published November 15, 2021. Accessed March 20, 2022.
17. La Corte R. Washington State governor Oks Bill banning for-profit jails. AP NEWS. <https://apnews.com/article/legislature-prisons-washington-legislation-immigration-ceda36fec7dfc3a56c8fe8f7a66d3d76>. Published April 14, 2021. Accessed March 8, 2023.
18. Buday M, Nellis A. The Sentencing Project; 2022. <https://www.sentencingproject.org/app/uploads/2022/10/Private-Prisons-in-the-United-States-2.pdf>. Accessed March 8, 2023.

RELEVANT AMA POLICY

H-430.986 Health Care While Incarcerated

1. Our AMA advocates for adequate payment to health care providers, including primary care and mental health, and addiction treatment professionals, to encourage improved access to comprehensive physical and behavioral health care services to juveniles and adults throughout the incarceration process from intake to re-entry into the community.
2. Our AMA advocates and requires a smooth transition including partnerships and information sharing between correctional systems, community health systems and state insurance programs to provide access to a continuum of health care services for juveniles and adults in the correctional system, including correctional settings having sufficient resources to assist incarcerated persons' timely access to mental health, drug and residential rehabilitation facilities upon release.
3. Our AMA encourages state Medicaid agencies to accept and process Medicaid applications from juveniles and adults who are incarcerated.
4. Our AMA encourages state Medicaid agencies to work with their local departments of corrections, prisons, and jails to assist incarcerated juveniles and adults who may not have been enrolled in Medicaid at the time of their incarceration to apply and receive an eligibility determination for Medicaid.
5. Our AMA advocates for states to suspend rather than terminate Medicaid eligibility of juveniles and

adults upon intake into the criminal legal system and throughout the incarceration process, and to reinstate coverage when the individual transitions back into the community.

6. Our AMA advocates for Congress to repeal the “inmate exclusion” of the 1965 Social Security Act that bars the use of federal Medicaid matching funds from covering healthcare services in jails and prisons.

7. Our AMA advocates for Congress and the Centers for Medicare & Medicaid Services (CMS) to revise the Medicare statute and rescind related regulations that prevent payment for medical care furnished to a Medicare beneficiary who is incarcerated or in custody at the time the services are delivered.

8. Our AMA advocates for necessary programs and staff training to address the distinctive health care needs of women and adolescent females who are incarcerated, including gynecological care and obstetrics care for individuals who are pregnant or postpartum.

9. Our AMA will collaborate with state medical societies, relevant medical specialty societies, and federal regulators to emphasize the importance of hygiene and health literacy information sessions, as well as information sessions on the science of addiction, evidence-based addiction treatment including medications, and related stigma reduction, for both individuals who are incarcerated and staff in correctional facilities.

10. Our AMA supports: (a) linkage of those incarcerated to community clinics upon release in order to accelerate access to comprehensive health care, including mental health and substance use disorder services, and improve health outcomes among this vulnerable patient population, as well as adequate funding; (b) the collaboration of correctional health workers and community health care providers for those transitioning from a correctional institution to the community; (c) the provision of longitudinal care from state supported social workers, to perform foundational check-ins that not only assess mental health but also develop lifestyle plans with newly released people; and (d) collaboration with community-based organizations and integrated models of care that support formerly incarcerated people with regard to their health care, safety, and social determinant of health needs, including employment, education, and housing.

11. Our AMA advocates for the continuation of federal funding for health insurance benefits, including Medicaid, Medicare, and the Children’s Health Insurance Program, for otherwise eligible individuals in pre-trial detention.

12. Our AMA advocates for the prohibition of the use of co-payments to access healthcare services in correctional facilities.

13. Our AMA encourages the following qualifications for the Director and Assistant Director of the Health Services Division within the Federal Bureau of Prisons: (a) MD or DO, or an international equivalent degree with at least five years of clinical experience at a Bureau of Prisons medical facility or a community clinical setting; (b) knowledge of health disparities among Black, American Indian and Alaska Native, and people of color, including the pathophysiological basis of the disease process and the social determinants of health that affect disparities; (c) knowledge of the health disparities among individuals who are involved with the criminal justice system.

14. Our AMA will collaborate with interested parties to promote the highest quality of health care and oversight for those who are involved in the criminal justice system by advocating for health administrators and executive staff to possess credentials and experience comparable to individuals in the community in similar professional roles. [CMS Rep. 02, I-16; Appended: Res. 417, A-19; Appended: Res. 420, A-19; Modified: Res. 216, I-19; Modified: Res. 503, A-21; Reaffirmed: Res. 229, A-21; Modified: Res. 127, A-22; Appended: Res. 244, A-23; Appended: Res. 429, A-23]

H-430.997 Standards of Care for Inmates of Correctional Facilities

Our AMA believes that correctional and detention facilities should provide medical, psychiatric, and substance use disorder care that meets prevailing community standards, including appropriate referrals for ongoing care upon release from the correctional facility in order to prevent recidivism. [Res. 60, A-84; Reaffirmed by CLRPD Rep. 3 - I-94; Amended: Res. 416, I-99; Reaffirmed: CEJA Rep. 8, A-09; Reaffirmation I-09 Modified in lieu of Res. 502, A-12; Reaffirmation: I-12; Modified: CSAPH Rep. 1, A-22]

D-350.983 Improving Medical Care in Immigrant Detention Centers

Our AMA will: (1) issue a public statement urging U.S. Immigrations and Customs Enforcement Office of Detention Oversight to (a) revise its medical standards governing the conditions of confinement at detention facilities to meet those set by the National Commission on Correctional Health Care, (b) take necessary steps to achieve full compliance with these standards, and (c) track complaints related to substandard healthcare quality; (2) recommend the U.S. Immigrations and Customs Enforcement refrain from partnerships with private institutions whose facilities do not meet the standards of medical, mental,

and dental care as guided by the National Commission on Correctional Health Care; and (3) advocate for access to health care for individuals in immigration detention. [Res. 017, A-17]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 203
(I-23)

Introduced by: Medical Student Section

Subject: Anti-Discrimination Protections for Housing Vouchers

Referred to: Reference Committee B

1 Whereas, adequate, safe, and affordable housing is an important social determinant of health,
2 yet studies on subsidized housing and health are limited in number and scope¹; and
3

4 Whereas, individuals in need of federal housing assistance and subsidized housing may bear a
5 greater burden of mental and physical illness, physical violence and economic hardship than the
6 general population¹⁻²; and
7

8 Whereas, the US Department of Health and Human Services and Housing Urban Development
9 (HUD) entered into a partnership in 2021 to expand affordable housing access, along with
10 services that address social determinants of health among vulnerable populations³; and
11

12 Whereas, the federal housing choice voucher program, commonly referred to as “Section 8” is a
13 federal housing program for tenants experiencing economic and related hardships^{2,4}; and
14

15 Whereas, 2 in 3 voucher households are not protected by anti-discrimination laws at the local,
16 state, or federal level, allowing for landlords to discriminate against and refuse the use of the
17 Section 8 vouchers by prospective tenants⁵; and
18

19 Whereas, over two-thirds of HUD beneficiaries (Section 8 or related program) are racial and
20 ethnic minorities, with 45% identifying as Black or African American⁷; and
21

22 Whereas, racial and ethnic minorities are less likely to be homeowners due to disparate
23 intergenerational wealth compared to the non-Hispanic white population⁸⁻⁹; and
24

25 Whereas, our American Medical Association recognizes that generational wealth gaps
26 experienced by Black or African American, American Indian or Alaska Native, and Hispanic
27 families are a consequence of structural racism and a barrier to achieving racial health equity
28 (D-60.965); and
29

30 Whereas, families’ length of stay in the Section 8 Housing Choice Voucher program is
31 increasing and rate of success in finding suitable low-income housing to utilize the voucher has
32 been decreasing since the 1980s, both largely due to rising housing costs, stagnant incomes,
33 and insufficient federal funding¹⁰; and
34

35 Whereas, the increasing wait times in Section 8 reinforce existing housing insecurity and
36 homelessness that track among disparities in race, especially in the difficulty of finding and
37 maintaining employment, and increasing childhood adverse events, leading to cognitive and
38 mental health problems, respiratory diseases, accidental and intentional injuries, and diminished
39 educational outcomes¹¹; therefore be it

- 1 RESOLVED, that our American Medical Association support local, state, and federal policies
 2 requiring landlords to accept Section 8 and related housing vouchers as valid sources of
 3 individual and family income (New HOD Policy); and be it further
 4
 5 RESOLVED, that our AMA support local, state, and federal policies preventing landlords from
 6 discriminating against individuals and families who utilize public assistance. (New HOD Policy)

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

Received: 09/11/2023

REFERENCES

1. Pomeroy ML, Johnson E, Weinstein AA. Subsidized Housing and Health: An Exploratory Study Examining Resident Perspectives on Community Health and Access to Care. *J Health Care Poor Underserved*. 2021;32(3):1415-1432. doi:10.1353/hpu.2021.0141
2. Jayasundara DS, Legerski EM, Danis FS, Ruddell R. Oil Development and Intimate Partner Violence: Implementation of Section 8 Housing Policies in the Bakken Region of North Dakota and Montana. *J Interpers Violence*. 2018;33(21):3388-3416. doi:10.1177/0886260518798359
3. HHS and HUD announce expanded partnership, new housing and services resource center. Published December 8, 2021. Accessed September 22, 2022. https://www.hud.gov/press/press_releases_media_advisories/hud_no_21_201
4. Housing Choice Vouchers Fact Sheet. U.S. Department of Housing and Urban Development. Accessed September 22, 2022. https://www.hud.gov/topics/housing_choice_voucher_program_section_8
5. Bell, A., Sard, B., Koepnick, B. Prohibiting Discrimination Against Renters Using Housing Vouchers Improves Results. Center on Budget and Policy Priorities. Last Updated December 20, 2018. Accessed September 22, 2022. <https://www.cbpp.org/research/housing/prohibiting-discrimination-against-renters-using-housing-vouchers-improves-results>
6. Ellen, I., O'Regan, K., Harwood, K. Advancing Choice in the Housing Choice Voucher Program: Source of Income Protections and Locational Outcomes. *Housing Policy Debate*. 2022. DOI: 10.1080/10511482.2022.2089196
7. Public Housing Statistics. *iProperty Management*. Last Updated May 9, 2022. Accessed September 22, 2022. <https://ipropertymanagement.com/research/public-housing-statistics>
8. Fenton, R. Unaffordable housing: cost-burdened housing estimates for South Carolina's minority population. *South Carolina State Library*. Published August 9, 2022. Accessed September 22, 2022. <https://dc.statelibrary.sc.gov/handle/10827/45438>
9. Eldemire, A., Luchtenberg, K., Wynter, M. Does Homeownership Reduce Wealth Disparities for Low-Income and Minority Households? *The Review of Corporate Finance Studies*. Volume 11, Issue 3. August 2022: Pages 465–510, <https://doi.org/10.1093/rcfs/cfac016>
10. Section 8 Family Data. *Section 8 Information*. Published March 24, 2020. Accessed August 28, 2022. <https://section8-information.org/section-8-statistics/>
11. Acosta S, Gartland E. Families Wait Years for Housing Vouchers Due to Inadequate Funding. Center on Budget and Policy Priorities. <https://www.cbpp.org/research/housing/families-wait-years-for-housing-vouchers-due-to-inadequate-funding>. Published July 22, 2021. Accessed September 18, 2022.

RELEVANT AMA POLICY

H-350.953 Racial Housing Segregation as a Determinant of Health and Public Access to Geographic Information Systems (GIS) Data

Our AMA will: (1) oppose policies that enable racial housing segregation; and (2) advocate for continued federal funding of publicly-accessible geospatial data on community racial and economic disparities and disparities in access to affordable housing, employment, education, and healthcare, including but not limited to the Department of Housing and Urban Development (HUD) Affirmatively Furthering Fair Housing (AFFH) tool. [Res. 405, A-18]

H-160.903 Eradicating Homelessness

Our AMA:

- (1) supports improving the health outcomes and decreasing the health care costs of treating the chronically homeless through clinically proven, high quality, and cost effective approaches which recognize the positive impact of stable and affordable housing coupled with social services;
- (2) recognizes that stable, affordable housing as a first priority, without mandated therapy or services compliance, is effective in improving housing stability and quality of life among individuals who are chronically-homeless;
- (3) recognizes adaptive strategies based on regional variations, community characteristics and state and local resources are necessary to address this societal problem on a long-term basis;
- (4) recognizes the need for an effective, evidence-based national plan to eradicate homelessness;

- (5) encourages the National Health Care for the Homeless Council to study the funding, implementation, and standardized evaluation of Medical Respite Care for homeless persons;
- (6) will partner with relevant stakeholders to educate physicians about the unique healthcare and social needs of homeless patients and the importance of holistic, cost-effective, evidence-based discharge planning, and physicians' role therein, in addressing these needs;
- (7) encourages the development of holistic, cost-effective, evidence-based discharge plans for homeless patients who present to the emergency department but are not admitted to the hospital;
- (8) encourages the collaborative efforts of communities, physicians, hospitals, health systems, insurers, social service organizations, government, and other stakeholders to develop comprehensive homelessness policies and plans that address the healthcare and social needs of homeless patients;
- (9) (a) supports laws protecting the civil and human rights of individuals experiencing homelessness, and (b) opposes laws and policies that criminalize individuals experiencing homelessness for carrying out life-sustaining activities conducted in public spaces that would otherwise be considered non-criminal activity (i.e., eating, sitting, or sleeping) when there is no alternative private space available; and
- (10) recognizes that stable, affordable housing is essential to the health of individuals, families, and communities, and supports policies that preserve and expand affordable housing across all neighborhoods. [Res. 401, A-15, Appended: Res. 416, A-18, Modified: BOT Rep. 11, A-18, Appended: BOT Rep. 16, A-19, Appended: BOT Rep. 28, A-19]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 204
(I-23)

Introduced by: Medical Student Section

Subject: Improving PrEP & PEP Access

Referred to: Reference Committee B

Whereas, pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP) are antiretroviral treatments that prevent human immunodeficiency virus (HIV) infection in high-risk populations¹; and

Whereas, the Centers for Disease Control and Prevention (CDC) recommends PrEP for: (1) people without HIV who have had anal or vaginal sex in the past six months without a condom, with an STI history in that period, or with a partner with HIV, and (2) for people without HIV who use injection drugs with a partner with HIV or who share injection equipment¹; and

Whereas, the CDC recommends PEP for people without HIV or with unknown HIV status with possible HIV exposure in the past 72 hours²; and

Whereas, HIV disproportionately affects men who have sex with men (MSM) and minoritized racial and ethnic groups, especially Black and Latine communities³⁻⁴; and

Whereas, under 25% of patients who meet PrEP criteria actually take PrEP, with disproportionate inequities among Black and Latine patients⁵⁻⁶; and

Whereas, 52% of new HIV diagnoses occur in Southern states, but only 27% of PrEP users reside in these states⁶; and

Whereas, various state laws increase PrEP and PEP access by creating collaborative practice agreements between physicians and pharmacists, allowing patients to seek prophylaxis at community pharmacies while being monitored by physicians^{5,7-14}; and

Whereas, a systematic review found that allowing patients to seek prophylaxis at pharmacies can result in found that 74-96% of patients filling a prescription within a week of evaluation, and multiple other studies demonstrate increased access for patients who may otherwise forgo PrEP due to logistical, financial, or travel barriers finding a clinic for initial HIV evaluation¹⁴⁻²³; and

Whereas, AMA Policy H-95.932 already supports the use of collaborative practice agreements with pharmacists for naloxone; and

Whereas, as multiple states are considering laws to increase access to PrEP and PEP at pharmacies, our AMA should take a position on this issue to bolster advocacy²⁴⁻²⁵; therefore be it

- 1 RESOLVED, that our American Medical Association support efforts to increase access to HIV
2 pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP) through the
3 establishment of collaborative practice agreements with physicians. (New HOD Policy)

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

Received: 09/19/2023

REFERENCES

1. PreExposure Prophylaxis for the Prevention of HIV Infection in the United States - 2021 Update.; 2021. <https://www.cdc.gov/hiv/pdf/risk/prep/cdc-hiv-prep-guidelines-2021.pdf>
2. Dominguez KL, Smith DK, Thomas V, et al. Updated guidelines for antiretroviral postexposure prophylaxis after sexual, injection drug use, or other nonoccupational exposure to HIV—United States, 2016. Cdc.gov. Published 2016. <https://stacks.cdc.gov/view/cdc/38856>
3. HIV.gov. HIV & AIDS Trends and U.S. Statistics Overview. HIV.gov. Published October 27, 2022. <https://www.hiv.gov/hiv-basics/overview/data-and-trends/statistics/>
4. National Profile | Volume 33 | HIV Surveillance | Reports | Resource Library | HIV/AIDS | CDC. www.cdc.gov. Published May 23, 2022. <https://www.cdc.gov/hiv/library/reports/hiv-surveillance/vol-33/content/national-profile.html>
5. Pharmacist- Initiated PrEP and PEP. National Alliance of State and Territorial AIDS Directors <https://nastad.org/sites/default/files/2021-11/PDF-Pharmacist-Initiated-PrEP-PEP.pdf>
6. Smith D, Van Handel M, Grey J. By Race/ethnicity, Blacks Have Highest Number Needing PrEP in the United States, 2015. www.natap.org. Published March 2018. Accessed April 10, 2023. https://www.natap.org/2018/CROI/croi_147.htm
7. Mayer KH, Agwu A, Malebranche D. Barriers to the Wider Use of Pre-exposure Prophylaxis in the United States: A Narrative Review. *Advances in Therapy*. 2020;37(5):1778-1811. doi:<https://doi.org/10.1007/s12325-020-01295-0>
8. Cohen S, Lubega S, Peters P, Wong S. Quick Clinical Guide: HIV PrEP Pre-Exposure Prophylaxis. www.cdph.ca.gov. https://www.cdph.ca.gov/Programs/CID/DOA/CDPH%20Document%20Library/QuickClinicalGuide_PrEP_ADA.pdf
9. Stevens L. Post-Exposure Prophylaxis in NYS. Published June 13, 2017. www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/webinars/docs/2017/hh_pep_in_nys.pdf
10. Bill Text - SB-159 HIV: preexposure and postexposure prophylaxis. Ca.gov. Published 2019. https://leginfo.ca.gov/faces/billNavClient.xhtml?bill_id=20190200SB159
11. SB325 Establishes provisions relating to preventing the acquisition of human immunodeficiency virus. www.leg.state.nv.us. Published March 22, 2021. Accessed April 10, 2023. <https://www.leg.state.nv.us/App/NELIS/REL/81st2021/Bill/7959/Text#>
12. House Bill 2958. Published 2021. <https://olis.oregonlegislature.gov/liz/2021r1/Measures/Overview/HB2958>
13. SB79. Published 2021. <https://www.senate.mo.gov/21info/pdf-bill/intro/SB79.pdf>
14. Weidle PJ, Lecher S, Botts LW, et al. HIV testing in community pharmacies and retail clinics: A model to expand access to screening for HIV infection. *Journal of the American Pharmacists Association*. 2014;54(5):486-492. doi:<https://doi.org/10.1331/japha.2014.14045>
15. Human Immunodeficiency Virus Infection Prevention Medications | Colorado General Assembly. leg.colorado.gov. Published 2020. <https://leg.colorado.gov/bills/hb20-1061>
16. Kennedy CE, Yeh PT, Atkins K, Ferguson L, Baggaley R, Narasimhan M. PrEP distribution in pharmacies: a systematic review. *BMJ Open*. 2022;12(2):e054121. doi:<https://doi.org/10.1136/bmjopen-2021-054121>
17. Crawford ND, Josma D, Morris J, Hopkins R, Young HN. Pharmacy-based pre-exposure prophylaxis support among pharmacists and men who have sex with men. *Journal of the American Pharmacists Association*. 2020;60(4):602-608. doi:<https://doi.org/10.1016/j.japh.2019.12.003>
18. Zhao A, Dangerfield DT, Nunn A, et al. Pharmacy-Based Interventions to Increase Use of HIV Pre-exposure Prophylaxis in the United States: A Scoping Review. *AIDS and Behavior*. 2021;26(5):1377-1392. doi:<https://doi.org/10.1007/s10461-021-03494-4>
19. Klepser DG, Klepser ME, Peters PJ, Hoover KW, Weidle PJ. Implementation and Evaluation of a Collaborative, Pharmacy-Based Hepatitis C and HIV Screening Program. *Preventing Chronic Disease*. 2022;19. doi:<https://doi.org/10.5888/pcd19.220129>
20. Havens JP, Scarsi KK, Sayles H, Klepser DG, Swindells S, Bares SH. Acceptability and Feasibility of a Pharmacist-Led Human Immunodeficiency Virus Pre-Exposure Prophylaxis Program in the Midwestern United States. *Open Forum Infectious Diseases*. 2019;6(10). doi:<https://doi.org/10.1093/ofid/ofz365>
21. Mayer KH, Chan PA, R. Patel R, Flash CA, Krakower DS. Evolving Models and Ongoing Challenges for HIV Preexposure Prophylaxis Implementation in the United States. *JAIDS Journal of Acquired Immune Deficiency Syndromes*. 2018;77(2):119-127. doi:<https://doi.org/10.1097/qai.0000000000001579>
22. Select Features of State Pharmacist Collaborative Practice Laws. Published 2012. https://www.cdc.gov/dhds/pubs/docs/pharmacist_state_law.pdf
23. Figueira I, Teixeira I, Rodrigues AT, Gama A, Dias S. Point-of-care HIV and hepatitis screening in community pharmacies: a quantitative and qualitative study. *International Journal of Clinical Pharmacy*. 2022;44(5):1158-1168. doi:<https://doi.org/10.1007/s11096-022-01444-1>
24. Collins B, Bronson H, Elamin F, Yerkes L, Martin E. The “No Wrong Door” Approach to HIV Testing: Results From a Statewide Retail Pharmacy-Based HIV Testing Program in Virginia, 2014-2016. *Public Health Reports*. 2018;133(2_suppl):34S42S. doi:<https://doi.org/10.1177/0033354918801026>
25. <https://www.nprillinois.org/people/maureen-foertsch-mckinney>. New law will allow pharmacists to prescribe HIV prevention medications. NPR Illinois. Published June 10, 2022. Accessed July 6, 2023. <https://www.nprillinois.org/health-harvest/2022-06-10/new-law-will-allow-pharmacists-to-prescribe-hiv-prevention-medications>

RELEVANT AMA POLICY**H-95.932 Increasing Availability of Naloxone and Other Safe and Effective Overdose Reversal Medications**

1. Our AMA supports legislative, regulatory, and national advocacy efforts to increase access to affordable naloxone and other safe and effective overdose reversal medications, including but not limited to collaborative practice agreements with pharmacists and standing orders for pharmacies and, where permitted by law, community-based organizations, law enforcement agencies, correctional settings, schools, and other locations that do not restrict the route of administration for naloxone and other safe and effective overdose reversal medications delivery.
2. Our AMA supports efforts that enable law enforcement agencies to carry and administer naloxone and other safe and effective overdose reversal medications .
3. Our AMA encourages physicians to co-prescribe naloxone and other safe and effective overdose reversal medications to patients at risk of overdose and, where permitted by law, to the friends and family members of such patients.
4. Our AMA encourages private and public payers to include all forms of naloxone and other safe and effective overdose reversal medications on their preferred drug lists and formularies with minimal or no cost sharing.
5. Our AMA supports liability protections for physicians and other healthcare professionals and others who are authorized to prescribe, dispense and/or administer naloxone and other safe and effective overdose reversal medications pursuant to state law.
6. Our AMA supports efforts to encourage individuals who are authorized to administer naloxone and other safe and effective overdose reversal medications to receive appropriate education to enable them to do so effectively.
7. Our AMA encourages manufacturers or other qualified sponsors to pursue the application process for over the counter approval of naloxone and other safe and effective overdose reversal medications with the Food and Drug Administration.
8. Our AMA supports the widespread implementation of easily accessible naloxone and other safe and effective overdose reversal medications rescue stations (public availability of naloxone and other safe and effective overdose reversal medications through wall-mounted display/storage units that also include instructions) throughout the country following distribution and legislative edicts similar to those for Automated External Defibrillators.
9. Our AMA supports the legal access to and use of naloxone and other safe and effective overdose reversal medications in all public spaces regardless of whether the individual holds a prescription.
10. Our AMA supports efforts to increase the availability, delivery, possession and use of mail-order overdose reversal medications, including naloxone, to help prevent opioid-related overdose, especially in vulnerable populations, including but not limited to underserved communities and American Indian reservation populations. [BOT Rep. 22, A-16; Modified: Res. 231, A-17; Modified: Speakers Rep. 01, A-17; Appended: Res. 909, I-17; Reaffirmed: BOT Rep. 17, A-18; Modified: Res. 524, A-19; Reaffirmed: BOT 09, I-19; Reaffirmed: Res. 219, A-21; Modified: Res. 505, A-23]

H-20.895 Pre-Exposure Prophylaxis (PrEP) for HIV

1. Our AMA will educate physicians, physicians-in-training, and the public about the effective use of pre-exposure prophylaxis for HIV and the US PrEP Clinical Practice Guidelines.
2. Our AMA supports the coverage of all approved PrEP regimens in all clinically appropriate circumstances.
3. Our AMA supports the removal of insurance barriers for all approved PrEP regimens, such as prior authorization, mandatory consultation with an infectious disease specialist, and other barriers that are not clinically relevant.
4. Our AMA advocates that individuals not be denied any insurance on the basis of PrEP use.
5. Our AMA encourages the discussion of and education about PrEP during routine sexual health counseling. [Res. 106, A-16; Modified: Res. 916, I-16; Appended: Res. 101, A-17; Modified: Res. 933, I-22]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 205
(I-23)

Introduced by: Oklahoma

Subject: Cannabis Product Safety

Referred to: Reference Committee B

1 Whereas, physicians prioritize patient safety, and the American Medical Association
2 Code of Medical Ethics underscores its commitment "to promote the art of medicine and
3 the betterment of public health"; and
4

5 Whereas, there are many legal implications due to the passage of state cannabis laws
6 and the associated regulations; and
7

8 Whereas, current AMA policy, Cannabis Legalization for Medicinal Use, D-95.969 states:
9 Our AMA (3) will develop model legislation requiring the following warning on all
10 cannabis products not approved by the U.S. Food and Drug Administration: "Marijuana
11 has a high potential for abuse. This product has not been approved by the Food and
12 Drug Administration for preventing or treating any disease process."; and
13

14 Whereas, existing AMA policy, Cannabis Legalization for Adult Use (commonly referred
15 to as recreational use), H-95.924 and Cannabis Warnings for Pregnant and
16 Breastfeeding Women, H-95.936, do not contain any such call for model legislation; and
17

18 Whereas, as the legalization of both medicinal and recreational cannabis use spreads
19 across the country, it becomes increasingly important that states be able to properly
20 regulate the production, marketing and sales of cannabis products; therefore be it
21

22 RESOLVED, that our American Medical Association draft state model legislation to help
23 states implement the provisions of AMA policies H-95.924, Cannabis Legalization for
24 Adult Use and H-95.936, Cannabis Warnings for Pregnant and Breastfeeding Women
25 that currently do not have such model language, including regulation of retail sales,
26 marketing and promotion (especially those aimed at children), misleading health claims,
27 and product labeling regarding dangers of use during pregnancy and breastfeeding.
28 (Directive to Take Action)

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

Received: 9/26/23

RELEVANT AMA POLICY

CBD Oil Use and the Marketing of CBD Oil H-95.911

Our AMA supports: (1) banning the advertising of cannabidiol (CBD) as a component of marijuana in places that children frequent; and (2) legislation and regulatory actions at the federal and state level to prohibit companies from selling CBD products if they make any unproven health and therapeutic claims.

Cannabis Legalization for Medicinal Use D-95.969

Our AMA: (1) believes that scientifically valid and well-controlled clinical trials conducted under federal investigational new drug applications are necessary to assess the safety and effectiveness of all new drugs, including potential cannabis products for medical use; (2) believes that cannabis for medicinal use should not be legalized through the state legislative, ballot initiative, or referendum process; (3) will develop model legislation requiring the following warning on all cannabis products not approved by the U.S. Food and Drug Administration: "Marijuana has a high potential for abuse. This product has not been approved by the Food and Drug Administration for preventing or treating any disease process."; (4) supports legislation ensuring or providing immunity against federal prosecution for physicians who certify that a patient has an approved medical condition or recommend cannabis in accordance with their state's laws; (5) believes that effective patient care requires the free and unfettered exchange of information on treatment alternatives and that discussion of these alternatives between physicians and patients should not subject either party to criminal sanctions; (6) will, when necessary and prudent, seek clarification from the United States Justice Department (DOJ) about possible federal prosecution of physicians who participate in a state operated marijuana program for medical use and based on that clarification, ask the DOJ to provide federal guidance to physicians; and (7) encourages hospitals and health systems to: (a) not recommend patient use of non-FDA approved cannabis or cannabis derived products within healthcare facilities until such time as federal laws or regulations permit its use; and (b) educate medical staffs on cannabis use, effects and cannabis withdrawal syndrome.

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.

Cannabis Warnings for Pregnant and Breastfeeding Women H-95.936

Our AMA advocates for regulations requiring point-of-sale warnings and product labeling for cannabis and

cannabis-based products regarding the potential dangers of use during pregnancy and breastfeeding wherever these products are sold or distributed.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 206
(I-23)

Introduced by: American Academy of Ophthalmology

Subject: The Influence of Large Language Models (LLMs) on Health Policy Formation and Scope of Practice

Referred to: Reference Committee B

1 Whereas, recent research suggests that large language models (LLMs) such as, generative
2 pretrained transformers (GPTs), and other augmented intelligence exhibit political biases^{1,2,3};
3 and
4

5 Whereas, recent research suggests that the reliability of LLMs in its question-answering (QA)
6 capability is variable⁴; and
7

8 Whereas, an AI Chatbot when asked the same questions included in the 2018 AMA Truth in
9 Advertising Survey⁵ answered that both MDs or DOs and Other Health Care Professionals
10 equally or either one should be allowed to perform the following specific activities: Treat chronic
11 pain by prescribing drugs or other substances that have a higher potential for addiction or
12 abuse, Write prescriptions for medication to treat mental health conditions such as
13 schizophrenia and bipolar disorder, Order and interpret diagnostic imaging studies like X-rays
14 and MRIs, and Administer and monitor anesthesia levels and patient condition before and
15 during surgery and also answered that that it did not know whether a Doctor of Medical Science
16 or a Doctor of Nursing Practice was a Physician; and
17

18 Whereas, when given a choice, an AI chatbot agreed with the statement that “patients would
19 benefit from scope of practice changes”; and
20

21 Whereas, an AI Chatbot misidentified states with and without expanded optometric scope of
22 practice laws that authorized optometrists to perform laser surgery and provided misinformation
23 on training requirements for optometrists to perform laser surgery; and
24

25 Whereas, misinformation, misleading information and biased information from LLMs may be
26 relied upon for policy advice and information by legislators and regulators when formulating
27 opinions on health policy; and
28

29 Whereas, our AMA has policy concerning false or misleading AI-generated medical advice
30 (Assessing the Potentially Dangerous Intersection Between AI and Misinformation H-480.935);
31 and
32

33 Whereas, existing AMA policy does not directly address false, biased or misleading AI-
34 generated content on health policy, physician truth in advertising, and scope of practice; and
35

36 Whereas, the First Amendment of the US Constitution does not allow the government to
37 regulate political bias and protects free speech; therefore be it

- 1 RESOLVED, that our American Medical Association encourage physicians to educate our
2 patients, the public, and policymakers about the benefits and risks of facing LLMs including
3 GPTs for advice on health policy, information on healthcare issues influencing the legislative
4 and regulatory process, and for information on scope of practice that may influence decisions
5 by patients and policymakers. (New HOD Policy)

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

Received: 9/26/23

REFERENCES

1. Hartmann, Jochen, Jasper Schwenzow, and Maximilian Witte. "The political ideology of conversational AI: Converging evidence on ChatGPT's pro-environmental, left-libertarian orientation." *arXiv preprint arXiv:2301.01768* (2023).
<https://arxiv.org/pdf/2301.01768.pdf>
2. Suguri Motoki, Fabio Yoshio and Pinho Neto, Valdemar and Rodrigues, Victor. "More Human than Human: Measuring ChatGPT Political Bias." (July 18, 2023). Motoki, F., Neto, V. P., & Rodrigues, V. (2023). More human than human: Measuring ChatGPT political bias. *Public Choice*.
https://www.researchgate.net/publication/373188439_More_human_than_human_measuring_ChateGPT_political_bias
3. Rystrom, Jonathan H. "Apolitical Intelligence? Auditing Delphi's responses on controversial political issues in the US." *arXiv preprint arXiv:2306.13000* (2023) <https://arxiv.org/pdf/2306.13000.pdf>
4. Shen, Xinyue, et al. "In chatgpt we trust? measuring and characterizing the reliability of chatgpt." *arXiv preprint arXiv:2304.08979* (2023) <https://arxiv.org/pdf/2304.08979.pdf>
5. Truth in Advertising Survey Results, AMA Resource Center https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/premium/arc/tia-survey_0.pdf

RELEVANT AMA POLICY

Assessing the Potentially Dangerous Intersection Between AI and Misinformation H-480.935

Our American Medical Association will: (1) study and develop recommendations on the benefits and unforeseen consequences to the medical profession of large language models (LLM) such as, generative pretrained transformers (GPTs), and other augmented intelligence-generated medical advice or content, and that our AMA propose appropriate state and federal regulations with a report back at A-24; (2) work with the federal government and other appropriate organizations to protect patients from false or misleading AI-generated medical advice; (3) encourage physicians to educate our patients about the benefits and risks of consumers facing LLMs including GPTs; and (4) support publishing groups and scientific journals to establish guidelines to regulate the use of augmented intelligence in scientific publications that include detailing the use of augmented intelligence in the methods, exclusion of augmented intelligence systems as authors, and the responsibility of authors to validate the veracity of any text generated by augmented intelligence. [Res. 247, A-23]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 207
(I-23)

Introduced by: Michigan

Subject: On-Site Physician Requirement for Emergency Departments

Referred to: Reference Committee B

1 Whereas, patients seeking emergency medical care should seek care at facilities prepared to
2 offer evaluation and medical diagnosis of undifferentiated acute symptoms, recognition and
3 stabilization of emergency conditions, appropriate emergency treatment when available and/or
4 transfer to a higher level of care for emergency conditions when appropriate; and
5

6 Whereas, facility designations using the term “emergency” within their title may be assumed by
7 laypersons or medical professionals to imply the ability to offer all of the above emergency
8 duties and services; and
9

10 Whereas, the shift from “supervision” to “collaboration” of non-physician practitioners (NPPs)
11 (e.g., APRNs, PAs, and CRNAs), may imply a lower degree of physician involvement in the care
12 of the patient in as much as, collaboration may imply mere consultation of the physician only
13 when deemed necessary by the NPP which is inadequate in the setting of acute medical care
14 because NPPs have not been trained in the great breadth of medicine, as have physicians, and
15 cannot consistently recognize all acute emergency situations in which immediate physician care
16 is required; and
17

18 Whereas, every patient presenting to a facility which represents itself as a place where patients
19 can seek emergency medical care should be under the direct and real-time care of a licensed
20 physician including the on-site and real-time supervision of NPPs; and
21

22 Whereas, despite an overall physician deficit, there is not a lack of emergency medicine (EM)
23 physician workforce as there is a predicted surplus of EM physicians by the year 2030; therefore
24 be it
25

26 RESOLVED, that our American Medical Association develop model state legislation and support
27 federal and state legislation or regulation requiring all facilities that imply the provision of
28 emergency medical care have the real-time, on-site presence of a physician, and on-site
29 supervision of non-physician practitioners (e.g., physician assistants and advanced practice
30 nurses) by a licensed physician with training and experience in emergency medical care whose
31 primary duty is dedicated to patients seeking emergency medical care in that emergency
32 department. (Directive to Take Action)

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

Received: 9/26/23

RELEVANT AMA POLICY

Physician and NonPhysician Licensure and Scope of Practice D-160.995

1. Our AMA will: (a) continue to support the activities of the Advocacy Resource Center in providing advice and assistance to specialty and state medical societies concerning scope of practice issues to include the collection, summarization and wide dissemination of data on the training and the scope of practice of physicians (MDs and DOs) and nonphysician groups and that our AMA make these issues a legislative/advocacy priority; (b) endorse current and future funding of research to identify the most cost effective, high-quality methods to deliver care to patients, including methods of multidisciplinary care; and (c) review and report to the House of Delegates on a periodic basis on such data that may become available in the future on the quality of care provided by physician and nonphysician groups.
2. Our AMA will: (a) continue to work with relevant stakeholders to recognize physician training and education and patient safety concerns, and produce advocacy tools and materials for state level advocates to use in scope of practice discussions with legislatures, including but not limited to infographics, interactive maps, scientific overviews, geographic comparisons, and educational experience; (b) advocate for the inclusion of non-physician scope of practice characteristics in various analyses of practice location attributes and desirability; (c) advocate for the inclusion of scope of practice expansion into measurements of physician well-being; and (d) study the impact of scope of practice expansion on medical student choice of specialty.
3. Our AMA will consider all available legal, regulatory, and legislative options to oppose state board decisions that increase non-physician health care provider scope of practice beyond legislative statute or regulation. [CME Rep. 1, I-00; Reaffirmed: CME Rep. 2, A-10; Modified: CCB/CLRPD Rep. 2, A-14; Appended: Res. 251, A-18; Appended: Res. 222, I-19]

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) Certified nurse practitioners, certified registered nurse anesthetists, certified nurse midwives, and clinical nurse specialists shall be licensed and regulated jointly by the state medical and nursing boards.
 - (6) Physicians must be responsible and have authority for initiating and implementing quality control programs for nonphysicians delivering medical care in integrated practices. [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; Modified: BOT Rep. 12, A-23 Reaffirmed: BOT Rep. 09, A-23]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 208
(I-23)

Introduced by: Young Physicians Section

Subject: Non-Physician Practitioners Oversight and Training

Referred to: Reference Committee B

Whereas, the number and utilization of non-physician providers (NPPs) is increasing; and

Whereas, there is increasing scope of practice for NPPs in many states; and

Whereas, patient safety should remain one of the main priorities in providing high quality healthcare; and

Whereas, the number of clinical hours required for physician board certification exceeds that of NPPs by over 10,000 hours; and

Whereas, data are limited in regards to competence, cost and quality of NPPs practicing without any type of physician supervision; and

Whereas, NPPs have the ability to practice in multiple specialties without a formalized graduate medical education program and engage in highly variable training experiences with very few “specialty” certifications; and

Whereas, the terminology “practicing at the top of license” in regards to non-physician providers does not appropriately reflect the significant variability in training and experiences of non-physician providers; and

Whereas, there is variability in regulatory and accrediting bodies for the different types of NPPs; therefore be it

RESOLVED, that our American Medical Association encourage oversight and regulation of non-physician providers by regulatory bodies comprised of individuals with equivalent and higher levels of training, including state composite medical boards. (New HOD Policy)

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

Received: 9/26/23

REFERENCES

1. Auerbach DI, Buerhaus PJ, Staiger DO. Implications Of The Rapid Growth Of The Nurse Practitioner Workforce In The US. *Health Aff (Millwood)*. 2020;39(2):273-279. doi:10.1377/hlthaff.2019.00686
2. Chekijian SA, Elia TR, Horton JL, Baccari BM, Temin ES. A Review of Interprofessional Variation in Education: Challenges and Considerations in the Growth of Advanced Practice Providers in Emergency Medicine. *AEM Educ Train*. 2020 Jul 10;5(2):e10469. doi: 10.1002/aet2.10469. PMID: 33796808; PMCID: PMC7995928.
3. State Practice Environment. Available at <https://www.aanp.org/advocacy/state/state-practice-environment>.
4. Scope of practice: Education matters. Available at <https://www.ama-assn.org/practice-management/scope-practice/scope-practice-education-matters>.

Physician and Nonphysician Licensure and Scope of Practice D-160.995

1. Our AMA will: (a) continue to support the activities of the Advocacy Resource Center in providing advice and assistance to specialty and state medical societies concerning scope of practice issues to include the collection, summarization and wide dissemination of data on the training and the scope of practice of physicians (MDs and DOs) and nonphysician groups and that our AMA make these issues a legislative/advocacy priority; (b) endorse current and future funding of research to identify the most cost effective, high-quality methods to deliver care to patients, including methods of multidisciplinary care; and (c) review and report to the House of Delegates on a periodic basis on such data that may become available in the future on the quality of care provided by physician and nonphysician groups.
2. Our AMA will: (a) continue to work with relevant stakeholders to recognize physician training and education and patient safety concerns, and produce advocacy tools and materials for state level advocates to use in scope of practice discussions with legislatures, including but not limited to infographics, interactive maps, scientific overviews, geographic comparisons, and educational experience; (b) advocate for the inclusion of non-physician scope of practice characteristics in various analyses of practice location attributes and desirability; (c) advocate for the inclusion of scope of practice expansion into measurements of physician well-being; and (d) study the impact of scope of practice expansion on medical student choice of specialty.
3. Our AMA will consider all available legal, regulatory, and legislative options to oppose state board decisions that increase non-physician health care provider scope of practice beyond legislative statute or regulation.

[CME Rep. 1, I-00; Reaffirmed: CME Rep. 2, A-10; Modified: CCB/CLRPD Rep. 2, A-14; Appended: Res. 251, A-18; Appended: Res. 222, I-19]

AMA Support for States in Their Development of Legislation to Support Physician-Led, Team Based Care D-35.982

1. Our AMA will continue to assist states in opposing legislation that would allow for the independent practice of certified registered nurse practitioners.
 2. Our AMA will assist state medical societies and specialty organizations that seek to enact legislation that would define the valued role of mid-level and other health care professionals within a physician-led team based model structured to efficiently deliver optimal quality patient care and to assure patient safety.
 3. Our AMA will actively oppose health care teams that are not physician-led.
- [Res. 240, A-13; Reaffirmation A-15]

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.

[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: 210
(I-23)

Introduced by: Medical Student Section

Subject: Immigration Status in Medicaid and CHIP

Referred to: Reference Committee B

1 Whereas, our American Medical Association has numerous policies calling for adequate federal
2 reimbursement for care for undocumented immigrants; and
3

4 Whereas, our AMA specifically supports Medicaid coverage for undocumented immigrants for
5 scheduled, outpatient, non-emergency maintenance dialysis and for healthcare during
6 pregnancy and up to 12 months postpartum; and
7

8 Whereas, our AMA “supports extending eligibility to purchase Affordable Care Act (ACA)
9 marketplace coverage to undocumented immigrants and Deferred Action for Childhood Arrivals
10 (DACA) recipients” and “recognizes the potential for state and local initiatives to provide
11 coverage to immigrants without regard to immigration status”; and
12

13 Whereas, in June 2023, our AMA wrote a letter to the Centers for Medicare and Medicaid
14 Services (CMS) supporting proposed regulations to extend Medicaid, Children’s Health
15 Insurance Program (CHIP), and ACA plans to Deferred Action for Childhood Arrivals (DACA)
16 participants and also expressing to CMS our stance on ACA coverage for undocumented
17 immigrants¹; and
18

19 Whereas, in the US, only documented adults and children (permanent residents, current visa
20 holders, and those with active refugee, asylum, trafficking, or another qualified or protected
21 status) are eligible for Medicaid and CHIP²; and
22

23 Whereas, undocumented immigrants are ineligible for Medicaid and CHIP aside from
24 emergency coverage and therefore only receive insurance through their employer, through their
25 educational institution if they are a student, or if purchased out-of-pocket²; and
26

27 Whereas, 11 million undocumented immigrants (including 650,000 DACA participants) reside in
28 the US, and over 5 million (nearly half) live in California, New York, and Texas³; and
29

30 Whereas, 5 million undocumented immigrants (nearly half) are completely uninsured, 2 to 3
31 times the uninsured rate among documented immigrants, 4 times the uninsured rate among
32 citizens, and 20% of the entire US uninsured population⁴; and
33

34 Whereas, about 20% of undocumented adults and over 30% of undocumented children live in
35 poverty, with a median household income of \$36,000, or 120% of the Federal Poverty Level
36 (FPL) threshold for a household of four⁵⁻⁶; and

Whereas, the median undocumented household income of 120% FPL is below the 138% FPL threshold for Medicaid eligibility in expansion states and well below the national average threshold for CHIP at 255% FPL⁵⁻⁷; and

Whereas, in addition to ethical considerations for coverage, fiscal concerns are alleviated by consistent data demonstrating that undocumented immigrants pay billions in federal and state taxes annually while receiving no public benefits in return, and if given some federal status, contributions to federal public funds would only increase⁸; and

Whereas, undocumented immigrants are and will continue to be a long-term part of American society, as the average individual has resided in the US for 15 years⁹; and

Whereas, while undocumented immigrants can sometimes access outpatient primary care at public and charity clinics, access to specialty or hospital care is greatly limited⁴; and

Whereas, while all hospitals are required to screen and stabilize undocumented immigrants in emergency departments, much of this care is costlier than necessary due to lack of earlier treatment and may then go uncompensated, and require being offset by public funds anyway, which could instead fund comprehensive outpatient coverage from the start¹⁰; and

Whereas, California, one of the states with the largest undocumented population, expanded Medicaid and CHIP to all otherwise eligible undocumented immigrants¹¹; and

Whereas, New York, one of the states with the largest undocumented population, expanded Medicaid to DACA participants and CHIP to undocumented children¹²; and

Whereas, expansion of Medicaid and CHIP to undocumented immigrants would significantly reduce the uninsured rate, increase reimbursement for physicians and hospitals providing uncompensated care, and avoid cost and resource burdens to the health system by promoting preventive, chronic, outpatient care over emergency and inpatient care; therefore be it

RESOLVED, that our American Medical Association advocate for the removal of eligibility criteria based on immigration status from Medicaid and CHIP. (Directive to Take Action)

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

Received: 09/27/2023

REFERENCES

1. Re: Clarifying Eligibility for a Qualified Health Plan Through an Exchange, Advance Payments of the Premium Tax Credit, Cost-Sharing Reductions, a Basic Health Program, and for Some Medicaid and Children's Health Insurance Programs for Deferred Action for Childhood Arrivals Recipients [CMS-9894-P]. American Medical Association. Published June 23, 2023. <https://searchlf.ama-assn.org/letter/documentDownload?url=%2FUnstructured%2Fbinary%2Fletter%2FLETTERS%2Ffisc.zip%2F2023-6-23-Letter-to-Becerra-and-Brooks-LaSure-re-NPRM-to-Expand-Healthcare-to-DACA-Recipients-v2.pdf>
2. Coverage for Lawfully Present Immigrants. Healthcare.Gov. Accessed April 30, 2023. <https://www.healthcare.gov/immigrants/lawfully-present-immigrants>
3. Capps R, Gelatt J, Ruiz Soto AG, Van Hook J. Unauthorized Immigrants in the United States: Stable Numbers, Changing Origin. Migration Policy Institute Published December 2020. Accessed April 30, 2023. https://www.migrationpolicy.org/sites/default/files/publications/mpi-unauthorized-immigrants-stablenumbers-changingorigins_final.pdf
4. Artiga S, Diaz M. Health Coverage and Care of Undocumented Immigrants. Kaiser Family Foundation. Published July 15, 2019. Accessed April 30, 2023. <https://www.kff.org/racial-equity-and-health-policy/issue-brief/health-coverage-and-care-of-undocumented-immigrants>
5. Passel JS, Cohn D. A Portrait of Unauthorized Immigrants in the United States. Pew Research Center. Published April 14, 2009. Accessed April 30, 2023. <https://www.pewresearch.org/hispanic/2009/04/14/a-portrait-of-unauthorized-immigrants-in-the-united-states>

6. Federal Poverty Level (FPL). Healthcare.Gov. Accessed April 30, 2023. <https://www.healthcare.gov/glossary/federal-poverty-level-fpl>
7. Medicaid and CHIP Income Eligibility Limits for Children as a Percent of the Federal Poverty Level. Published January 1, 2023. Accessed April 30, 2023. <https://www.kff.org/health-reform/state-indicator/medicaid-and-chip-income-eligibility-limits-for-children-as-a-percent-of-the-federal-poverty-level>
8. Medicaid and CHIP Income Eligibility Limits for Children as a Percent of the Federal Poverty Level. Published January 1, 2023. Accessed April 30, 2023. <https://www.kff.org/health-reform/state-indicator/medicaid-and-chip-income-eligibility-limits-for-children-as-a-percent-of-the-federal-poverty-level>
9. Campoy A. The typical undocumented immigrant has been in the US for over a decade. Quartz. Published June 12, 2019. Accessed September 27, 2023. <https://qz.com/1641076/how-long-the-typical-undocumented-immigrant-has-been-in-the-us>
10. Undocumented Aliens: Questions Persist about Their Impact on Hospitals' Uncompensated Care Costs. Government Accountability Office. Published May 21, 2004. Accessed April 30, 2023. <https://www.gao.gov/products/gao-04-472>
11. Beam A, Thompson D. California first to cover health care for all immigrants. Published July 1, 2022. Accessed September 27, 2023. <https://apnews.com/article/health-california-immigration-gavin-newsom-medicare-b09edcb2b89ab041b520f431f8aab4b6>
12. Immigrants - Your Health Insurance Options. NYC Health Insurance Link. <https://www.nyc.gov/site/ochia/find-what-fits/immigrants.page>

RELEVANT AMA POLICY

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

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 by Ref. Cmt. B, A-96; Reaffirmation A-02; Reaffirmation A-07; Reaffirmed: BOT Rep. 22, A-17; Reaffirmation: A-19; Reaffirmation: I-19]

D-440.985 Health Care Payment for Undocumented Persons

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. 01, A-17; Reaffirmation: A-19; Reaffirmation: I-19]

H-130.967 Action Regarding Illegal Aliens

Our AMA supports the legislative and regulatory changes that would require the federal government to provide reasonable payment for federally mandated medical screening examinations and further examination and treatment needed to stabilize a condition in patients presenting to hospital emergency departments, when payment from other public or private sources is not available. [BOT Rep. MM, A-89; Reaffirmed by BOT Rep. 17 - I-94; Reaffirmed by Ref. Cmt. B, A-96; Reaffirmation A-02; Reaffirmation A-07; Reaffirmed: BOT Rep. 22, A-17]

H-290.957 Medicaid Dialysis Policy for Undocumented Patients

Our AMA will work with the Centers for Medicare and Medicaid Services and state Medicaid programs to cover scheduled outpatient maintenance dialysis for undocumented patients with end stage kidney disease under Emergency Medicaid. [Res. 121, A-21]

D-290.974 Extending Medicaid Coverage for One Year Postpartum

Our AMA will work with relevant stakeholders to: (1) support and advocate, at the state and federal levels, for extension of Medicaid and Children's Health Insurance Program (CHIP) coverage to at least 12 months after the end of pregnancy; and (2) expand Medicaid and CHIP eligibility for pregnant and postpartum non-citizen immigrants. [Res. 221, A-19; Modified: Joint CMS/CSAPH Rep. 1, I-21; Modified: Res. 701, I-21]

H-165.823 Options to Maximize Coverage under the AMA Proposal for Reform

1. That our AMA advocate for a pluralistic health care system, which may include a public option, that focuses on increasing equity and access, is cost-conscious, and reduces burden on physicians.

2. Our AMA will advocate that any public option to expand health insurance coverage must meet the following standards:

a. The primary goals of establishing a public option are to maximize patient choice of health plan and maximize health plan marketplace competition.

b. Eligibility for premium tax credit and cost-sharing assistance to purchase the public option is restricted to individuals without access to affordable employer-sponsored coverage that meets standards for minimum value of benefits.

- c. Physician payments under the public option are established through meaningful negotiations and contracts. Physician payments under the public option must be higher than prevailing Medicare rates and at rates sufficient to sustain the costs of medical practice.
 - d. Physicians have the freedom to choose whether to participate in the public option. Public option proposals should not require provider participation and/or tie physician participation in Medicare, Medicaid and/or any commercial product to participation in the public option.
 - e. The public option is financially self-sustaining and has uniform solvency requirements.
 - f. The public option does not receive advantageous government subsidies in comparison to those provided to other health plans.
 - g. The public option shall be made available to uninsured individuals who fall into the “coverage gap” in states that do not expand Medicaid – having incomes above Medicaid eligibility limits but below the federal poverty level, which is the lower limit for premium tax credits – at no or nominal cost.
3. Our AMA supports states and/or the federal government pursuing auto-enrollment in health insurance coverage that meets the following standards:
- a. Individuals must provide consent to the applicable state and/or federal entities to share their health insurance status and tax data with the entity with the authority to make coverage determinations.
 - b. Individuals should only be auto-enrolled in health insurance coverage if they are eligible for coverage options that would be of no cost to them after the application of any subsidies. Candidates for auto-enrollment would, therefore, include individuals eligible for Medicaid/Children’s Health Insurance Program (CHIP) or zero-premium marketplace coverage.
 - c. Individuals should have the opportunity to opt out from health insurance coverage into which they are auto-enrolled.
 - d. Individuals should not be penalized if they are auto-enrolled into coverage for which they are not eligible or remain uninsured despite believing they were enrolled in health insurance coverage via auto-enrollment.
 - e. Individuals eligible for zero-premium marketplace coverage should be randomly assigned among the zero-premium plans with the highest actuarial values.
 - f. Health plans should be incentivized to offer pre-deductible coverage including physician services in their bronze and silver plans, to maximize the value of zero-premium plans to plan enrollees.
 - g. Individuals enrolled in a zero-premium bronze plan who are eligible for cost-sharing reductions should be notified of the cost-sharing advantages of enrolling in silver plans.
 - h. There should be targeted outreach and streamlined enrollment mechanisms promoting health insurance enrollment, which could include raising awareness of the availability of premium tax credits and cost-sharing reductions, and establishing a special enrollment period.
4. Our AMA: (a) will advocate that any federal approach to cover uninsured individuals who fall into the “coverage gap” in states that do not expand Medicaid--having incomes above Medicaid eligibility limits but below the federal poverty level, which is the lower limit for premium tax credit eligibility--make health insurance coverage available to uninsured individuals who fall into the coverage gap at no or nominal cost, with significant cost-sharing protections; (b) will advocate that any federal approach to cover uninsured individuals who fall into the coverage gap provide states that have already implemented Medicaid expansions with additional incentives to maintain their expansions; (c) supports extending eligibility to purchase Affordable Care Act (ACA) marketplace coverage to undocumented immigrants and Deferred Action for Childhood Arrivals (DACA) recipients, with the guarantee that health plans and ACA marketplaces will not collect and/or report data regarding enrollee immigration status; and (d) recognizes the potential for state and local initiatives to provide coverage to immigrants without regard to immigration status. [CMS Rep. 1, I-20; Appended: CMS Rep. 3, I-21; Reaffirmation: A-22; Reaffirmed: CMS Rep. 3, A-22; Reaffirmed: Res. 122, A-22; Modified: Res. 813, I-22]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 213
(I-23)

Introduced by: Medical Student Section

Subject: Health Technology Accessibility for Aging Patients

Referred to: Reference Committee B

1 Whereas, recent advancements in health technology (wearable devices, smartphone apps,
2 telehealth, patient portals, and EHR access) may not be accessible to older patients¹⁻²; and
3

4 Whereas, older adults' fears of loss of independence can be exacerbated by increasing reliance
5 on younger caregivers to navigate technology, especially during the COVID pandemic³⁻⁵; and
6

7 Whereas, research shows that many subpopulations of older adults, including those with
8 dementia, want to use and benefit from health technology in increased independence, security,
9 and quality of life, but struggle to learn and find and receive assistance⁶⁻⁸; and
10

11 Whereas, while no standardized definition of "age-friendliness" in technology exists, successful
12 examples include simpler design components and user interfaces, larger font sizes, improved
13 visual contrast, fewer multitasking features, predictable and non-startling sounds, captions,
14 reassurance of data safety, and reduced reliance on manual dexterity⁹⁻¹²; and
15

16 Whereas, the National Health and Aging Trends Study reports that more than 1 in 4 Americans
17 over the age of 71 have visual impairment¹³; and
18

19 Whereas, patients with visual impairment risk privacy when using third-party software such as
20 screen readers and mobile devices to receive their health information¹⁴⁻¹⁵; and
21

22 Whereas, studies show that telehealth and online chat services during the pandemic were not
23 compatible with third-party screen readers¹⁶; and
24

25 Whereas, in 2019, the National Federation of the Blind sued Epic for inaccessible software, with
26 Epic typically working case-by-case with individual systems to integrate screen readers¹⁷⁻¹⁸; and
27

28 Whereas, accessible electronic health records for patients with visual impairment improves
29 quality of care and increases patient agency in their healthcare decisions^{16,19-22}; and
30

31 Whereas, regulations require extending accessibility of digital documentation to people with
32 physical, sensory, and cognitive disabilities²³; and
33

34 Whereas, AMA Policy D-115.990 "Prescription Container Labeling" seeks to "improve
35 prescription labeling for visually or otherwise impaired patients"; and
36

37 Whereas, advance care plans are often stored in physical format, with patients being
38 inconvenienced by needing to maintain multiple printed copies, regularly inform various close
39 contacts of updated decisions, and bring copies to any healthcare encounter²⁴⁻²⁵; and

Whereas, asking patients to keep photos of advance care plans on phones or rely on family to express wishes are unreliable and can lead to outcomes contradicting patient wishes²⁶⁻³⁰; and

Whereas, family and caregivers are not optimal proxies for communicating advance care plans, as over one-third of surrogates do not know patients' DNR statuses and over one-fourth report DNR statuses incongruent with documentation²⁶; and

Whereas, a 2018 study showed that over half of advance care plans at one metropolitan VA hospital were stored as free text in progress notes instead of the designated centralized location, including 70% of documents declaring changes from previous orders, and 50% lacked accompanying explanatory information from patient discussions³¹; therefore be it

RESOLVED, that our American Medical Association support the development of a standardized definition of "age-friendliness" in health information technology (HIT) advancements New HOD Policy); and be it further

RESOLVED, that our AMA encourage appropriate parties to identify current best practices to set expectations of HIT developers to ensure that they create devices and technology applicable to and easily accessible by older adults (New HOD Policy); and be it further

RESOLVED, that our AMA work with relevant organizations to encourage the utilization of industry standards of web content accessibility to make electronic health record software accessible for patients with visual impairments without requiring them to use third-party programs (Directive to Take Action); and be it further

RESOLVED, that our AMA require EHR providers to provide standardized, easily accessible digital storage space for advance care paperwork. (New HOD Policy)

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

Received: 09/27/2023

REFERENCES

1. Dunne N. How healthcare is changing in the digital age. World Economic Forum. Published September 6, 2017. Accessed August 24, 2021. <https://www.weforum.org/agenda/2017/09/health-digital-age>
2. Lam K, Lu AD, Shi Y, Covinsky KE. Assessing Telemedicine Unreadiness Among Older Adults in the United States During the COVID-19 Pandemic. *JAMA Intern Med*. 2020;180(10):1389-1391.
3. Lindquist LA, Ramirez-Zohfeld V, Forcucci C, Sunkara P, Cameron KA. Overcoming Reluctance to Accept Home-Based Support from an Older Adult Perspective. *J Am Geriatr Soc*. 2018;66(9). doi:10.1111/jgs.15526
4. Vaportzis E, Clausen MG, Gow AJ. Older Adults Perceptions of Technology and Barriers to Interacting with Tablet Computers: A Focus Group Study. *Front Psychol*. 2017;8:1687.
5. Cosco TD, Fortuna K, Wister A, Riadi I, Wagner K, Sixsmith A. COVID-19, Social Isolation, and Mental Health Among Older Adults: A Digital Catch-22. *J Med Internet Res*. 2021;23(5):e21864.
6. Lorenz K, Freddolino PP, Comas-Herrera A, Knapp M, Damant J. Technology-based tools and services for people with dementia and carers: Mapping technology onto the dementia care pathway. *Dementia*. 2019;18(2):725-741.
7. Scheibe M, Lang C, Druschke D, et al. Independent Use of a Home-Based Telemonitoring App by Older Patients With Multimorbidity and Mild Cognitive Impairment: Qualitative Study. *JMIR Hum Factors*. 2021;8(3):e27156.
8. Diaz-Orueta U, Hopper L, Konstantinidis E. Shaping technologies for older adults with and without dementia: Reflections on ethics and preferences. *Health Informatics J*. 2020;26(4):3215-3230.
9. Bryant M. How technologies can help the elderly age at home. Published February 16, 2017. Accessed September 16, 2021. <https://www.healthcarediver.com/news/how-technologies-can-help-the-elderly-age-at-home/436386>
10. Usability for Seniors: Challenges and Changes. Accessed September 16, 2021. <https://www.nngroup.com/articles/usability-for-senior-citizens/>
11. Rouzaud Laborde C, Cenko E, Mardini MT, et al. Satisfaction, Usability, and Compliance With the Use of Smartwatches for Ecological Momentary Assessment of Knee Osteoarthritis Symptoms in Older Adults: Usability Study. *JMIR Aging*. 2021;4(3):e24553.
12. Pak R, McLaughlin AC. *Aging, Technology and Health*. London: Elsevier; 2018.
13. Killeen OJ, De Lott LBJ, Zhou Y, et al. Population Prevalence of Vision Impairment in US Adults 71 Years and Older: The National Health and Aging Trends Study. *JAMA Ophthalmol*. 2023;141(2):197-204. doi:10.1001/jamaophthalmol.2022.5840

14. Keskin OF, Caramancion KM, Tatar I, Raza O, Tatar U. Cyber Third-Party Risk Management: A Comparison of Non-Intrusive Risk Scoring Reports. *Electronics*. 2021;10(10):1168. doi:10.3390/electronics10101168.
15. Ahmed T, Hoyle R, Connelly K, Crandall D, Kapadia A. Privacy Concerns and Behaviors of People with Visual Impairments. In: *Proceedings of the 33rd Annual ACM Conference on Human Factors in Computing Systems*. ACM; 2015:3523-3532. doi:10.1145/2702123.2702334.
16. Flatten Inaccessibility: How COVID-19 Impacted Adults Who Are Blind, Have Low Vision, or Are Deafblind Early in the Pandemic. The American Foundation for the Blind. Accessed March 12, 2022. <https://www.afb.org/research-and-initiatives/flatten-inaccessibility-survey>.
17. Clockwork.net. National Federation of the Blind Sues Epic Systems: New Chapter in Accessibility Litigation for Employers and Technology Vendors - Fredrikson & Byron · Fredrikson & Byron, P.A. Fredrikson & Byron. Accessed March 12, 2022. https://www.fredlaw.com/internet_technology_trademark_advertising_alerts/2019/01/09/2054/national_federation_of_the_blind_sues_epic_systems_new_chapter_in_accessibility_litigation_for_employers_and_technology_vendors
18. Supporting Accessible Scheduling Software for Blind and Low-Vision Users. EpicShare. Accessed March 9, 2022. <https://www.epicshare.org/share-and-learn/supporting-accessible-scheduling-software-for-blind-and-low-vision-users>.
19. Healthcare Accessibility - Going Beyond Ramps and Elevators. Equidox. Published May 15, 2019. Accessed April 15, 2022. <https://equidox.co/blog/healthcare-accessibility-going-beyond-ramps-and-elevators>
20. Yi YJ. Web accessibility of healthcare Web sites of Korean government and public agencies: a user test for persons with visual impairment. *Univ Access Inf Soc*. 2020;19(1):41-56. doi:10.1007/s10209-018-0625-5.
21. Rosner Y, Perlman A. The Effect of the Usage of Computer-Based Assistive Devices on the Functioning and Quality of Life of Individuals who are Blind or have low Vision. *Journal of Visual Impairment & Blindness*. 2018;112(1):87-99. doi:10.1177/0145482X1811200108.
22. How Can an Accessible EHR Experience Benefit Patients With Disabilities? Accessed April 15, 2022. <https://www.ironbridgecorp.com/blog/how-can-an-accessible-ehr-experience-benefit-patients-with-disabilities>
23. U.S. Access Board - Information and Communication Technology. Accessed March 12, 2022. <https://www.access-board.gov/ict.html>
24. Huber MT, Highland JD, Krishnamoorthi VR, Tang JW. Utilizing the Electronic Health Record to Improve Advance Care Planning: A Systematic Review. *Am J Hosp Palliat Care*. 2018;35(3). doi:10.1177/1049909117715217
25. Advance Care Planning: Health Care Directives. Accessed September 15, 2021. <http://www.nia.nih.gov/health/advance-care-planning-health-care-directives>
26. Cunico G, Aivazidou E, Mollona E. Beyond financial proxies in Cohesion Policy inputs' monitoring: A system dynamics approach. *Eval Program Plann*. 2021;89:101964.
27. Tsiaperas T. Doctors ignored dying mom's DNR order, family says in suit against Methodist Health. *The Dallas Morning News*. <https://www.dallasnews.com/news/courts/2017/05/12/doctors-ignored-dying-mom-s-dnr-order-family-says-in-suit-against-methodist-health/>. Published May 12, 2017. Accessed September 15, 2021.
28. Span P. The Patients Were Saved. That's Why the Families Are Suing. *The New York Times*. <https://www.nytimes.com/2017/04/10/health/wrongful-life-lawsuit-dnr.html>. Published April 10, 2017. Accessed September 15, 2021.
29. Pope TM. Legal Briefing: New Penalties for Ignoring Advance Directives and Do-Not-Resuscitate Orders. *J Clin Ethics*. 2017;28(1). Accessed September 15, 2021. <https://pubmed.ncbi.nlm.nih.gov/28436933H-480.937>
30. Dillon E, Chuang J, Gupta A, et al. Provider Perspectives on Advance Care Planning Documentation in the Electronic Health Record: The Experience of Primary Care Providers and Specialists Using Advance Health-Care Directives and Physician Orders for Life-Sustaining Treatment. *Am J Hosp Palliat Care*. 2017;34(10). doi:10.1177/1049909117693578
31. Walker E, McMahan R, Barnes D, Katen M, Lamas D, Sudore R. Advance Care Planning Documentation Practices and Accessibility in the Electronic Health Record: Implications for Patient Safety. *J Pain Symptom Manage*. 2018;55(2):256. doi:10.1016/j.jpainsymman.2017.09.018

RELEVANT AMA POLICY

H-480.937 Addressing Equity in Telehealth

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. [CMS Rep. 7, A-21; Reaffirmation: A-22; Reaffirmed: Res. 213, A-23; Reaffirmation: A-23]

D-140.953 Timely Promotion and Assistance in Advance Care Planning and Advance Directives

Our AMA will: (1) begin a low cost in-house educational effort aimed at physicians, to include relevant billing and reimbursement information, encouraging physicians to lead by example and complete their own advance directives; (2) encourage practicing physicians to voluntarily publicize the fact of having executed our own advance directives, and to share readily available educational materials regarding the importance and components of advance directives in offices and on practice websites, as a way of starting the conversation with patients and families; (3) strongly encourage all physicians of relevant specialties providing primary or/and advanced illness care to include advance care planning as a routine part of their patient care protocols when indicated, including advance directive documentation in patients' medical records (including electronic medical records), as a suggested standard health maintenance practice; (4) collaborate (prioritized and made more urgent by the ongoing COVID-19 pandemic) with stakeholder groups, such as legal, medical, hospital, medical education, and faith-based communities as well as interested citizens, to promote completion of advance directives by all individuals who are of legal age and competent to make healthcare decisions, and to promote the adoption and use of electronic systems to make patients' advance directives readily available to treatment teams regardless of location; and (5) actively promote the officially recognized designation of April 16 as National Healthcare Decisions Day. [Res. 602, A-21]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 215
(I-23)

Introduced by: Medical Student Section

Subject: A Public Health-Centered Criminal Justice System

Referred to: Reference Committee B

1 Whereas, our AMA supports ending cash bail, jail diversion programs, drug and veteran courts,
2 compassionate release, and research into alternatives to incarceration; and
3

4 Whereas, the US has the highest incarceration rates in the world with over 2.1 million people in
5 prison in 2018, causing significant harm to individual and community health¹⁻⁵; and
6

7 Whereas, despite homicide rates staying consistent, the number of people imprisoned for
8 violent crimes increased by 300% from 1980 to 2009^{2,3}; and
9

10 Whereas, people incarcerated in the US experience higher rates of nearly all infections,
11 including HIV, STIs, TB, HCV, COVID, and quadruple the rate of mental illness, due in part to
12 crowding, squalor, solitary confinement, assault, and reduced healthcare access⁶⁻¹⁸; and
13

14 Whereas, individuals face a 250% greater mortality risk in the first 2 years after release,
15 including extremely disproportionate risk of drug overdose¹⁵; and
16

17 Whereas, racial injustice in police, jury selection, and courts impose the brunt of the carceral
18 system's abuses on individuals from Black and other minoritized communities²⁵⁻³⁰; and
19

20 Whereas, up to 45% of people are imprisoned due to technical parole violations, rather than
21 offenses that truly cause harm to communities and exacerbating crowding³¹; and
22

23 Whereas, mandatory minimums require judges to sentence offenders to a pre-specified
24 minimum sentence for a particular crime, but are not effective for decreasing crime, with for
25 example cocaine use rates remaining unchanged despite mandatory minimums³²⁻³⁴; and
26

27 Whereas, despite the attempt at standardization under mandatory minimums, minimums are
28 higher for offenses disproportionately used to charge Black individuals and are more often
29 enforced against Black defendants by prosecutors compared to white defendants, even for the
30 same charge, as prosecutors gain greater influence in deciding when to prosecute³⁵⁻³⁸; and
31

32 Whereas, "three-strikes" policies significantly increase the sentence for subsequent felonies
33 after two previous felonies on record, which means that in some states, an individual charged
34 with more than two felonies at one time can receive all three strikes at once³⁹⁻⁴¹; and
35

36 Whereas, three-strikes policies consistently fail to reduce recidivism, generate massive
37 economic burden, and further detract from effective reentry into society^{39,42}; and

Whereas, three-strikes policies and mandatory minimum sentencing deprive judges of the ability to tailor sentencing based on mitigating factors⁴³⁻⁴⁶; and

Whereas, individuals age 65 and older are the fastest growing demographic among those incarcerated, due in part to longer sentences, resulting in a population that requires greater care for chronic illness and disabilities and support for activities of daily living⁴⁷; and

Whereas, the bipartisan 2018 First Step Act was signed by President Trump, lowering mandatory minimums, easing the three-strike rule, and increasing good time credits and earned time credits, but only affects the 7% of individuals incarcerated in federal prisons⁴⁴⁻⁴⁹; and

Whereas, survivors of violence themselves report preferences for undergo violence prevention training for perpetrators instead of incarceration, short sentences and rehabilitation, and funds and resources for social programs for youth over increased investment in prisons⁵⁴; and

Whereas, multiple analyses of real-world federal, state, and international efforts conclude that both crime and recidivism do not increase with reduced prison sentences⁵⁵⁻⁵⁸; therefore be it

RESOLVED, that our American Medical Association support legislation that reduces the negative health impacts of incarceration by:

- a. advocating for decreasing the magnitude of penalties, including the length of prison sentences, to create a criminal justice model focused on citizen safety and improved public health outcomes and rehabilitative practices rather than retribution,
- b. advocating for legislation and regulations that reduce the number of people placed in prison conditions, such as preventing people who were formerly incarcerated from being sent back to prison without justifiable cause, and
- c. supporting the continual review of sentences for people at various time points of their sentence to enable early release of people who are incarcerated but unlikely to pose a risk to society (Directive to Take Action); and be it further

RESOLVED, that our AMA (1) recognize the inefficacy of mandatory minimums and three-strike rules and the negative consequences of resultant longer prison sentences to the health of incarcerated individuals, and (2) support legislation that reduces or eliminates mandatory minimums and three-strike rules. (New HOD Policy)

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

Received: 09/27/2023

REFERENCES

1. Walmsley, R. 2018. World Prison Population List. Institute for Criminal Policy Research, 12, pp.1-19. Retrieved from: <https://www.prisonstudies.org/sites/default/files/resources/downloads/wppl_12.pdf>.
2. Cooper, A and Smith, E. 2011. Homicide Trends in the United States, 1980-2008. Bureau of Justice Statistics. Retrieved from: <<https://bjs.ojp.gov/content/pub/pdf/htus8008.pdf>>.
3. The Next Step: Ending Excessive Punishment for Violent Crimes. 2020. The Sentencing Project. Retrieved from <<https://www.sentencingproject.org/wp-content/uploads/2019/03/The-Next-Step.pdf>>.
4. Thomas, J and Torrone, E. 2008. Incarceration as Forced Migration: Effects on Selected Community Health Outcomes. American Journal of Public Health, 98(Supplement_1), pp.S181-S184.
5. Olson, S and Anderson, K. 2020. The effects of incarceration and reentry on community health and well-being. National Academies of Sciences, Engineering, and Medicine.
6. Saloner, B, Parish, K, Ward, J, DiLaura, G. and Dolovich, S. 2020. COVID-19 Cases and Deaths in Federal and State Prisons. JAMA, 324(6), pp.602.
7. Morris, M, Brown, B and Allen, S. 2017. Universal opt-out screening for hepatitis C virus (HCV) within correctional facilities is an effective intervention to improve public health. International Journal of Prisoner Health, 13(3/4), pp.192-199.
8. Davis DM, Bello JK, Rottnek F. 2018. Care of Incarcerated Patients. Am Fam Physician, 98(10), pp. 577-583.
9. Kessler RC, Avenevoli S, Costello EJ, et al. 2009. Design and field procedures in the US National Comorbidity Survey Replication Adolescent Supplement (NCS-A). Int J Methods Psychiatr Res;18(2), pp. 69-83. doi:10.1002/mpr.279.

10. Substance Abuse and Mental Health Services Administration, 2020. Key substance use and mental health indicators in the United States. Results from the 2019 National Survey on Drug Use and Health. Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. Available at: <<https://www.samhsa.gov/data/>>.
11. Cloud DH, Drucker E, Browne A, Parsons J. 2015. Public Health and Solitary Confinement in the United States. *Am J Public Health*, 105(1), pp. 18-26. doi:10.2105/AJPH.2014.302205.
12. Brinkley-Rubinstein L, Sivaraman J, Rosen DL, et al. 2019. Association of Restrictive Housing During Incarceration With Mortality After Release. *JAMA Netw Open*, 2(10):e1912516. doi:10.1001/jamanetworkopen.2019.12516.
13. Beck A. 2015. Use of Restrictive Housing in U.S. Prisons and Jails, 2011–12. U.S. Department of Justice. Retrieved from: <<https://www.bjs.gov/content/pub/pdf/urhuspj1112.pdf>>.
14. Paynter MJ, Drake EK, Cassidy C, Snelgrove-Clarke E. 2019. Maternal health outcomes for incarcerated women: A scoping review. *J Clin Nurs*, 28(11-12), pp. 2046-2060. doi:10.1111/jocn.14837.
15. Binswanger IA, Stern MF, Deyo RA, et al. 2007. Release from prison- a high risk of death for former inmates. *N Engl J Med*, 356(2), pp.157-165. doi:10.1056/NEJMsa064115.
16. Heard-Garris N, Winkelman TNA, Choi H, et al. 2019. Health Care Use and Health Behaviors Among Young Adults With History of Parental Incarceration. *Pediatrics*, 142(3):e20174314. doi:10.1542/peds.2017-4314.
17. Heard-Garris N, Sacotte KA, Winkelman TNA, et al. 2019. Association of Childhood History of Parental Incarceration and Juvenile Justice Involvement With Mental Health in Early Adulthood. *JAMA Netw Open*, 2(9):e1910465. doi:10.1001/jamanetworkopen.2019.10465.
18. Barnert ES, Perry R, Morris RE. 2016. How Does Incarcerating Young People Affect Their Adult Health Outcomes? *Academic Pediatrics*, 16:99–109.
19. Couloute, L. and Kopf, D., 2021. Out of Prison & Out of Work: Unemployment among formerly incarcerated people. Northampton, MA: Prison Policy Initiative. Retrieved from: <<https://www.prisonpolicy.org/reports/outofwork.html>>.
20. Berghuis M. 2018. Reentry programs for adult male offender recidivism and reintegration: A systematic review and meta-analysis. *International journal of offender therapy and comparative criminology*, 62(14), pp. 4655-76.
21. Visher CA, Lattimore PK, Barrick K, Tueller S. 2017. Evaluating the long-term effects of prisoner reentry services on recidivism: What types of services matter? *Justice Quarterly*, 34(1), pp. 136-65.
22. Baquero M, Zweig K, Angell SY, Meropol SB. 2020. Health Behaviors and Outcomes Associated With Personal and Family History of Criminal Justice System Involvement, New York City, 2017. *Am J Public Health*, 110(3), pp. 378-384. doi:10.2105/AJPH.2019.305415.
23. Testa A, Jackson DB, Vaughn MG, Bello JK. 2020. Incarceration as a unique social stressor during pregnancy: Implications for maternal and newborn health. *Soc Sci Med*, 246:112777. doi:10.1016/j.socscimed.2019.112777.
24. Wildeman C, Wang EA. 2017. Mass incarceration, public health, and widening inequality in the USA. *Lancet*, 389(10077), pp.1464-1474. doi:10.1016/S0140-6736(17)30259-3.
25. Equal Justice Initiative, 2010. Illegal Racial Discrimination in Jury Selection: A Continuing Legacy. Montgomery, AL: Library of Congress. Retrieved from: <<https://lccn.loc.gov/2016417619>>.
26. Taylor, C., 2013. Introduction: African Americans, Police Brutality, and the U.S. Criminal Justice System. *The Journal of African American History*, 98(2), pp.200-204.
27. American Civil Liberties Union, 2020. A Tale of Two Countries Racially Targeted Arrests in the Era of Marijuana Reform. Retrieved from: <https://www.aclu.org/sites/default/files/field_document/tale_of_two_countries_racially_targeted_arrests_in_the_era_of_marijuana_reform_revised_7.1.20_0.pdf>.
28. Duarte CDP, Salas-Hernández L, Griffin JS. 2020. Policy Determinants of Inequitable Exposure to the Criminal Legal System and Their Health Consequences Among Young People. *Am J Public Health*, 110(S1), pp. S43-S49. doi:10.2105/AJPH.2019.305440.
29. Camplain R, Camplain C. 2020. Racial/Ethnic Differences in Drug- and Alcohol-Related Arrest Outcomes in a Southwest County From 2009 to 2018. *Am J Public Health*, 110(Suppl 1): S85–S92.
30. Bop.gov. 2021. BOP Statistics: Inmate Offenses. Retrieved from: <https://www.bop.gov/about/statistics/statistics_inmate_offenses.jsp> [Accessed 5 November 2021].
31. The Council of State Governments Justice Center, 2019. Confined and Costly: How Supervision Violations Are Filling Prisons and Burdening Budgets. Bureau of Justice Assistance, Office of Justice Programs, U.S. Department of Justice. Retrieved from: <<https://csgjusticecenter.org/publications/confined-costly/>>.
32. Neely CR. 2021. Mandatory minimums: equal but unequal. *SSRN Electronic Journal*. doi:10.2139/ssrn.3771980.
33. Walker LS, Mezuk B. 2018. Mandatory minimum sentencing policies and cocaine use in the U.S., 1985-2013. *BMC Int Health Hum Rights*, 18(1), pp. 43. doi:10.1186/s12914-018-0182-2.
34. Wodak D. 2018. Mandatory Minimums and the War on Drugs. *The Palgrave Handbook of Philosophy and Public Policy*. Cham, Switzerland. pp. 51-62. doi.org/10.1007/978-3-319-93907-0_5.
35. Lynch, M, Barno, M, Omori, M. 2021. Prosecutors, court communities, and policy change: The impact of internal DOJ reforms on federal prosecutorial practices. *Criminology*, 59, pp. 480– 519. doi: 10.1111/1745-9125.12275.
36. Gillette, C. 2020. Do Mandatory Minimums Increase Racial Disparities in Federal Criminal Sentencing? *Undergraduate Economic Review*, 17(1)9. Retrieved from: <<https://digitalcommons.iwu.edu/uer/vol17/iss1/9>>.
37. Fischman, JB and Schanzenbach, MM. 2012. Racial Disparities Under the Federal Sentencing Guidelines. *Journal of Empirical Legal Studies*, 9, pp. 729-764. doi:10.1111/j.1740-1461.2012.01266.x.
38. Nir E, Liu S. 2021. The Challenge of Imposing Just Sentences Under Mandatory Minimum Statutes: A Qualitative Study of Judicial Perceptions. *Criminal Justice Policy Review*. doi:10.1177/08874034211030555.
39. Tomislav V. Kovandzic, John J. Sloan III & Lynne M. Vieraitis. 2004. "Striking out" as crime reduction policy: The impact of "three strikes" laws on crime rates in U.S. cities. *Justice Quarterly*, 21:2, pp. 207-239, doi: 10.1080/07418820400095791.
40. Reasons to Oppose Three Strikes. American Civil Liberties Union. Retrieved from: <<https://www.aclu.org/other/10-reasons-oppose-3-strikes-youre-out>>.
41. An Overview of the First Step Act. Federal Bureau of Prisons. 2018. Retrieved from: <<https://www.bop.gov/inmates/fsa/overview.jsp>>.

42. McMillon D, Simon CP, Morenoff J. 2014. Modeling the underlying dynamics of the spread of crime. PLoS One, 9(4):e88923. doi:10.1371/journal.pone.0088923.
43. Reasons to Oppose Three Strikes. American Civil Liberties Union. Retrieved from: <<https://www.aclu.org/other/10-reasons-oppose-3-strikes-youre-out>>.
44. Caulkins, JP. 2001. How large should the strike zone be in “three strikes and you’re out” sentencing laws. Journal of Quantitative Criminology, 17, pp. 227-246.
45. Austin, J, Clark, J, Hardyman, P, & Henry, A. 2000. Three strikes and you’re out: The Implementation and impact of strikes laws. National Institute of Justice. Washington, DC:
46. An Overview of the First Step Act. Federal Bureau of Prisons. 2018. Retrieved from: <<https://www.bop.gov/inmates/fsa/overview.jsp>>.
47. Aging Prison Population. National Commission on Correctional Health Care. <https://www.ncchc.org/aging-prison-population>
48. Gramlich, J. 2021. America’s incarceration rate falls to lowest level since 1995. Pew Research Center. Retrieved from: <<https://www.pewresearch.org/fact-tank/2021/08/16/americas-incarceration-rate-lowest-since-1995/>>.
49. Correctional Populations in the United States, 2019 – Statistical Tables. US Department of Justice. Retrieved from: <<https://bjs.ojp.gov/sites/g/files/xyckuh236/files/media/document/cpus19st.pdf>>.
50. Hollinger, A. 2020. Funding Indigent Defense: A Judicial Solution to a Legislative Failure. The George Washington Law Review, 88(195), pp.1-30. Retrieved from: <<https://www.gwlr.org/wp-content/uploads/2020/11/88-Geo.-Wash.-L.-Rev.-Arguendo-195.pdf>>
51. Green, B. 2003. Criminal Neglect: Indigent Defense from a Legal Ethics Perspective Ethics Symposium What Do Clients Want: Practice Contexts. Emory Law Journal, 52(1169), pp.1-32. Retrieved from: <https://ir.lawnet.fordham.edu/faculty_scholarship/272>.
52. Pruitt, L and Colgan, B. 2010. Justice Deserts: Spatial Inequality and Local Funding of Indigent Defense. Arizona Law Review, 52(219), pp.1-98. Retrieved from: <<https://arizonalawreview.org/pdf/52-2/52arizrev219.pdf>>.
53. Fairfax, R. 2013. Searching for Solutions to the Indigent Defense Crisis in the Broader Criminal Justice Reform Agenda. Yale Law Journal, 122(2316), pp.1-20. Retrieved from: <<https://digitalcommons.law.yale.edu/cgi/viewcontent.cgi?article=5584&context=yjlj>>.
54. Alliance for Safety and Justice. 2016. Crime Survivors Speak: The First-Ever National Survey of Victims' Views on Safety and Justice. Oakland, CA: National Institute of Corrections, pp.1-32. Retrieved from: <<https://nicic.gov/crime-survivors-speak-first-ever-national-survey-victims-views-safety-and-justice>>.
55. Bird, M, Lofstrom, M, Martin, B, Raphael, S and Nguyen, V., 2018. The Impact of Proposition 47 on Crime and Recidivism. San Francisco, CA: Public Policy Institute of California, pp.1-32. Retrieved from: <https://www.ppic.org/wp-content/uploads/r_0618mbr.pdf>.
56. Hunt, K and Peterson, A. 2014. Recidivism Among Offenders Receiving Retroactive Sentence Reductions: The 2007 Crack Cocaine Amendment. Washington, D.C.: United States Sentencing Commission, pp.1-19. Retrieved from: <https://www.ussc.gov/sites/default/files/pdf/research-and-publications/research-projects-and-surveys/miscellaneous/20140527_Recidivism_2007_Crack_Cocaine_Amendment.pdf>.
57. Mauer, M. 2018. Long-Term Sentences: Time to Reconsider the Scale of Punishment. The Sentencing Project. Retrieved from: <<https://www.sentencingproject.org/publications/long-term-sentences-time-reconsider-scale-punishment/>>.
58. Sterbenz C. 2014. Why Norway's Prison System is so Successful. Retrieved from <<https://www.businessinsider.com/why-norways-prison-system-is-so-successful-2014-12>>.

RELEVANT AMA POLICY

H-95.931 AMA Support for Justice Reinvestment Initiatives

Our AMA supports justice reinvestment initiatives aimed at improving risk assessment tools for screening and assessing individuals for substance use disorders and mental health issues, expanding jail diversion and jail alternative programs, and increasing access to reentry and treatment programs. [Res. 205, A-16]

H-80.993 Ending Money Bail to Decrease Burden on Lower Income Communities

Our AMA: (1) recognizes the adverse health effects of pretrial detention; and (2) will support legislation that promotes the use of non-financial release options for individuals charged with nonviolent crimes. [Res. 408, A-18; Reaffirmed: Res. 234, A-22]

H-430.980 Compassionate Release for Incarcerated Patients

Our AMA supports policies that facilitate compassionate release for incarcerated patients on the basis of serious medical conditions and advanced age; will collaborate with appropriate stakeholders to develop clear, evidence-based eligibility criteria for timely compassionate release; and promote transparent reporting of compassionate release statistics, including numbers and demographics of applicants, approvals, denials, and revocations, and justifications for decisions. [BOT Rep. 10, I-20]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 216
(I-23)

Introduced by: Senior Physicians Section

Subject: Saving Traditional Medicare

Referred to: Reference Committee B

1 Whereas, Traditional Medicare signed into law on July 30, 1965, by President Lyndon B.
2 Johnson, has provided healthcare coverage to millions of elderly and disabled Americans for
3 decades, and is a vital lifeline for those who rely on it for access to affordable, high-quality
4 healthcare services; and

5
6 Whereas, Traditional Medicare faces challenges such as funding shortfalls, rising healthcare
7 costs, and the progressive take over by alternative private health plans [A.k.a. Medicare
8 “Advantage”] now covering over 50% of the Medicare eligible individuals¹; and

9
10 Whereas, Medicare Advantage plans have strayed from the core mission of Traditional
11 Medicare plans with numerous allegations of potential fraud and waste; and

12
13 Whereas, Medicare Advantage spending [\$7 Trillion over the next decade] is largely driven by
14 star quality rating “bonus” payments currently at \$12.8B [up 30% over 2022]²; and

15
16 Whereas, Whereas, Coding “intensity” by Medicare Advantage plans has resulted in \$23B in
17 overpayments for 2023 with risk scores 10.8% higher than Traditional Medicare^{3,4}; therefore be
18 it

19
20 RESOLVED, That our American Medical Association continue its efforts to fix the flawed
21 Medicare payment system for physicians recognizing that Traditional Medicare is a critical
22 healthcare program while educating the public on the benefits and threats of Medicare Part C
23 expansion (Directive to Take Action); and be it further

24
25 RESOLVED, That our AMA continue to address the funding challenges facing Traditional
26 Medicare through legislative reform and policy changes that increase revenue streams, reduce
27 waste and inefficiency, while at the same time advocating for sustainable, inflation-adjusted
28 reimbursement to clinicians (Directive to Take Action); and be it further

29
30 RESOLVED, That our AMA address Medicare plans overpayments by urging the Department of
31 Justice to prosecute those found complicit in fraudulent activity (Directive to Take Action); and
32 be it further

33
34 RESOLVED, That our AMA advocate for change in CMS risk adjustment methods to guarantee
35 a level playing field by using a competitive bidding process to replace the current benchmark
36 system for determining Medicare Advantage bonus payments (Directive to Take Action); and be
37 it further

38
39 RESOLVED, That our AMA support the “Save Medicare ACT” which proposes renaming
40 Medicare “Advantage” plans as “Alternative Private Health Plans”. (New HOD Policy)

Fiscal Note: Moderate - between \$5,000 - \$10,000

Received: 09/27/23

REFERENCES

1. Biniek, J.F. (2023, February 17). Is the Biden administration proposing cuts to Medicare Advantage? The Kaiser Family Foundation. Retrieved from: <https://www.kff.org/policy-watch/is-the-biden-administration-proposing-cuts-to-medicare-advantage/>
2. Biniek, J.F., Damico, A; Neuman, T. (2023, August 9). Spending on Medicare Advantage Quality Bonus Payments Will Reach at Least \$12.8 Billion in 2023. The Kaiser Family Foundation. Retrieved from: [Spending on Medicare Advantage Quality Bonus Payments Will Reach at Least \\$12.8 Billion in 2023 | KFF](#)
3. *Ibid.*
4. Ryan, M. R., Chopra, Z., Meyers, D.J., Brown, E.C.F., Murray, R.C., Williams, T.C. (2023, Sept.). Favorable Selection In Medicare Advantage Is Linked To Inflated Benchmarks And Billions In Overpayments To Plans. *Health Affairs*, 42(9), 2630-2640.

RELEVANT AMA POLICY

Strengthening Medicare Through Competitive Bidding H-330.886

Our AMA supports the following principles to guide the use of competitive bidding among health insurers in the Medicare program:

- a. Eligible bidders should be subject to specific quality and financial requirements to ensure sufficient skill and capacity to provide services to beneficiaries.
 - b. Bidding entities must be able to demonstrate the adequacy of their physician and provider networks.
 - c. Bids must be based on a clearly defined set of standardized benefits that should include, at a minimum, all services provided under the traditional Medicare program and a cap on out-of-pocket expenses.
 - d. Bids should be developed based on the cost of providing the minimum set of benefits to a standardized Medicare beneficiary within a given geographic region.
 - e. Geographic regions should be defined to ensure adequate coverage and maximize competition for beneficiaries in a service area.
 - f. All contracting entities should be required to offer beneficiaries a plan that includes only the standardized benefit package. Expanded benefit options could also be offered for beneficiaries willing to pay higher premiums.
 - g. Processes and resources must be in place to provide beneficiary education and support for choosing among alternative plans.
2. Our AMA supports using a competitive bidding process to determine federal payments to Medicare Advantage plans.

Citation: CMS Rep. 7, I-13; Reaffirmed: CMS Rep. 01, A-23

Strategies to Strengthen the Medicare Program H-330.896

Our AMA supports the following reforms to strengthen the Medicare program, to be implemented together or separately, and phased-in as appropriate:

1. Restructuring beneficiary cost-sharing so that patients have a single premium and deductible for all Medicare services, with means-tested subsidies and out-of-pocket spending limits that protect against catastrophic expenses. The cost-sharing structure should be developed to provide incentives for appropriate utilization while discouraging unnecessary or inappropriate patterns of care. The use of preventive services should also be encouraged. Simultaneously, policymakers will need to consider modifications to Medicare supplemental insurance (i.e., Medigap) benefit design standards to ensure that policies complement, rather than duplicate or undermine, Medicare's new cost-sharing structure.
2. Offering beneficiaries a choice of plans for which the federal government would contribute a standard amount toward the purchase of traditional fee-for-service Medicare or another health insurance plan approved by Medicare. All plans would be subject to the same fixed contribution amounts and regulatory requirements. Policies would need to be developed, and sufficient resources allocated, to ensure appropriate government standard-setting and regulatory oversight of plans.
3. Restructuring age-eligibility requirements and incentives to match the Social Security schedule of benefits.

Citation: CMS Rep.10, A-07; Reaffirmed: CMS Rep.5, I-12; Modified: Res. 508, A-14; Reaffirmed: CMS Rep.3, I-21

Medicare Advantage Plans D-330.923

Our AMA encourages the Centers for Medicare & Medicaid Services to award Medicare Advantage Programs only to those health plans that meet all of the following criteria: (1) an 85% or higher medical loss ratio; (2) physician payment rates are no less than Medicare Fee for Service rates; and (3) use enforceable contracts that prohibit unilateral changes in physician payment rates.

Citation: Res. 837, I-08; Reaffirmed: Res.116, A-17; Reaffirmation: I-18

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: 217
(I-23)

Introduced by: International Medical Graduates Section

Subject: Addressing Work Requirements for J-1 Visa Waiver Physicians

Referred to: Reference Committee B

1 Whereas, The J-1 visa serves as a non-immigrant exchange visitor visa, frequently utilized by
2 International Medical Graduates (IMGs) seeking medical residency or fellowship training in the
3 United States; and
4

5 Whereas, The J-1 visa permits individuals to remain in the U.S., typically for up to seven years,
6 during the completion of their Graduate Medical Education (GME); and
7

8 Whereas, Upon fulfilling their GME, these individuals are mandated by U.S. immigration law to
9 return to their home country for a minimum of two years before becoming eligible for an H-1B
10 visa to re-enter and work in the United States, or for permanent residency; and
11

12 Whereas, J-1 physicians upon completing GME are confronted with two primary options: firstly,
13 they can adhere to the two-year home residency requirement, or secondly, they can pursue a
14 waiver of this obligation; and
15

16 Whereas, A J-1 visa waiver nullifies the two-year home residency prerequisite, granting
17 physicians the ability to transition to H-1B visa status. In exchange, physicians commit to
18 serving in federally designated Health Professional Shortage Areas (HPSAs), Medically
19 Underserved Areas (MUAs), or among Medically Underserved Populations (MUPs). These
20 physicians should dedicate three years to delivering safety-net services to indigent or
21 underserved individuals, all while functioning under H-1B status. Common pathways for
22 obtaining waivers include the Conrad 30 Waiver Program, the Appalachian Regional
23 Commission (ARC), the Delta Regional Authority (DRA), and the Department of Health and
24 Human Services (HHS) program; and
25

26 Whereas, For a waiver application, physicians must possess a full-time employment contract,
27 involving at least 40 hours of work per week as a direct care physician; and
28

29 Whereas, The stringent requirement of 40 hours of direct patient care for physicians within the
30 The J-1 waiver program places a significant burden. Balancing patient care, essential
31 administrative tasks, and professional growth becomes challenging within this demanding
32 schedule. Physicians find themselves navigating the complexities of continuous patient care
33 while also aiming to dedicate time to administrative responsibilities and pursue non-clinical
34 leadership roles. This rigid structure hampers their ability to effectively deliver high-quality
35 medical services while fostering their own professional progress; therefore be it

1 RESOLVED, That our American Medical Association acknowledge that the requirement of 40
2 hours of direct patient care could impose a burden on IMG physicians and may hinder
3 opportunities for professional growth (New HOD Policy); and be it further
4

5 RESOLVED, That our AMA advocate for a revision in the J-1 waiver physician's requirement,
6 proposing a transition to a comprehensive 40-hour work requirement that encompasses both
7 direct clinical responsibilities and other professional activities. (Directive to Take Action)

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

Received: 9/27/23

REFERENCES

1. U.S. Department of State - Waiver of the Exchange Visitor Two-Year Home-Country Physical Presence Requirement:
<https://travel.state.gov/content/travel/en/us-visas/study/exchange/waiver-of-the-exchange-visitor.html>
2. J-1 Visa Waiver – U. S. Department of State: <https://j1visa waiver recommendation.state.gov/>
3. Conrad 30 Waiver Program – U. S. Citizen and Immigration Service (USCIS): <https://www.uscis.gov/working-in-the-united-states/students-and-exchange-visitors/conrad-30-waiver-program>
4. State Department's J-1 Visa Exchange Visitor Program – U. S. Department of State:
<https://travel.state.gov/content/travel/en/us-visas/study/exchange.html>

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 218
(I-23)

Introduced by: American Academy of Child and Adolescent Psychiatry, American Academy of Psychiatry and the Law, American Association for Geriatric Psychiatry, American Psychiatric Association

Subject: Youth Residential Treatment Program Regulation

Referred to: Reference Committee B

1 Whereas, residential treatment including substance use treatment facilities play a crucial role in
2 the behavioral health system of states, providing support for mental health and substance use
3 disorder (M/SUD) recovery through 24/7 structured living environments for individuals who do
4 not require inpatient care; and

5
6 Whereas, the regulatory processes for these facilities are predominantly governed by state
7 statutes and regulations, leading to inconsistencies in oversight and licensing standards across
8 states and types of facilities; and

9
10 Whereas, many states lack laws regulating these programs, and questions remain on the
11 effectiveness of existing laws; and

12
13 Whereas, caregivers are often unable to find child and adolescent residential treatment
14 programs in their communities and need to send the child across state lines to access
15 residential treatment programs; and

16
17 Whereas, despite licensing requirements, incidents of maltreatment and death occur in
18 residential facilities, according to data collected by the U.S. Department of Health and Human
19 Services. In 2005, 1,503 incidents of maltreatment by staff were reported in 34 states, including
20 physical abuse, neglect, deprivation of necessities, and sexual abuse. Furthermore, in 2006, at
21 least one death occurred in residential facilities in 28 states, with accidents and suicides being
22 the most common causes; and

23
24 Whereas, state agencies may not adequately monitor facilities due to fluctuating staffing levels
25 and inconsistent oversight standards, particularly in facilities that are exempt from licensing
26 requirements, including some juvenile justice facilities and private programs and academies.
27 These gaps in oversight may put vulnerable youth at increased risk of harm; and

28
29 Whereas, The 2018 Family First Prevention Services Act mandates that qualified residential
30 treatment programs (QRTPs) receiving Federal funds must use a trauma-informed practice
31 model; are staffed by registered or licensed staff who can provide care consistent with the
32 treatment model; and are licensed and nationally accredited by the Commission on
33 Accreditation of Rehabilitation Facilities, the Joint Commission on Accreditation of Healthcare
34 Organizations, the Council on Accreditation, or others approved organizations; and

35
36 Whereas, many programs do not receive government funding and are not subject to federal
37 regulations, individual states are responsible for regulating them. However, many states exempt

these facilities from licensing requirements, and those with religious affiliations may not be subject to regulation by education and child welfare agencies; and

Whereas, The New York Times has reported on the “troubled teen” industry and the harm it inflicts on children with mental health and behavioral issues due to a reliance on archaic tactics, a lack of oversight and regulation, lack of use of evidence-based and effective treatments, and a focus on maximizing profit, and that despite years of scrutiny, not enough has changed; and

Whereas, Stop Institutional Child Abuse Act was a bill that was introduced in the House of Representatives in 2020 by Representative Adam Schiff of California. The bill aimed to improve oversight and accountability for residential programs for troubled youth, which have been known to subject children to physical, emotional, and sexual abuse. The bill would have required such programs to be licensed and would have created a national database of complaints and violations. Unfortunately, the bill did not make it out of committee, and therefore was not passed into law. This is just one example of the federal government's failure to adequately address the issue of institutional child abuse⁷; therefore be it

RESOLVED, that our American Medical Association advocate for the federal government to work with relevant parties to develop federal licensing standards for youth residential treatment programs (Directive to Take Action); and be it further

RESOLVED, that our AMA recognize the need for federal licensing standards for all youth residential treatment facilities (including private and juvenile facilities) to ensure basic safety and well-being standards for youth. (New HOD Policy)

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

Received: 9/27/23

REFERENCES

1. Allroggen, M., Rau, T., Ohlert, J., & Fegert, J. M. (2017). Lifetime prevalence and incidence of sexual victimization of adolescents in institutional care. *Child abuse & neglect*, 66, 23-30.
2. Behar, L., Friedman, R., Katz-Leavy, J., Pinto, A., & Boyles, W. Addressing Abuse and Mistreatment of Youth Placed in Residential "Treatment" Facilities. *Systems of Care*, 289.
3. Friedman, R. M., Pinto, A., Behar, L., Bush, N., Chirolla, A., Epstein, M., ... & Young, C. K. (2006). Unlicensed residential programs: The next challenge in protecting youth. *American Journal of Orthopsychiatry*, 76(3), 295-303.
4. Hobbs, G. F., Hobbs, C. J., & Wynne, J. M. (1999). Abuse of children in foster and residential care. *Child abuse & neglect*, 23(12), 1239-1252.
5. Intensive/qualified residential treatment. Intensive/Qualified Residential Treatment - Child Welfare Information Gateway. (n.d.). Retrieved April 14, 2023, from <https://www.childwelfare.gov/topics/outofhome/group-residential-care/intensive/>
6. Milnamow, C. (2022, December 4). The Trouble Team Industry: Should the federal government intervene? Retrieved April 14, 2023, from <https://lawreview.law.miami.edu/the-trouble-team-industry-should-the-federal-government-intervene/>
7. Schiff, A. (2020). H.R. 9116, Stop Institutional Child Abuse Act. 116th Congress.
8. Stockton, A. (2022, October 11). Can you punish a child's mental health problems away? The New York Times. Retrieved April 13, 2023, from <https://www.nytimes.com/interactive/2022/10/11/opinion/teen-mental-health-care.html?smid=nytcore-ios-share&referringSource=articleShare>
9. U.S. Government Accountability Office (2007). Residential treatment programs: Concerns regarding abuse and death in certain programs for troubled youth. Residential Treatment Programs: Concerns Regarding Abuse and Death in Certain Programs for Troubled Youth | U.S. GAO. Retrieved April 13, 2023, from <https://www.gao.gov/products/gao-08-146t>
10. U.S. Government Accountability Office (2008). Residential facilities: State and Federal Oversight Gaps May Increase Risk to Youth Well-being. U.S. GAO Retrieved September 26, 2023, <https://www.gao.gov/assets/gao-08-696t.pdf>

RELEVANT AMA POLICY

H-95.965 Residential Treatment for Women with Substance Use Disorder

Our AMA encourages state medical societies to support an exemption in public aid rules that would allow for the coverage of residential drug treatment programs for women with child-bearing potential. [Res. 405, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11; Modified: CSAPH Rep. 1, A-21]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 219
(I-23)

Introduced by: Washington, American Association of Public Health Physicians

Subject: Improving Access to Post-Acute Medical Care for Patients with Substance Use Disorder (SUD)

Referred to: Reference Committee B

1 Whereas, patients with substance use disorder (SUD) including opioid use disorder (OUD) who
2 are discharging from the hospital frequently require continued post-acute medical care in
3 settings such as skilled nursing facilities (SNFs); and
4

5 Whereas, such patients face barriers to successfully reaching post-acute medical care,
6 including discriminatory policies that seek to reject admission of patients with OUD¹ and
7 regulatory prohibitions against continuing opioid agonist therapy such as methadone at SNFs²;
8 and
9

10 Whereas, policies against admission of patients with OUD may violate the Americans with
11 Disabilities Act³; and
12

13 Whereas, methadone treatment for OUD with methadone must be dispensed at a methadone
14 clinic regardless of stay in a SNF; and
15

16 Whereas, rural SNFs are situated long distances away from methadone treatment centers,
17 making transportation a barrier to continuation of methadone or rehabilitation stay at an SNF;
18 and
19

20 Whereas, the use of methadone for the treatment of OUD is not covered by Medicare Part D
21 and retail pharmacies are prohibited from dispensing it for this purpose; and
22

23 Whereas, optimizing SNF care for patients with OUD/SUDs may ultimately require changes in
24 regulations regarding treating SUD/OUDs during SNF admission; and
25

26 Whereas, impediments to discharging patients to post-acute medical care exacerbate the crisis
27 in hospital discharge, leading to increased lengths of stay and worsening hospital overcrowding;
28 therefore be it
29

30 RESOLVED, that our American Medical Association advocate to ensure that patients who
31 require a post-acute medical care setting are not discriminated against because of their history
32 of substance use disorder (Directive to Take Action); and be it further
33

34 RESOLVED, that our AMA advocate that our federal, state, and local governments remove
35 barriers to opioid agonist therapy (including methadone, buprenorphine or other appropriate
36 treatments) at skilled nursing facilities (Directive to Take Action); and be it further

- 1 RESOLVED, that our AMA advocate that Medicare and Medicaid provide coverage for
- 2 substance use and opioid use disorder treatments in skilled nursing facilities. (Directive to Take
- 3 Action)

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

Received: 9/27/23

REFERENCES

1. Kimmel SD, Rosenmoss S, Bearnot B, Larochelle M, Walley AY. Rejection of Patients With Opioid Use Disorder Referred for Post-acute Medical Care Before and After an Anti-discrimination Settlement in Massachusetts. *J Addict Med*. 2021 Jan-Feb 01;15(1):20-26. doi: 10.1097/ADM.0000000000000693. PMID: 32675798; PMCID: PMC7859880.
2. Cohen SM, Joab R, Bolles KM, Friedman S, Kimmel SD. Ending Medical Complicity With Skilled-Nursing Facility Discrimination Against People With Opioid Use Disorder. *Ann Intern Med*. 2023 Mar;176(3):410-412. doi: 10.7326/M22-3049. Epub 2023 Feb 7. PMID: 36745883.
3. Administering or dispensing of narcotic drugs. 21 C.F.R. Vol Title 21, Volume 9; Chapter II2005.
4. Wakeman, S. E., and Rich, J. D. 2017. "Barriers to Post-Acute Care for Patients on Opioid Agonist Therapy; An Example of Systematic Stigmatization of Addiction." *Journal of General Internal Medicine* 32(1): 17-19.
5. Baird, J. and Griese, B. 2018. "Unfortunately, Turning Away Opioid Addicts Might be Necessary." *McKnight's Long-Term Care News*, May 7.
6. Medicare Payment Advisory Commission (MedPAC). 2020. "Chapter 8: Skilled Nursing Facility Services." Report to the Congress: Medicare Payment Policy.
7. Wood, E., Samet, J. H., and Volkow, N. D. 2013. "Physician Education in Addiction Medicine." *JAMA* 310(16): 1673-4. World Health Organization. 2019.
8. Ronan MV and Herzig SJ. Hospitalizations related to opioid abuse/dependence and associated serious infections increased sharply, 2002-12. *Health Aff (Millwood)*. 2016;35(5):832-837.
9. *Comprehensive Drug Abuse Prevention and Control Act of 1970 (The Controlled Substances Act)*. 21. Vol 841970:1236 – 1296.

RELEVANT AMA POLICY

Treating Opioid Use Disorder in Hospitals D-95.967

1. Our AMA's Opioid Task Force will work together with the American Hospital Association and other relevant organizations to identify best practices that are being used by hospitals and others to treat opioid use disorder as a chronic disease, including identifying patients with this condition; initiating or providing opioid agonist or partial agonist therapy in inpatient, obstetric and emergency department settings; providing cognitive and behavioral therapy as well as other counseling as appropriate; establishing appropriate discharge plans, including education about opioid use disorder; and participating in community-wide systems of care for patients and families affected by this chronic medical disease.
2. Our AMA will advocate for states to evaluate programs that currently exist or have received federal or state funding to assist physicians, hospitals and their communities to coordinate care for patients with the chronic disease of opioid use disorder.
3. Our AMA will take all necessary steps to seek clarification of interpretations of 21 CFR 1306.07 by the DEA and otherwise seek administrative, statutory and regulatory solutions that will allow for (a) prescribers with the waiver permitting the prescribing of buprenorphine for opioid use disorder to be able to do so, when indicated, for hospitalized inpatients, using a physician order rather than an outpatient prescription, and (b) hospital inpatient pharmacies to be able to fill such authorizations by prescribers without this constituting a violation of federal regulations.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 220
(I-23)

Introduced by: American College of Legal Medicine, Richard Wilbur, MD, JD, FCLM,

Subject: Merit-Based Process for the Selection of all Federal Administrative Law Judges

Referred to: Reference Committee B

1 Whereas, Medicare and Medicaid beneficiaries must appeal their coverage and payment
2 disputes to Health and Human Services Administrative Law Judges (ALJs); and
3

4 Whereas, Medicare and Medicaid beneficiaries deserve competent and neutral Health and
5 Human Services ALJs presiding over their disputes with Medicare and Medicaid; and
6

7 Whereas, Medicare and Medicaid providers and suppliers must appeal their payment disputes
8 to Health and Human Services ALJs; and
9

10 Whereas, Medicare and Medicaid providers and suppliers deserve competent and neutral
11 Health and Human Services ALJs presiding over their payment disputes with Medicare; and
12

13 Whereas, Social Security beneficiaries must appeal their coverage and payment disputes to
14 Social Security ALJs; and
15

16 Whereas, Social Security beneficiaries deserve competent and neutral Social Security ALJs
17 presiding over their coverage and payment disputes with Social Security; and
18

19 Whereas, the Administrative Procedure Act of 1946 controls the federal agencies, including the
20 Department of Health and Human Services (Medicare and Medicaid) and Social Security¹; and
21

22 Whereas, from 1946 until 2018, attorney candidates who wanted to become federal
23 administrative law judges (ALJs) were required:

- 24 a. to pass an examination on administrative law given by the U.S. Department of Personnel
25 Management, and only the top three scoring candidates were offered positions as
26 federal administrative law judges (ALJs),
- 27 b. to have at least seven years of experience in an area of law relevant to administrative
28 proceedings, and
- 29 c. to prove they had the ability to write clear and understandable decisions following an
30 administrative proceeding; and
31

32 Whereas, following the Supreme Court decision in *Lucia v. SEC*², Executive Order (E.O.)
33 13,843 was signed³; and
34

35 Whereas, E.O. 13,843 removed all federal administrative law judges (ALJs) from the competitive
36 civil service; and

37 Whereas, the only current requirements for a new federal ALJ are a license to practice law
38 somewhere in the United States and an appointment to be an ALJ for a federal agency, with the
39 appointment made by the temporary, politically appointed agency head; and

1 Whereas, E.O 13,843 politicizes the federal ALJ service and will result in the appointment of
2 questionably competent ALJs⁴; therefore be it
3

4 RESOLVED, that our American Medical Association support the pre-2018, merit-based process
5 for the selection of all federal administrative law judges (ALJs), including the requirements that:
6

7 1. All federal ALJ candidates must be licensed and authorized to practice law under the laws of
8 a State, the District of Columbia, the Commonwealth of Puerto Rico, or any territorial court
9 established under the United States Constitution throughout the ALJ selection process,
10

11 2. All federal ALJ candidates must have a full seven (7) years of experience as a licensed
12 attorney preparing for, participating in, and/or reviewing formal hearings or trials involving
13 litigation and/or administrative law at the Federal, State, or local level, and
14

15 3. All federal ALJ candidates must pass an examination, the purpose of which is to evaluate the
16 competencies/knowledge, skills, and abilities essential to performing the work of an
17 Administrative Law Judge. (New HOD Policy)

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

Received: 9/26/23

REFERENCES

1. https://sourcebook.acus.gov/wiki/Administrative_Procedure_Act/view
2. 138 S. Ct. 2044 (2018)
3. <https://www.federalregister.gov/documents/2018/07/13/2018-15202/excepting-administrative-law-judges-from-the-competitive-service>
4. <https://www.govexec.com/oversight/2018/07/judges-union-supreme-court-decision-excuse-politicize-aljs/149773/>
5. <https://www.opm.gov/policy-data-oversight/classification-qualifications/general-schedule-qualification-standards/specialty-areas/administrative-law-judge-positions/>

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 222
(I-23)

Introduced by: Association for Clinical Oncology, College of American Pathologists

Subject: Expansion of Remote Digital Laboratory Access Under CLIA

Referred to: Reference Committee B

1 Whereas, the Centers for Medicare and Medicaid Services (CMS) used certain enforcement
2 discretion and flexibility to expand laboratory capacity during the Public Health Emergency
3 (PHE) posed by COVID-19, including certain Clinical Laboratory Improvement Amendments of
4 1988 (CLIA) regulations¹; and

5
6 Whereas, one important enforcement discretion was allowing pathologists and other laboratory
7 personnel to remotely review digital clinical laboratory data, digital results, and digital images
8 without obtaining a separate CLIA certificate for the remote testing site, provided that the
9 primary site or home base had such a certificate²; and

10
11 Whereas, CMS plans to continue this enforcement discretion after the PHE ends³, and

12
13 Whereas, the discretion specifies relevance to “pathologists and laboratory personnel”; and

14
15 Whereas, other physician specialties in addition to pathologists, such as hematologists and
16 oncologists, may have qualifications to evaluate blood smears for the evaluation of acute
17 hematologic disorders⁴; and

18
19 Whereas, current interpretation of CMS guidance does not appear to allow hematologists or
20 oncologists to use digital hematology microscopy platforms for the remote evaluation of blood
21 smears without obtaining individual CLIA licenses for each remote physician; and

22
23 Whereas, current interpretation creates an unnecessary burden in the inability to review blood
24 smears and other digital pathology remotely, which can result in delays in care and increased
25 cost of care; therefore be it

26
27 RESOLVED, that our American Medical Association advocate to the Centers for Medicare and
28 Medicaid Services that post-Public Health Emergency enforcement discretion of Clinical
29 Laboratory Improvement Amendments of 1988 (CLIA) regulations 42 C.F.R. §§ 493.35(a),
30 493.43(a), and 493.55(a)(2) that requires laboratories to file a separate application for each
31 laboratory location unless it meets a regulatory exception, be clarified to include all qualified
32 physicians under CLIA, to review digital data, digital results, and digital images at a remote
33 location under the primary location CLIA certificate. (Directive to Take Action)

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

Received: 10/11/23

REFERENCES

1. <https://www.cms.gov/files/document/qso-23-15-clia.pdf>
2. <https://www.cms.gov/files/document/qso-23-15-clia.pdf>
3. <https://www.cms.gov/files/document/qso-23-15-clia.pdf>
4. <https://www.rcpath.org/discover-pathology/news/fact-sheets/haematology.html>

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 223
(I-23)

Introduced by: Association for Clinical Oncology

Subject: Initial Consultation for Clinical Trials Under Medicare Advantage

Referred to: Reference Committee B

1 Whereas, more than half of the Medicare-eligible population is enrolled in a Medicare
2 Advantage plan¹; and
3

4 Whereas, existing AMA policy H-460.930(3) affirms the inherent obligation of capitation
5 programs and managed care organizations to invest in broad-based clinical research, including
6 significant financial contribution to support such research²; and
7

8 Whereas, at A-23, our AMA adopted policy H-460.882 advocating that the Centers for Medicare
9 and Medicaid Services (CMS) require that Medicare Advantage Organizations (MAO) pay
10 physicians and non-physician providers directly for the routine costs of clinical trials, as opposed
11 to the current practice of switching the patient to original Medicare when enrolled on a clinical
12 trial and requiring that patients pay out-of-pocket copays and coinsurance before later being
13 reimbursed by the MAO³; and
14

15 Whereas, no institution or managed care network, however large, can offer all relevant clinical
16 trials; and
17

18 Whereas, coverage of the initial consultation of an out-of-network physician for the purpose of
19 enrollment in a clinical trial remains a financial barrier to clinical trial enrollment for Medicare
20 Advantage patients, as those patients have not yet enrolled in a clinical trial; and
21

22 Whereas, current Medicare policy under National Coverage Determination (NCD) 310.1 states
23 that Managed Care Organizations “may have reporting requirements when enrollees participate
24 in clinical trials, in order to track and coordinate their members’ care, but *cannot require prior*
25 *authorization or approval*” (emphasis added)⁴; and
26

27 Whereas, NCD 310.1 has the effect that Medicare Advantage patients must currently self-refer
28 for consultation for an out-of-network clinical trial; therefore be it
29

30 RESOLVED, that our American Medical Association amend policy H-460.882, “Coverage of
31 Routine Costs in Clinical Trials by Medicare Advantage Organizations,” by addition to read as
32 follows:

33 4. Our AMA advocate that the Centers for Medicare and Medicaid Services allow out-of-
34 network referral of patients with Medicare Advantage for the purpose of consultation for
35 enrollment in a clinical trial, and that these consultations be considered administratively
36 as participation in a clinical trial. (Modify Current HOD Policy)

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

Received: 10/11/23

REFERENCES

1. <https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2023-enrollment-update-and-key-trends/>
2. <https://policysearch.ama-assn.org/policyfinder/detail/%22Importance%20of%20Clinical%20Research%20H-460.930%22?uri=%2FAMADoc%2FHOD.xml-0-4178.xml>
3. <https://policysearch.ama-assn.org/policyfinder/detail/H-460.882%20?uri=%2FAMADoc%2FHOD.xml-H-460.882.xml>
4. <https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?NCDId=1&ncdver=2r=2>

RELEVANT AMA POLICY**H-460.882 Coverage of Routine Costs in Clinical Trials by Medicare Advantage Organizations**

(1) Our American Medical Association will advocate that the Centers for Medicare and Medicaid Services require that Medicare Advantage Organizations (MAOs) pay for routine costs for services that are provided as part of clinical trials covered under the Clinical Trials National Coverage Determination 310.1, just as the MAO would have been required to do so had the patient not enrolled in the qualified clinical trial.

(2) Our AMA will advocate for the Centers for Medicare and Medicaid Services (CMS) and Medicare Advantage Organizations (MAOs) to communicate and coordinate the payment for services associated with participation in clinical trials, covered under the Clinical Trials National Coverage Determination 310.1, and to ensure that physicians and non-physician providers are paid directly in order to eliminate the requirement that patients seek reimbursement for billed services.

(3) Our AMA will take the position that Medicare Advantage Organizations (MAOs) and their participating physicians shall actively encourage patients to enroll in clinical trials.

Importance of Clinical Research H-460.930

(1) Given the profound importance of clinical research as the transition between basic science discoveries and standard medical practice of the future, the AMA will a) be an advocate for clinical research; and b) promote the importance of this science and of well-trained researchers to conduct it.

(2) Our AMA continues to advocate vigorously for a stable, continuing base of funding and support for all aspects of clinical research within the research programs of all relevant federal agencies, including the National Institutes of Health, the Agency for Healthcare Research and Quality, the Centers for Medicare & Medicaid Services, the Department of Veterans Affairs and the Department of Defense.

(3) The AMA believes it is an inherent obligation of capitation programs and managed care organizations to invest in broad-based clinical research (as well as in health care delivery and outcomes research) to assure continued transition of new developments from the research bench to medical practice. The AMA strongly encourages these groups to make significant financial contributions to support such research.

(4) Our AMA continues to encourage medical schools a) to support clinical research; b) to train and develop clinical researchers; c) to recognize the contribution of clinical researchers to academic medicine; d) to assure the highest quality of clinical research; and e) to explore innovative ways in which clinical researchers in academic health centers can actively involve practicing physicians in clinical research.

(5) Our AMA encourages and supports development of community and practice-based clinical research networks.

D-285.959 Prevent Medicare Advantage Plans from Limiting Care

Our AMA will: (1) ask the Centers for Medicare and Medicaid Services to further regulate Medicare Advantage Plans so that the same treatment and authorization guidelines are followed for both fee-for-service Medicare and Medicare Advantage patients, including admission to inpatient rehabilitation facilities; and (2) advocate that proprietary criteria shall not supersede the professional judgment of the patient's physician when determining Medicare and Medicare Advantage patient eligibility for procedures and admissions. Citation: Res. 706, A-21

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 224
(I-23)

Introduced by: Association for Clinical Oncology

Subject: ERISA Preemption of State Laws Regulating Pharmacy Benefit Managers

Referred to: Reference Committee B

1 Whereas, pharmacy benefit managers (PBMs) are third party companies that function as
2 intermediaries between insurance providers and pharmaceutical manufacturers to create
3 formularies, negotiate rebates with manufacturers, process claims, create pharmacy networks,
4 review drug utilization, and manage mail-order specialty pharmacies¹; and

5
6 Whereas, the four largest PBMs collectively have a 68 percent share of the national commercial
7 market²; and

8
9 Whereas, the largest PBMs are integrated with the largest health insurance companies and
10 wholly owned mail-order specialty pharmacies, which allows them to influence which drugs are
11 prescribed to patients, which pharmacies patients can use, and how much patients pay³; and

12
13 Whereas, PBMs have substantial influence over independent pharmacies, which have
14 collectively voiced concerns that PBMs negotiate and leverage contractual terms with these
15 pharmacies that are confusing, unfair, arbitrary, and harmful to their business⁴; and

16
17 Whereas, PBMs engage in potentially harmful and anti-competitive practices such as charging
18 fees and clawbacks to unaffiliated pharmacies; steering patients toward PBM-owned
19 pharmacies; potentially unfair auditing of unaffiliated pharmacies; the use of complicated and
20 opaque pharmacy reimbursement methods; and negotiating rebates and fees with drug
21 manufacturers that may skew the formulary incentives and impact the cost of prescription drugs
22 to patients⁵; and

23
24 Whereas, since 2017, states have enacted more than 100 laws to address the ways PBMs
25 contribute to high costs⁶; and

26
27 Whereas, the Employee Retirement Income Security Act of 1974 (ERISA) is a federal law that
28 sets minimum standards for most voluntarily established retirement and health plans in private
29 industry⁷; and

30
31 Whereas, ERISA plans cover about 141 million workers and beneficiaries, or about 44 percent
32 of the population⁸; and

33
34 Whereas, ERISA threatens enforcement of state laws that impact employer-sponsored health
35 insurance, especially the self-funded plans that comprise 64 percent of employer-sponsored
36 coverage⁹; and

37
38 Whereas, ERISA preemption dilutes states' ability to collect data, control prices, and protect
39 consumers¹⁰; and

Whereas, the U.S. Supreme Court's 2020 opinion *Rutledge v. PCMA* clarified that state laws that affect or regulate health care costs are not necessarily preempted even though they may alter the incentives and decisions facing employer-sponsored plans;¹¹ and

Whereas, despite the *Rutledge* ruling, ERISA jurisprudence has been unpredictable, leaving states to regulate and legislate under uncertainty; therefore be it

RESOLVED, that our American Medical Association study enacted state pharmacy benefit management (PBM) legislation and create a model bill that would avoid the Employment Retirement Income Security Act of 1974 (ERISA) preemption. (Directive to Take Action)

Fiscal Note: Moderate - between \$5,000 - \$10,000

Received: 10/10/23

REFERENCES

1. <https://content.naic.org/cipr-topics/pharmacy-benefit-managers>
2. <https://www.ama-assn.org/system/files/prp-pbm-shares-hhi.pdf>
3. <https://www.ftc.gov/news-events/news/press-releases/2023/05/ftc-deepens-inquiry-prescription-drug-middlemen>
4. <https://www.ftc.gov/news-events/news/press-releases/2023/05/ftc-deepens-inquiry-prescription-drug-middlemen>
5. <https://www.ftc.gov/news-events/news/press-releases/2023/05/ftc-deepens-inquiry-prescription-drug-middlemen>
6. <https://nashp.org/legislative-approaches-to-curbing-drug-costs-targeted-at-pbms-2017-2021/>
7. <https://www.dol.gov/general/topic/health-plans/erisa#:~:text=The%20Employee%20Retirement%20Income%20Security,for%20individuals%20in%20these%20plans>
8. <https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/fact-sheets/what-is-erisa#:~:text=These%20plans%20cover%20about%20141.59%20percent%20earn%20health%20benefits>
9. <https://www.commonwealthfund.org/publications/issue-briefs/2022/may/state-cost-control-reforms-erisa-preemption>
10. <https://www.commonwealthfund.org/publications/issue-briefs/2022/may/state-cost-control-reforms-erisa-preemption>
11. <https://www.healthaffairs.org/content/forefront/implications-i-rutledge-v-pcma-i-state-health-care-cost-regulation>

RELEVANT AMA POLICY

AMA Policy on ERISA H-285.915

1. Our AMA will seek, through amendment of the ERISA statute, through enactment of separate federal patient protection legislation, through enactment of similar state patient protection legislation that is uniform across states, and through targeted elimination of the ERISA preemption of self-insured health benefits plans from state regulation, to require that such self-insured plans: (a) Ensure that plan enrollees have access to all needed health care services; (b) Clearly disclose to present and prospective enrollees any provisions restricting patient access to or choice of physicians, or imposing financial incentives concerning the provision of services on such physicians; (c) Be regulated in regard to plan policies and practices regarding utilization management, claims submission and review, and appeals and grievance procedures; (d) Conduct scientifically based and physician-directed quality assurance programs; (e) Be legally accountable for harm to patients resulting from negligent utilization management policies or patient treatment decisions through all available means, including proportionate or comparative liability, depending on state liability rules; (f) Participate proportionately in state high-risk insurance pools that are financed through participation by carriers in that jurisdiction; (g) Be prohibited from indemnifying beneficiaries against actions brought by physicians or other providers to recover charges in excess of the amounts allowed by the plan, in the absence of any provider contractual agreement to accept those amounts as full payment; (h) Inform beneficiaries of any discounted payment arrangements secured by the plan, and base beneficiary coinsurance and deductibles on these discounted amounts when providers have agreed to accept these discounted amounts as full payment; (i) Be subject to breach of contract actions by providers against their administrators; and (j) Adopt coordination of benefits provisions applying to enrollees covered under two or more plans.

2. Our AMA will continue to advocate for the elimination of ERISA preemption of self-insured health plans from state insurance laws consistent with current AMA policy.