APPENDIX - REPORTS OF REFERENCE COMMITTEES
2024 Interim Meeting of the American Medical Association House of Delegates

Reference committee reports from the House of Delegates meeting are provided for the sake of convenience and because they are part of the record of each meeting.

The Proceedings reflect the official record of the actions taken by the House of Delegates and have precedence over reference committee reports, as the Proceedings are prepared using multiple sources, including a transcript of debate. Policies deriving from House actions are recorded in PolicyFinder, which is updated following each House of Delegates meeting.

Note: The original language of report recommendations and the original resolve clauses from resolutions are included in the reference committee reports with a gray background as in this example:

> The Board of Trustees recommends that the following be adopted in lieu of the resolution and the remainder of this report be filed.

In addition, where the reference committee proposes changes in addition to or different from changes proposed by the original item of business, those changes are shown with double underscore or ~~double strikethrough~~, and in some cases are highlighted in yellow.

DISCLAIMER

The following is a preliminary report of actions taken by the House of Delegates at its 2024 Interim Meeting and should not be considered final. Only the Official Proceedings of the House of Delegates reflect official policy of the Association.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (I-24)

Final Report of Reference Committee on Amendments to Constitution and Bylaws

Carlos Latorre, MD, Chair

Your Reference Committee recommends the following consent calendar for acceptance:

RECOMMENDED FOR ADOPTION

1. BOT Report 22 – Specialty Society Representation in the House of Delegates – Five-Year Review
2. BOT Report 23 – Advocating for the Informed Consent for Access to Transgender Health
3. BOT Report 24 – Physicians Arrested for Non-Violent Crimes While Engaging in Public Protests
4. CCB Report 01 – Resolution Deadline Clarification
5. CCB Report 02 – Name Change for Reference Committee
6. CEJA Report 01 – Expanding Access to Palliative Care
7. Resolution 003 – On the Ethics of Human Lifespan Prolongation
8. Resolution 006 – Opposition to the Deceptive Relocation of Migrants and Asylum Seekers
9. Resolution 008 – Missing and Murdered Black Women and Girls
10. Resolution 010 – Development of Resources for Medical Staffs to Engage in Collective Negotiation with Hospital and Health Systems

RECOMMENDED FOR ADOPTION AS AMENDED

11. BOT Report 08 – Increasing Access to Medical Care for People Seeking Asylum
12. BOT Report 14 – Privacy Protection and Prevention of Further Trauma for Victims of Distribution of Intimate Videos and Images Without Consent
13. BOT Report 18 – Expanding Palliative Care
14. CCB Report 03 – Bylaw Amendments to Address Medical Student Leadership
15. Resolution 001 – Addressing Gender-Based Pricing Disparities
16. Resolution 002 – Anti-Doxxing Data Privacy Protection
17. Resolution 005 – Updating the American Medical Association Definition of Infertility

RECOMMENDED FOR REFERRAL

18. CEJA Report 02 – Protecting Physicians Who Engage in Contracts to Deliver Health Care Services

19. Resolution 004 – Improving Usability of Electronic Health Records for Transgender and Gender Diverse Patients
20. Resolution 007 – Supporting Diversity in Research

RECOMMENDED FOR REFERRAL FOR DECISION

21. Resolution 009 – Opposition to Creation or Enforcement of Civil Litigation, Commonly Referred to as Civil Causes of Action

RECOMMENDED FOR NOT ADOPTION

22. Resolution 011 – American Kidney Donation Legislation

If you wish to propose an amendment to an item of business, click here: Submit New Amendment

RECOMMENDED FOR ADOPTION

(1) BOT REPORT 22 - SPECIALITY SOCIETY REPRESENTATION IN THE HOUSE OF DELEGATES – FIVE-YEAR REVIEW

RECOMMENDATION:

Your Reference Committee recommends that BOT Report 22 be adopted and the remainder of the Report be filed.

HOD ACTION: Recommendations in BOT Report 22 adopted and the remainder of the Report be filed.

The Board of Trustees recommends that the following be adopted, and the remainder of this report be filed:

1. The American Academy of Allergy, Asthma & Immunology, American College of Cardiology, American College of Chest Physicians, American College of Emergency Physicians, American College of Gastroenterology, American College of Nuclear Medicine, American Medical Group Association, International Society for the Advancement of Spine Surgery, and National Association of Medical Examiners retain representation in the American Medical Association House of Delegates. (Directive to Take Action)

No testimony was heard. Your Reference Committee recommends that the report be adopted.

(2) BOT REPORT 23 - ADVOCATING FOR THE INFORMED CONSENT FOR ACCESS TO TRANSGENDER HEALTH

RECOMMENDATION:

Your Reference Committee recommends that BOT Report 23 be adopted and remainder of the Report be filed.

HOD ACTION: Recommendations in BOT Report 23 adopted and the remainder of the Report be filed.

In light of these considerations, the Board of Trustees recommends that the following be adopted in lieu of Resolution 011-I-22, “Advocating for the Informed Consent for Access to Transgender Health Care,” and the remainder of this report be filed:

1.That our AMA unambiguously supports access to and insurance coverage of medically necessary gender-affirming care but does not identify a preferred model of care for determining medical necessity. The AMA vigorously advocates for equitable payment policies, relying on the evidence-based professional guidelines and recommendations set by professional medical associations, as well as individual physician clinical judgment, on questions of appropriate clinical criteria. (New HOD Policy)

2.That Policy H-185.927, "Clarification of Medical Necessity for Treatment of Gender Dysphoria," be reaffirmed. (Reaffirm HOD Policy)

3. That Policy H-140.824, "Healthcare Equity Through Informed Consent and a Collaborative Healthcare Model for the Gender Diverse Population," be reaffirmed. (Reaffirm HOD Policy)

4. That Policy H-295.847, "Increasing Access to Gender-Affirming Care Through Expanded Training and Equitable Coverage," be reaffirmed. (Reaffirm HOD Policy)

5. That Policy H-185.950, "Removing Financial Barriers to Care for Transgender Patients," be amended by addition and deletion to read as follows:

Our AMA supports public and private health insurance coverage for evidence-based treatment of gender-affirming care gender dysphoria as recommended by the patient's physician. (Modify current HOD Policy)

Limited in-person testimony was heard. Testimony was in strong support with one testimony calling for referral to explore emerging data on gender affirming care for minors. Your Reference Committee recommends that the report be adopted.

(3) BOT REPORT 24 - PHYSICIANS ARRESTED FOR NON-VIOLENT CRIMES WHILE ENGAGED IN PUBLIC PROTESTS

RECOMMENDATION:

Your Reference Committee recommends that Board of Trustees Report 24 be <u>adopted</u> and remainder of the report be <u>filed.</u>

HOD ACTION: Recommendations in BOT Report 24 <u>adopted</u> and the remainder of the report <u>filed.</u>

The Board of Trustees recommends that Res 009 be adopted as amended and the remainder of the report be filed:

That our AMA advocate to appropriate credentialing organizations and payers – including the Federation of State Medical Boards, state and territorial licensing boards, hospital and hospital system accrediting boards, and organizations that compensate physicians for provision of healthcare goods and services – that ~~misdemeanor or felony~~ arrests of physicians <u>for nonviolent civil disobedience occurring while</u> ~~as a result of~~ exercising their First Amendment rights of

protest ~~through nonviolent civil disobedience~~ should not be deemed germane to the ability to safely and effectively practice medicine. (Directive to Take Action)

Limited in-person testimony was heard in unanimous support. Your Reference Committee recommends that the report be adopted.

(4) CCB REPORT 01 RESOLUTION DEADLINE CLARIFICATION

RECOMMENDATION:

Your Reference Committee recommends that CCB Report 01 be <u>adopted</u> and the remainder of the Report be <u>filed.</u>

HOD ACTION: Recommendations in CCB Report 01 <u>adopted</u> and the remainder of the Report <u>filed.</u>

The Council on Constitution and Bylaws recommends that the following recommendation be adopted, and that the balance of the report be filed. Adoption requires the affirmative vote of two thirds of the members of the House of Delegates present and voting following a one-day layover.

1) That our AMA Bylaws be amended by insertion and deletion as follows:

2.11.3 Introduction of Business.

2.11.3.1 Resolutions.

<u>2.11.3.1.1 On-Time Resolutions.</u> To be considered as regular business, each resolution must be introduced by a delegate or organization represented in the House of Delegates and must have been submitted to the AMA not later than 45 days prior to the commencement of the meeting at which it is to be considered, with the following exceptions.

2.11.3.1.1.<u>1</u> AMA Sections. Resolutions presented from ~~the business~~ meetings of the AMA Sections <u>convened prior to the coinciding House of Delegates meeting but after the 45 day on-time deadline</u> may be presented for consideration by the House of Delegates <u>upon adoption by the Section</u> and no later than the <u>commencement</u> ~~recess~~ of the House of Delegates opening session to be accepted as regular business. Section ~~R~~<u>r</u>esolutions presented after the <u>commencement</u> ~~recess~~ of the opening session of the House of Delegates will be accepted in accordance with Bylaw 2.11.3.1.3.

2.11.3.1.2 Late Resolutions. Late resolutions may be presented by a delegate <u>or organization represented in the House of Delegates</u> any time after the 45-day resolution deadline until the <u>commencement of the</u> opening session of the House of Delegates, and will be accepted as business of the House of Delegates only upon two-thirds vote of delegates present and voting.

2.11.3.1.3 Emergency Resolutions. Resolutions of an emergency nature may be presented by a delegate any time after the commencement of the opening session of the House of Delegates. Emergency resolutions will be accepted as business only upon a three-fourths vote of delegates present and voting, and if accepted shall be ~~presented to~~ considered by the House of Delegates without ~~consideration~~ deliberation by a reference committee. ~~A simple majority vote of the delegates present and voting shall be required for adoption.~~

(Modify Bylaws)

Online testimony was in general support. In-person testimony was heard in unanimous support. Your Reference Committee recommends that the report be adopted.

(5) CCB REPORT 02 - NAME CHANGE FOR REFERENCE COMMITTEE

RECOMMENDATION:

Your Reference Committee recommends that CCB Report 02 be adopted and the remainder of the Report be filed.

HOD ACTION: Recommendations in CCB Report 02 adopted and the remainder of the Report filed.

The Council on Constitution and Bylaws recommends that the following recommendation be adopted and that the remainder of this report be filed. Adoption requires the affirmative vote of two-thirds of the members of the House of Delegates present and voting following a one-day layover:

1) That our AMA Bylaws be amended by insertion and deletion as follows:

2.13 Committees of the House of Delegates.

2.13.1 Reference Committees of the House of Delegates.

2.13.1.1 Ethics and ~~Amendments to the Constitution and~~ Bylaws. All ~~proposed amendments to the Constitution or Bylaws, and~~ matters pertaining to ethics, the Principles of Medical Ethics of the AMA and to the AMA Constitution and Bylaws shall be referred to this committee.

(Modify Bylaws)

Online testimony was in unanimous support. No in-person testimony was heard. Your Reference Committee recommends that the report be adopted.

(6) CEJA REPORT 01 - EXPANDING ACCESS TO PALLIATIVE CARE

RECOMMENDATION:

Your Reference Committee recommends that CEJA Report 01 be adopted and the remainder of the Report be filed.

HOD ACTION: Recommendations in CEJA Report 01 adopted and the remainder of the Report be filed.

Given both the AMA Policy and CEJA's historical support of addressing the palliative needs of patients and the duty of clinicians to provide optimal palliative care to patients, it is recommended that the *Code of Medical Ethics* be amended to include a new opinion on Palliative Care.

Physicians have clinical ethical responsibilities to address the pain and suffering occasioned by illness and injury and to respect their patients as whole persons. These duties require physicians to assure the provision of effective palliative care whenever a patient is experiencing serious, chronic, complex, or critical illness, regardless of prognosis. Palliative care is sound medical treatment that includes the comprehensive management and coordination of care for pain and other distressing symptoms including physical, psychological, intellectual, social, spiritual, and existential distress from serious illness. Evaluation and treatment are patient-centered but with an additional focus on the needs, values, beliefs, and culture of patients and those who love and care for them in decision-making accordingly.

Palliative care is widely acknowledged to be appropriate for patients who are close to death, but persons who have chronic, progressive, and/or eventually fatal illnesses often have symptoms and experience suffering early in the disease course. The clinical ethical responsibilities to address symptoms and suffering may therefore sometimes entail a need for palliative care before the terminal phase of disease. Moreover, the duty to respect patients as whole persons should lead physicians to encourage patients with chronic, progressive, and/or eventually fatal conditions to identify surrogate medical decision makers, given the likelihood of a loss of decisional capacity during medical treatment.

When caring for patients' physicians should:

(a) Integrate palliative care into treatment.
(b) Seek and/or provide palliative care, as necessary, for the management of symptoms and suffering occasioned by any serious illness or condition, at any stage, and at any age throughout the course of illness.
(c) Offer palliative care simultaneously with disease modifying interventions, including attempts for cure or remission.
(d) Be aware of, and where needed, engage palliative care expertise in care.

Physician as a profession should:

(e) Advocate that palliative care be accessible for all patients, as necessary, for the management of symptoms and suffering occasioned by any serious illness or condition, at any stage, and at any age throughout the course of illness. (New Policy)

The majority of online testimony was in strong support and a minority asked for a minor clarification. In-person testimony was in general support. CEJA testified in person that they agreed with the minor clarification proffered during online testimony and that this clarification had been addressed in the report. Your Reference Committee recommends that the report be adopted.

(7) RESOLUTION 003 - ON THE ETHICS OF HUMAN LIFESPAN PROLONGATION

RECOMMENDATION:

Your Reference Committee recommends that Resolution 003 be <u>adopted.</u>

HOD ACTION: Resolution 003 <u>adopted.</u>

RESOLVED, that our American Medical Association undertake an evaluation of the ethics of extension of the human lifespan, currently considered to be 120 years, with the goal of providing guidance and/or guidelines for clinical practice, research and potential regulatory challenges. (Directive to Take Action)

The majority of online testimony was in support. In-person testimony was provided by the author of the resolution to clarify language based on the online testimony. Your Reference Committee recommends that the resolution be adopted.

(8) RESOLUTION 006 - OPPOSITION TO THE DECEPTIVE RELOCATION OF MIGRANTS AND ASYLUM SEEKERS

RECOMMENDATION:

Your Reference Committee recommends that Resolution 006 be <u>adopted.</u>

HOD ACTION: Resolution 006 <u>adopted.</u>

RESOLVED, that our American Medical Association oppose the relocation of migrants and asylum-seekers by state or federal authorities without timely and appropriate resources to meet travelers' needs, especially when deceptive or coercive practices are used (New HOD Policy); and be it further

RESOLVED, that our AMA support state and federal efforts to protect the health and safety of traveling migrants and asylum-seekers and investigate possible abuse and human rights violations. (New HOD Policy)

Online testimony was mixed, with a slight majority of testimony in support. Extensive in-person testimony was heard in general support. Testimony in support noted that the resolution highlights a pressing need and is within the AMA's purview. Testimony in opposition explained that the resolution was political in nature and inflammatory. Your Reference Committee recommends that the report be adopted.

(9) RESOLUTION 008 - MISSING AND MURDERED BLACK WOMEN AND GIRLS

RECOMMENDATION:

Your Reference Committee recommends that Resolution 008 be adopted.

HOD ACTION: Resolution 008 adopted.

RESOLVED, that our American Medical Association advocate that the United States Department of Justice collect data on missing persons and homicide cases involving Black women and girls, including the total number of cases, the rate at which the cases are solved, the length of time the cases remain open, and a comparison to similar cases involving different demographic groups (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for the United States Department of Justice, legislators, and other stakeholders to collect data on Amber Alerts, including the total number of Amber Alerts issued, aggregated by the child's race and sex (Directive to Take Action); and be it further

RESOLVED, that our AMA encourage state medical societies to work with legislators, advocates, and other stakeholders to establish equity in policy and practices related to missing and murdered black women and girls. (New HOD Policy)

The majority of online testimony was in support. In-person testimony was heard in unanimous support. Your Reference Committee recommends that the resolution be adopted.

(10) RESOLUTION 010 - DEVELOPMENT OF RESOURCES FOR MEDICAL STAFFS TO ENGAGE IN COLLECTIVE NEGOTIATION WITH HOSPITAL AND HEALTH SYSTEMS

RECOMMENDATION:

Your Reference Committee recommends that Resolution 010 be adopted.

HOD ACTION: Resolution 010 adopted.

RESOLVED, that our American Medical Association develop and distribute comprehensive materials to enable medical staffs to become effective agents for collective negotiation with hospitals and health systems (Directive to Take Action); and be it further

RESOLVED, that our AMA allocate appropriate resources and support to assist medical staffs in understanding their rights, the negotiation process, and strategies for successful collective action (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for policies at the state and federal levels that support the rights of medical staffs to engage in collective negotiation with hospital systems (Directive to Take Action).

In-person testimony was in nearly unanimous support. Limited testimony in opposition called for referral for further study due to legal and financial concerns. Your Reference Committee recommends that Resolution 010 be adopted.

RECOMMENDED FOR ADOPTION AS AMENDED

(11) BOT REPORT 08 - INCREASING ACCESS TO MEDICAL CARE FOR PEOPLE SEEKING ASYLUM

RECOMMENDATION A:

That provision 8 of policy H-350.957 in BOT Report 08 be amended by addition as follows:

8. Our AMA encourages provision of resources to assist people seeking asylum, including social and legal services.

RECOMMENDATION B:

That BOT Report 08 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Recommendations in BOT Report 08 adopted as amended and the remainder of the report filed.

The AMA recognizes that there are many facets to the legal U.S. immigration system, including medical evaluation. Asylum seekers are in need of care and assistance, and medical students, trainees, and physicians should play a role in this medical care. The AMA supports opportunities for interested physicians to gain further education and training to care for these patients.

The Board of Trustees therefore recommends that the following recommendations be adopted and the remainder of this report be filed.

That Policy H-350.957 be amended by addition and deletion to read as follows:

3. Our AMA ~~will~~ calls for asylum seekers to receive medically-appropriate care, including vaccinations, in a patient centered, language and culturally appropriate way upon presentation for asylum regardless of country of origin.
4. Our AMA supports efforts to train physicians to conduct medical and psychiatric forensic evaluations for asylum seekers.
5. Our AMA supports medical education that addresses the challenges of life-altering events experienced by asylum seekers.
6. Our AMA urges physicians to provide medically-appropriate care for asylum seekers.
7. Our AMA encourages physicians to seek out organizations or agencies in need of physicians to provide these services.
8. Our AMA encourages provision of resources to assist people seeking asylum.

Online testimony supported the amendments proffered by your Reference Committee in the Preliminary Report. Online testimony was in near unanimous support; the original authors of the resolution proffered an amendment to better address unique needs and barriers to health care

that asylum seekers face. In-person testimony was heard in unanimous support. Your Reference Committee recommends that the report be adopted as amended.

(12) BOT REPORT 14 - PRIVACY PROTECTION AND PREVENTION OF FURTHER TRAUMA FOR VICTIMS OF DISTRIBUTION OF INTIMATE VIDEOS AND IMAGES WITHOUT CONSENT

RECOMMENDATION A:

Your Reference Committee recommends that BOT Report 14 be amended by addition as follows:

That our American Medical Association (AMA) encourage the development of public and private sector initiatives to prevent and address image-based sexual violence or abuse. (New HOD Policy)

RECOMMENDATION B:

That BOT Report 14 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Recommendations in BOT Report 14 adopted as amended and the remainder of the report filed.

The Board of Trustees recommends that the following be adopted and the remainder of the report be filed:

1. That our American Medical Association (AMA) encourage the development of public and private sector initiatives to prevent and address image-based sexual violence. (New HOD Policy)

2. That Policy D-515.975 be rescinded as having been accomplished by this report.

Online testimony was in unanimous support. The majority of in-person testimony was in support with limited opposition. Testimony in support noted that the report provides a good first step in addressing a growing problem. Testimony in opposition noted that the definitions were ambiguous. Proffered amendments suggested minor language changes for clarity. Your Reference Committee recommends that the report be adopted as amended.

(13) BOT REPORT 18 - EXPANDING PALLIATIVE CARE

RECOMMENDATION A:

That recommendation provision 2 in BOT Report 18 be amended by addition and deletion as follows:

(2) recognizes that palliative care is the comprehensive management and coordination of care for pain and other distressing symptoms, including physical, psychological, intellectual, social, psychosocial, spiritual, and the existential consequences of a serious illness, which improves the quality of life of patients and their families/caregivers, and that generalist and subspecialist palliative care evaluation and ~~that palliative care~~ treatments are patient-centered and family-oriented~~.~~, emphasizing shared decision-making according to the needs, values, beliefs, and culture or cultures of the patient and their family or chosen family

RECOMMENDATION B:

That recommendation provision 4 in BOT Report 18 be amended by addition and deletion as follows:

(4) recognizes that palliative care can be offered alongside curative or life-prolonging treatments at any stage of illness, whereas hospice is a specific type of palliative care, typically reserved for individuals with a prognosis of six months or less ~~who have chosen to forego most life-prolonging therapies, whereas palliative can be offered alongside curative or life-prolonging treatments at any stage of illness~~.

RECOMMENDATION C:

That BOT Report 18 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Recommendations of BOT Report 18 adopted as amended and the remainder of the report filed.

In light of these considerations, the Board of Trustees Report 18 reaffirms H-295.825, Palliative Care and End-of-Life Care; H-70.915, Good Palliative Care; D-295.969, Geriatric and Palliative Care Training for Physicians; and recommends that alternate Resolution 722, “Expanding

Protection of End-of-Life Care," be adopted in lieu of Resolution 722 and this report be titled "Expanding Palliative Care" and the remainder of this report be filed:

Our American Medical Association:

(1) recognizes that access to palliative care, including hospice, is a human right.

(2) recognizes that palliative care is the comprehensive management and coordination of care for pain and other distressing symptoms, including physical, psychological, intellectual, social, psychosocial, spiritual, and the existential consequences of a serious illness, which improves the quality of life of patients and their families/caregivers and that palliative care evaluation and that palliative care treatments are patient-centered and family-oriented., emphasizing shared decision-making according to the needs, values, beliefs, and culture or cultures of the patient and their family or chosen family.

(3) recognizes that palliative care can be offered in all care settings through a collaborative team approach involving all disciplines (e.g., physicians, nurses, social workers, spiritual care providers, therapists, pharmacists) and should be available at any stage of a serious illness from birth to advanced age and may be offered simultaneously with disease modifying interventions.

(4) recognizes that hospice is a specific type of palliative care, reserved for individuals with a prognosis of six months or less who have chosen to forego most life-prolonging therapies, whereas palliative can be offered alongside curative or life-prolonging treatments at any stage of illness.

(5) recognizes that palliative care differs from physician assisted suicide in that palliative care does not intentionally cause death. In fact, palliative treatments that relieve symptom distress have been shown in numerous studies to prolong life.

(6) will work with interested state medical societies and medical specialty societies and vigorously advocate for broad, equitable access to palliative care, including hospice, to ensure that all populations, particularly those from underserved or marginalized communities have access to these essential services.

(7) opposes the imposition of criminal and civil penalties or other retaliatory efforts against physicians for assisting in, referring patients to, or providing palliative care services, including hospice.

(New HOD Policy)

Online testimony was generally in support, with amendments proffered for clarity and to highlight the importance of both generalist and subspecialist palliative care treatments. In-person testimony was heard in general support of the report as amended by your Reference Committee in the Preliminary Report. Limited in-person testimony highlighted that physician assisted suicide is beyond the scope of this report. Your Reference Committee recommends that the report be adopted as amended.

(14) CCB REPORT 03 - BYLAW AMENDMENTS TO ADDRESS MEDICAL STUDENT LEADERSHIP

RECOMMENDATION A:

That CCB Report 03 section 7.7.3.1 be amended by deletion as follows:

7.7.3.1 Section Representatives on the Governing Council. If a representative of the ~~Medical Student Section,~~ Resident and Fellow Section or Young Physicians Section ceases to meet the criteria for membership in the section from which elected within 90 days prior to the Annual Meeting, such member shall be permitted to serve in office until the conclusion of the Annual Meeting in the calendar year in which they cease to meet the membership requirement of the respective section. If a representative of the Medical Student Section graduates from an educational program during their governing council term, such medical student member shall be permitted to serve in office for up to 200 days after graduation but not extending past ~~until~~ the completion of the Annual Meeting following graduation.

RECOMMENDATION B:

That CCB Report 03 section 7.10.3.1 be amended by deletion as follows:

7.10.3.1 Section Representatives on the Governing Council. If a representative of the ~~Medical Student Section,~~ Resident and Fellow Section or Young Physicians Section ceases to meet the criteria for membership in the section from which elected within 90 days prior to the Annual Meeting, such member shall be permitted to serve in office until the conclusion of the Annual Meeting in the calendar year in which they cease to meet the membership requirement of the respective section. If any representative of the Medical Student Section graduates from an educational program during their governing council term, such medical student member shall be permitted to serve in office for up to 200 days after graduation but not extending past ~~until~~ the completion of the Annual Meeting following graduation.

RECOMMENDATION C:

That CCB Report 03 section 7.12.2.3 be amended by addition as follows:

7.12.2.3 If any ~~medical student,~~ resident/fellow or young physician member of the governing council ceases to meet the criteria for membership in the section they represent within 90 days prior to the Annual Meeting they will be permitted to continue to serve in their position until the conclusion of the Annual Meeting in the calendar year in which they cease to meet the membership requirement of their section. If any medical student member graduates from an educational program during their governing council term, such medical student member shall be permitted to serve in office for up to 200 days after graduation but not extending past the completion of the Annual Meeting following graduation.

RECOMMENDATION D:

That CCB Report 03 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Recommendations in CCB Report 03 adopted as amended and the remainder of the report filed.

The Council on Constitution and Bylaws recommends that the following recommendation be adopted; that Policy D-605.985 be rescinded; and that the remainder of this report be filed. Adoption requires the affirmative vote of two-thirds of the members of the House of Delegates present and voting following a one-day layover:

1) That our AMA Bylaws be amended by insertion and deletion as follow:

3 Officers

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3.5.6 Medical Student Trustee. The Medical Student Section shall elect the medical student trustee annually. The medical student trustee shall have all of the rights of a trustee to participate fully in meetings of the Board, including the right to make motions and to vote on policy issues, intra-Board elections or other elections, appointments or nominations conducted by the Board of Trustees.

3.5.6.1 Term. The medical student trustee shall be elected at the Business Meeting of the Medical Student Section prior to the Interim Meeting for a term of one year beginning at the close of the next Annual Meeting and concluding at the close of the second Annual Meeting following the meeting at which the trustee was elected.

3.5.6.2 Re-election. The medical student trustee shall be eligible for re-election as long as the trustee remains eligible for medical student membership in AMA.

3.5.6.3 Cessation of Enrollment. The term of the medical student trustee shall terminate and the position shall be declared vacant if the medical student trustee should cease to be eligible for medical student membership in the AMA by virtue of the termination of the trustee's enrollment in an educational program. If the medical student trustee graduates from an educational program during their term, ~~within 90 days prior to an Annual Meeting~~, the trustee shall be permitted to continue to serve on the Board of Trustees for up to 200 days after graduation but not extending past the Annual Meeting following graduation. ~~until completion of the Annual Meeting.~~

6 Councils

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6.11 Term of Resident/Fellow Physician or Medical Student Member. A resident/fellow physician ~~or medical student member~~ of a Council who completes residency or fellowship ~~or who graduates from an educational program within 90 days prior to an Annual Meeting~~ shall be permitted to serve on the Council until the completion of the Annual Meeting following completion. A medical student member of a Council who graduates from an educational program during their term ~~within 90 days prior to an Annual Meeting~~ shall be permitted to serve on the Council for up to 200 days after graduation but not extending past the completion of the Annual Meeting following graduation. Service on a Council as a resident/fellow physician and/or medical student member shall not be counted in determining maximum Council tenure.

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7 Sections

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7.3 Medical Student Section. The Medical Student Section is a fixed Section.

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7.3.1 Membership. All active medical student members of the AMA shall be members of the Medical Student Section.

7.3.2 Cessation of Eligibility. If any officer or Governing Council member ceases to meet the membership requirements of Bylaw 7.3.1 prior to the expiration of the term for which elected, the term of such officer or member shall terminate and the position shall be declared vacant. If the officer or member graduates from an educational program during their term ~~within 90 days prior to an Annual Meeting~~, the officer or member shall be permitted to continue to serve in office for up to 200 days after graduation but not extending past ~~until the completion of~~ the Annual Meeting following graduation.

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7.7 Minority Affairs Section. The Minority Affairs Section is a delineated Section.

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7.7.3.1 Section Representatives on the Governing Council. If a representative of the ~~Medical Student Section,~~ Resident and Fellow Section or Young Physicians Section ceases to meet the criteria for membership in the section from which elected within 90 days prior to the Annual Meeting, such member shall be permitted to serve in office until the conclusion of the Annual Meeting in the calendar year in which they cease to meet the membership requirement of the respective section. If a representative of the Medical Student Section graduates from an educational program during their governing council term, such medical student member shall be permitted to serve in office for up to 200 days after graduation but not extending past until the completion of the Annual Meeting following graduation.

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7.10 Women Physicians Section. The Women Physicians Section is a delineated Section.

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7.10.3.1 Section Representatives on the Governing Council. If a representative of the ~~Medical Student Section,~~ Resident and Fellow Section or Young Physicians Section ceases to meet the criteria for membership in the section from which elected within 90 days prior to the Annual Meeting, such member shall be permitted to serve in office until the conclusion of the Annual Meeting in the calendar year in which they cease to meet the membership requirement of the respective section. If any representative of the Medical Student Section graduates from an educational program during their governing council term, such medical student member shall be permitted to serve in office for up to 200 days after graduation but not extending past until the completion of the Annual Meeting following graduation.

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7.12 LGBTQ+ Section. The LGBTQ+ Section is a delineated Section.

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7.12.2.3 If any ~~medical student,~~ resident/fellow or young physician member of the governing council ceases to meet the criteria for membership in the section they represent within 90 days prior to the Annual Meeting they will be permitted to continue to serve in their position until the conclusion of the Annual Meeting in the calendar year in which they cease to meet the membership requirement of their section. If any medical student member graduates from an educational program during their governing council term, such medical student shall be permitted to serve in office for up to 200 days after graduation but not extending past the completion of the Annual Meeting following graduation.

(Modify Bylaws)

The majority of online testimony was in support, with amendments proffered for clarity and consistency of language. In-person testimony was heard in unanimous support as amended by your Reference Committee in the Preliminary Report. Your Reference Committee recommends that the report be adopted as amended.

(15) RESOLUTION 001 - ADDRESSING GENDER-BASED PRICING DISPARITIES

RECOMMENDATION A:

That the resolve of Resolution 001 be amended by addition as follows:

RESOLVED, that our American Medical Association support federal and state efforts to minimize gender-based pricing disparities, especially in healthcare services and products. (New HOD Policy)

RECOMMENDATION B:

That Resolution 001 be adopted as amended.

HOD ACTION: Resolution 001 adopted as amended.

RESOLVED, that our American Medical Association support federal and state efforts to minimize gender-based pricing disparities in healthcare services and products. (New HOD Policy)

Online testimony was in unanimous support of the resolution, with an amendment proffered to highlight the fact that gender-based pricing disparities are not relegated to health care services and products alone. In-person testimony was heard in near unanimous support of the resolution as amended by your Reference Committee in the Preliminary Report. Your Reference Committee recommends that the resolution be adopted as amended.

(16) RESOLUTION 002 - ANTI-DOXXING DATA PRIVACY PROTECTION

RECOMMENDATION A:

That the first resolve of Resolution 002 be amended by addition and deletion as follows:

RESOLVED, that our American Medical Association support all physicians and medical students ~~healthcare providers, that provide reproductive and gender-affirming care~~ who experience doxxing, support nondiscrimination and privacy protection for employees, and availability of resources on doxxing (New HOD Policy); and be it further

RECOMMENDATION B:

That the second resolve of Resolution 002 be amended by addition and deletion as follows:

RESOLVED, that our AMA work with partners to support data privacy and anti-doxxing laws to prevent harassment, threats, and non-consensual publishing of information for all physicians and medical students ~~who provide reproductive and gender-affirming care~~ (Directive to Take Action); and be it further

RECOMMENDATION C:

That the third resolve of Resolution 002 be amended by addition and deletion as follows:

RESOLVED, that our AMA encourage institutions, employers, and state medical societies to provide educational and legal resources ~~and~~ as well as support for all physicians and medical students ~~who provide reproductive and gender-affirming care~~ who are affected by doxxing (New HOD Policy); and be it further

RECOMMENDATION D:

That Resolution 002 be adopted as amended.

HOD ACTION: Resolution 002 adopted as amended.

RESOLVED, that our American Medical Association support physicians and healthcare providers that provide reproductive and gender-affirming care who experience doxxing, support nondiscrimination and privacy protection for employees, and availability of resources on doxing (New HOD Policy); and be it further

RESOLVED, that our AMA work with partners to support data privacy and anti-doxxing laws to prevent harassment, threats, and non-consensual publishing of information for physicians who provide reproductive and gender-affirming care (Directive to Take Action); and be it further

RESOLVED, that our AMA encourage institutions, employers, and state medical societies to provide legal resources and support for physicians who provide reproductive and gender-affirming care who are affected by doxing (New HOD Policy); and be it further

RESOLVED, that our AMA encourage institutions, employers, and medical societies to provide training and education on the issue of doxxing. (New HOD Policy)

Online testimony was in unanimous support of the resolution. The majority of in-person testimony was in favor of the resolution as amended in the Preliminary Report, with near unanimous support that the resolution also be amended to broaden the scope and apply to all physicians. Additionally, in-person testimony requested an amendment to include medical students and access to educational resources for physicians. Your Reference Committee recommends that the resolution be adopted as amended.

(17) RESOLUTION 005 - UPDATING THE AMERICAN MEDICAL ASSOCIATION DEFINITION OF INFERTILITY

RECOMMENDATION A:

The first resolve of Resolution 005 be amended by addition as follows:

RESOLVED, that our American Medical Association amend policy H-420.952 "Recognition of Infertility as a Disease" by addition, to state:

1.Our AMA supports the World Health Organization's designation of infertility as a disease state with multiple etiologies requiring a range of interventions to advance fertility treatment and prevention.

2.Our AMA also supports the American Society for Reproductive Medicine's definition of infertility as (a) the inability to achieve a successful pregnancy based on a patient's medical, sexual, and reproductive history, age, physical findings, diagnostic testing, or any combination of those factors; (b) the need for medical intervention, including, but not limited to, the use of donor gametes or donor embryos in order to achieve a successful pregnancy either as an individual or with a partner; and (c) in patients having regular unprotected intercourse and without any known etiology for either partner suggestive of impaired reproductive ability, the patient should be reevaluated at 12 months when the female partner is under 35 years of age and at 6 months when the female partner is 35 years of age or older. Nothing in this definition shall be used to deny or delay treatment to any individual, regardless of relationship status or sexual orientation (Modify Current HOD Policy); and be it further

3. Our AMA affirms that nothing in this definition shall be used to deny or delay treatment to any individual, regardless of relationship status, sexual orientation, or gender identity (Modify Current HOD Policy); and be it further

RECOMMENDATION B:

That the second resolve of Resolution 005 be amended by addition and deletion as follows:

RESOLVED, that our AMA work with other interested organizations to communicate with third-party payers that discrimination in coverage of fertility services on the basis of marital status, ~~or~~ sexual orientation, or gender identity cannot be justified (Directive to Take Action); and be it further

RECOMMENDATION C:

That a new resolve be included by addition after the second resolve:

RESOLVED, that our American Medical Association work with state societies and other interested organizations to encourage all states to recognize the American Society for Reproductive Medicine's definition of infertility, and further communicate with third-party payers that discrimination in coverage of fertility services on the basis of marital status, sexual orientation, or gender identity cannot be justified; and be it further

RECOMMENDATION D:

That Resolution 005 be adopted as amended.

HOD ACTION: Resolution 005 adopted as amended.

RESOLVED, that our American Medical Association amend policy H-420.952 "Recognition of Infertility as a Disease" by addition, to state:

1.Our AMA supports the World Health Organization's designation of infertility as a disease state with multiple etiologies requiring a range of interventions to advance fertility treatment and prevention.

2.Our AMA also supports the American Society for Reproductive Medicine's definition of infertility as (a) the inability to achieve a successful pregnancy based on a patient's medical, sexual, and reproductive history, age, physical findings, diagnostic testing, or any combination of those factors; (b) the need for medical intervention, including, but not limited to, the use of donor gametes or donor embryos in order to achieve a successful pregnancy either as an individual or with a partner; and (c) in patients having regular unprotected intercourse and without any known etiology for either partner suggestive of impaired reproductive ability, evaluation should be evaluated at 12 months when the female partner is under 35 years of age and at 6 months when the female partner is 35 years of age or older. Nothing in this definition shall be used to deny or delay treatment to any individual, regardless of relationship status or sexual orientation. (Modify Current HOD Policy); and be it further

RESOLVED, that our AMA work with other interested organizations to communicate with third-party payers that discrimination in coverage of fertility services on the basis of marital status or sexual orientation cannot be justified (Directive to Take Action); and be it further

RESOLVED, that our AMA reaffirm policy H-510.984 "Infertility Benefits for Veterans," (Reaffirm HOD Policy); and be it further

RESOLVED, that our AMA report back on this issue at I-25. (Directive to Take Action)

Online testimony was in near unanimous agreement that the resolution be adopted. Two amendments were proffered by the authors to address feedback that the term "gender identity" be used in the first two resolve clauses, as well as an additional resolve clause be added to address the issue of states using outdated definitions of infertility. In-person testimony was in overwhelming support of the amendment proffered by your Reference Committee in the Preliminary Report. Your Reference Committee recommends that the resolution be adopted as amended.

RECOMMENDED FOR REFERRAL

(18) CEJA REPORT 02 - PROTECTING PHYSICIANS WHO ENGAGE IN CONTRACTS TO DELIVER HEALTH CARE SERVICES

RECOMMENDATION:

Your Reference Committee recommends that CEJA Report 02 be referred and the remainder of the Report be filed.

HOD ACTION: Recommendations of CEJA Report 02 referred and the remainder of the Report filed.

In view of these deliberations, the Council on Ethical and Judicial Affairs recommends that Opinion 11.2.3, "Contracts to Deliver Health Care Services," be amended by addition and deletion as follows and the remainder of this report be filed:

While profitmaking is not inherently unethical, no part of the health care system that supports or delivers patient care should place profits over such care. Physicians have a fundamental ethical obligation to put the welfare of patients ahead of other considerations, including personal financial interests. This obligation requires ~~them to~~ that before entering into contracts to deliver health care services, physicians consider carefully the proposed contract to assure themselves that its terms and conditions ~~of contracts to deliver health care services before entering into such contracts to ensure that those contracts~~ do not create untenable conflicts of interest or compromise their ability to fulfill their ethical and professional obligations to patients.

Ongoing evolution in the health care system continues to bring changes to medicine, including changes in reimbursement mechanisms, models for health care delivery, restrictions on referral and use of services, clinical practice guidelines, and limitations on benefits packages. While these changes are intended to enhance quality, efficiency, and safety in health care, they can also put at risk physicians' ability to uphold professional ethical standards ~~of informed consent and fidelity to patients~~ and can impede physicians' freedom to exercise independent professional judgment and tailor care to meet the needs of individual patients.
As physicians seek capital to support their practices or enter into various differently structured contracts to deliver health care services—with group practices, hospitals, health plans, investment firms, or other entities—they should be mindful that while ~~many~~ some arrangements have the potential to promote desired improvements in care, ~~some~~ other arrangements ~~also~~ have the potential to ~~impede~~ put patients' interests at risk and to interfere with physician autonomy.

When contracting with entities, or having a representative do so on their behalf, to provide health care services, physicians should:

(a) Carefully review the terms of proposed contracts, preferably with the advice of legal and ethics counsel, ~~or have a representative do so on their behalf~~ to assure themselves that the arrangement:
(i) minimizes conflict of interest with respect to proposed reimbursement mechanisms, financial or performance incentives, restrictions on care, or other mechanisms intended to influence physicians' treatment recommendations or direct what care patients receive, in keeping with ethics guidance;
(ii) does not compromise the physician's own financial well-being or ability to provide high-quality care through unrealistic expectations regarding utilization of services or terms that expose the physician to excessive financial risk;
(iii) ~~allows~~ ensures the physician can ~~to~~ appropriately exercise professional judgment;
(iv) includes a mechanism to address grievances and supports advocacy on behalf of individual patients;
(v) is transparent and permits disclosure to patients;
(vi) enables physicians to have significant influence on, or preferably outright control of, decisions that impact practice staffing.

(b) Negotiate modification or removal of any terms that unduly compromise physicians' ability to uphold ethical or professional standards.

When entering into contracts as employees, preferably with the advice of legal and ethics counsel, physicians should:
(c) Advocate for contract provisions to specifically address and uphold physician ethics and professionalism.

(d) Advocate that contract provisions affecting practice align with the professional and ethical obligations of physicians and negotiate to ensure that alignment.

(e) Advocate that contracts do not require the physician to practice beyond their professional capacity and provide contractual avenues for addressing concerns related to good practice, including burnout or related issues.

(Modify HOD/CEJA Policy)

Online testimony was mixed but generally in support. Extensive in-person mixed testimony was heard. Supporting testimony noted that financial incentives do not apply only to private equity-owned practices and that the report accurately addressed current reality. Opposing testimony noted that the report placed too high of a bar on physicians contracting with private equity and needs stronger language to guide those working for private equity investors. Your Reference Committee recommends that this report be referred with report back at A-25.

(19) RESOLUTION 004 - IMPROVING USABILITY OF ELECTRONIC HEALTH RECORDS FOR TRANSGENDER AND GENDER DIVERSE PATIENTS

RECOMMENDATION:

Your Reference Committee recommends that Resolution 004 be referred.

HOD ACTION: Resolution 004 referred.

RESOLVED, that our American Medical Association amend policy H-315.967 "Inclusive Gender, Sex, and Sexual Orientation Options on Medical Documentation" by addition and deletion to read as follows:

Promoting Inclusive Gender, Sex, and Sexual Orientation Options on Medical Documentation, H315.967

Our AMA: (1) supports the voluntary inclusion of a patient's ~~biological sex~~current clinical sex, sex assigned at birth, current gender identity, legal sex on identification documents, sexual orientation, ~~preferred~~ gender pronoun(s), ~~preferred~~ chosen name, and clinically relevant, sex specific anatomy in medical documentation, and related forms, including in electronic health records, in a culturally-sensitive and voluntary manner, with efforts to improve visibility and awareness of transgender and gender diverse patients' chosen name and pronouns in all relevant EHR screens and to de-emphasize or conceal legalname except when required for insurance and billing purposes; (2) Will advocate for the inclusion of an organ inventory encompassing medical transition history and a list of current present organs in EHRs, with efforts to link organ-specific examinations and cancer screenings to the current organ inventory rather than sex or gender identity; (~~2~~3). Will advocate for collection of patient data in medical documentation and in medical research studies, according to current best practices, that is inclusive of sexual orientation, gender identity, and other sexual and gender minority traits for the purposes of research into patient and population health; (~~3~~4) Will research the problems related to the handling of sex and gender within health information technology (HIT) products and how to best work with vendors so their HIT products treat patients equally and appropriately, regardless of sexual or gender identity; (~~4~~5) Will investigate the use of personal health records to reduce physician burden in maintaining accurate patient information instead of having to query each patient regarding sexual orientation and gender identity at each encounter; and (~~5~~6) Will advocate for the incorporation of recommended best practices into electronic health records and other HIT products at no additional cost to physicians automatically. (7) Will advocate for patient informed consent regarding how gender identity and related data will be used with the ability to opt out of recording aforementioned data without compromising patient care; (Modify Current HOD Policy); and be it further

RESOLVED, that our AMA supports the use of the term "chosen name" over "preferred name," recognizing the value of the term "chosen name" to transgender and gender-diverse patients (New HOD Policy).

Online testimony was mixed, with the majority in support of the resolution. In-person mixed testimony was heard, with the majority in support of referral. Supporting testimony noted the importance of the issue and the collection of data. Opposing testimony stated further clarification of terms like “clinical sex” was necessary, as well as protecting the confidentiality and privacy of minors. Your Reference Committee recommends that this resolution be referred.

(20) RESOLUTION 007 - SUPPORTING DIVERSITY IN RESEARCH

RECOMMENDATION:

Your Reference Committee recommends that Resolution 007 be referred.

HOD ACTION: Resolution 007 referred.

RESOLVED, that our American Medical Association support the use of language interpreters and translators in clinical and medical research participation to promote equitable data collection and outcomes (New HOD Policy); and be it further

RESOLVED, that our AMA encourage all Institutional and Research Review Boards (IRBs) to develop and publish transparent guidelines for interpreter services to ensure appropriate enrollment and ongoing participation of medical and clinical research participants with Limited English Proficiency and Deaf or Hard of Hearing people (New HOD Policy); and be it further

RESOLVED, that our AMA advocate for the Department of Health and Human Services and Office for Human Research Protections (OHRP) to update their guidance on “Informed Consent of Subjects Who Do Not Speak English (1995)” (Directive to Take Action); and be it further

RESOLVED, that our AMA support the creation of a federal standard upon which individual Institutional Review Boards (IRBs) may base their recommendations. (New HOD Policy)

Online testimony was mixed, with those in opposition calling for referral. In-person testimony was mixed, with the majority calling for referral, noting that the resolution needs more work and is unclear. The author testified in support of referral. Your Reference Committee recommends that the resolution be referred with report back at A-25.

RECOMMENED FOR REFERRAL FOR DECISION

(21) RESOLUTION 009 - OPPOSITION TO CREATION OR ENFORCEMENT OF CIVIL LITIGATION, COMMONLY REFERRED TO AS CIVIL CAUSES OF ACTION

RECOMMENDATION:

Your Reference Committee recommends that Resolution 009 be referred for decision.

HOD ACTION: Resolution 009 referred for decision.

RESOLVED, that our American Medical Association affirms that civil causes of action in healthcare should be limited to causes of action that address alleged violations of a physician's duty to meet the standard of care in the treatment of patients. (New HOD Policy)

Online testimony was mixed. In-person testimony was in support of the resolution; however, testimony also expressed concern over potential legal issues with the current phrasing of the recommendations. Due to testimony urging immediate action as a result of pending legislation, your Reference Committee recommends that the resolution be referred for decision.

RECOMMENDED FOR NOT ADOPTION

(22) RESOLUTION 011 - AMERICAN KIDNEY DONATION LEGISLATION

RECOMMENDATION:

Your Reference Committee recommends that Resolution 011 <u>be not adopted.</u>

HOD ACTION: Resolution 011 <u>not adopted.</u>

RESOLVED, that our American Medical Association support federal legislation for pilot studies of non-monetary or monetary incentives, including delayed tax credits, to increase living kidney donations (Directive to Take Action).

In-person testimony was extensive and mixed. Testimony in support noted the pressing need to increase living kidney donation, which has not increased in the past 20 years despite educational programs and outreach. Testimony in opposition cited the dangers of financial incentives for organ donation, such as coercion, and the likelihood of a disproportional impact on minority and vulnerable communities. It was noted that the resolution quoted *Code of Medical Ethics* Opinion 6.1.3, which pertains to studying incentives for cadaveric organ donations but incorrectly applied it to living organ donations. The *Code of Medical Ethics* Opinion 6.1.1, which pertains to living organ donations, states that one should “ensure that living donors do not receive payment of any kind for any of their solid organs” and therefore, it would not be appropriate to support Federal Legislation as called for by the resolution. Your reference committee recommends this resolution be not adopted.

Madam Speaker, this concludes the report of Reference Committee on Amendments to Constitution and Bylaws. I would like to thank Dr. Tate Hinkle, Dr. Ana Leech, Dr. John Maa, Dr. Elizabeth Conner, Dr. Raymond Lorenzoni, and Dr. Michael Hanak and all those who testified before the committee.

Tate Hinkle, MD
Am. Acad. of Family Physicians

Ana Leech, MD
Am. Acad. Hospice and Palliative Medicine

John Maa, MD
California Medical Association

Elizabeth Conner, MD, MPH
Massachusetts Medical Society

Raymond Lorenzoni, MD
Connecticut State Medical Society

Michael Hanak, MD
Am. Acad. of Family Physicians

Carlos Latorre, MD
Mississippi State Medical Association
Chair

DISCLAIMER

The following is a preliminary report of actions taken by the House of Delegates at its 2024 Interim Meeting and should not be considered final. Only the Official Proceedings of the House of Delegates reflect official policy of the Association.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (I-24)

Final Report of Reference Committee B

Dale Mandel, MD, Chair

Your Reference Committee recommends the following consent calendar for acceptance:

RECOMMENDED FOR ADOPTION

1. Board of Trustees Report 02 — On-Site Physician Requirements for Emergency Departments
2. Board of Trustees Report 06 — Health Technology Accessibility for Aging Patients
3. Board of Trustees Report 09 — Corporate Practice of Medicine Prohibition
4. Resolution 205 — Native American Medical Debt
5. Resolution 218 — Time Sensitive Credentialing of New Providers with an Insurance Carrier

RECOMMENDED FOR ADOPTION AS AMENDED

6. Board of Trustees Report 01 — Assessing the Intersection Between AI and Health Care
7. Board of Trustees Report 04 — Addressing Work Requirements for J-1 Visa Waiver Physicians
8. Resolution 202 — Calling for a Multifaceted Approach to the Illicit Fentanyl Crisis
9. Resolution 203 — Alternative Pathways for International Medical Graduates
10. Resolution 204 — Support for Physician-Supervised Community Paramedicine Programs
11. Resolution 206 — Protect Infant and Young Child Feeding
12. Resolution 207 — Accountability for G-605.009: Requesting A Task Force to Preserve the Patient-Physician Relationship Task Force Update and Guidance
13. Resolution 208 — Medicare Part B Enrollment and Penalty Awareness
14. Resolution 210 — Laser Surgery
15. Resolution 211 — Water Bead Injuries
16. Resolution 212 — Addressing the Unregulated Body Brokerage Industry
17. Resolution 213 — Sustainable Long-term Funding for Child Psychiatry Access Programs
18. Resolution 214 — Advocating for Evidence-Based Strategies to Improve Rural Obstetric Health Care and Access
19. Resolution 216 — Clearing Federal Obstacles for Supervised Injection Sites
20. Resolution 222 — Rollback on Physician Performance Measures
21. Resolution 229 — Supporting Penalties on Insurers Who Fail to Pay Doctors

RECOMMENDED FOR ADOPTION IN LIEU OF

22. Resolution 201 — Boarding Patients in the Emergency Room
    Resolution 230 — Addressing and Reducing Patient Boarding in Emergency Departments

RECOMMENDED FOR REFERRAL

23. Board of Trustees Report 03 — Reforming Stark Law's Blanket Self-Referral Ban
24. Resolution 226 — Information Blocking Rule

RECOMMENDED FOR REFERRAL FOR DECISION

25. Resolution 228 — Codification of the Chevron Deference Doctrine

RECOMMENDED FOR NOT ADOPTION

26. Resolution 221 — Medicare Coverage for Non-PAR Physicians

RECOMMENDED FOR REAFFIRMATION IN LIEU OF

27. Resolution 215 — Advocating for Federal and State Incentives for Recruitment and Retention of Physicians to Practice in Rural Areas
28. Resolution 217 — Expand Access to Skilled Nursing Facility Services for Patients with Opioid Use Disorder
29. Resolution 219 — Advocate to Continue Reimbursement for Telehealth / Telemedicine Visits Permanently
30. Resolution 220 — MIPS Reform
31. Resolution 223 — Mandated Economic Escalators in Insurance Contracts
32. Resolution 225 — Elimination of Medicare 14-Day Rule
33. Resolution 227 — Medicare Payment Parity for Telemedicine Services
34. Resolution 231 — Establish Pregnancy as a Federal Qualifying Life Event Triggering a Special Enrollment Period

Amendments:
If you wish to propose an amendment to an item of business, click here: Submit New Amendment

RECOMMENDED FOR ADOPTION

(1) BOARD OF TRUSTEES REPORT 02 — ON-SITE PHYSICIAN REQUIREMENTS FOR EMERGENCY DEPARTMENTS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Board of Trustees Report 2 be adopted and the remainder of the Report be filed.

HOD ACTION: Recommendations in Board of Trustees Report 2 adopted and the remainder of the Report filed.

The AMA Board of Trustees recommends that the following be adopted in lieu of Resolution 207-I-23 entitled, "On-Site Physician Requirement for EDs," and the remainder of the report be filed:

1. That our American Medical Association recognize that the preferred model of emergency care is the on-site presence of a physician in the emergency department (ED) whose primary duty is to provide care in that ED, and support state and federal legislation or regulation requiring that a hospital with an ED must have a physician on-site and on duty who is primarily responsible for the emergency department at all times the emergency department is open. (New HOD Policy)

2. That our AMA, in the pursuit of any legislation or regulation requiring the on-site presence of a physician who is primarily responsible for care in the emergency department (ED), will support state medical associations in developing appropriate rural exceptions to such a requirement if, based on the needs of their states, the association chooses to pursue certain alternative supervision models for care provided in EDs in remote rural areas that cannot meet such a requirement due to workforce limitations, ensuring that exceptions only apply where needed. These exceptions shall preserve 24/7 physician supervision of the ED and provide for the availability of a physician to provide on-site care. (New HOD Policy)

Your Reference Committee heard mixed but mostly supportive testimony for the recommendations in Board of Trustees Report 2. Your Reference Committee heard two amendments. First, an amendment to the second recommendation would specify that an appropriate rural exception requires that a physician be available by phone at all times and in person within 30 minutes. Your Reference Committee feels that the language of the original recommendation is not incompatible with this proposed amendment and allows states more flexibility in crafting limited rural exceptions that meet their unique needs while still preserving physician-led care. Your Reference Committee also heard an amendment that would remove reference to AMA's potential support of federal legislation that might require a hospital with an ED to have a physician on-site and on duty who is primarily responsible for the emergency department at all times. Because the 24/7 physical presence of a physician is the preferred model of emergency care, and recognizing the value of federal legislation governing emergency departments, your

Reference Committee feels it is appropriate that AMA be free to support potential federal legislation to that end. Therefore, your Reference Committee recommends that Board of Trustees Report 2 be adopted, and that the remainder of the Report be filed.

(2) BOARD OF TRUSTEES REPORT 06 — HEALTH TECHNOLOGY ACCESSIBILITY FOR AGING PATIENTS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Board of Trustees Report 6 be adopted and the remainder of the Report be filed.

HOD ACTION: Recommendations in Board of Trustees Report 6 adopted and the remainder of the Report filed.

The Board of Trustees recommends that the following recommendations be adopted in lieu of Resolution 213-I-23, and the remainder of the report be filed.:

That our American Medical Association amend Policy H-480-937 by addition and the title be changed by addition.

Policy H-480-937, ADDRESSING EQUITY IN TELEHEALTH AND HEALTH TECHNOLOGY

1. Our American Medical Association recognizes access to broadband internet as a social 6 determinant of health.
2. Our AMA encourages initiatives to measure and strengthen digital literacy, with appropriate education programs, and with an emphasis on programs designed with and for historically marginalized and minoritized populations.
3. Our AMA 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. Our AMA supports efforts to design and to improve the usability of existing electronic health record (EHR) and 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 other mental or physical disabilities.
5. Our AMA 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. Our AMA 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. Our AMA supports efforts to ensure payers allow all contracted physicians to provide care via telehealth.
8. Our AMA 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.
9. Our AMA 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.
10. Our AMA encourages the development of improved solutions to incorporate structured advance care planning (ACP) documentation standards that best meet the requisite needs for patients and physicians to easily store and access in the EHR complete and accurate ACP documentation that maintains the flexibility to capture unique, patient-centered details.
11. Our AMA encourages hospitals, health systems, and physician practices to provide a method other than electronic communication for patients who are without technological proficiency or access. (Modify Current HOD Policy)

Your Reference Committee heard testimony in support of Board of Trustees Report 6. Your Reference Committee heard that the recommendations in the Report amplify the message and recognition that equity in telehealth should expand beyond the population of older adults. Testimony reflected that the Report is a meaningful update to current AMA policy and reflects the increasing use of health technology and its impact on aging patients. Testimony specifically cited that, as the demographic of those over age 85 is rising due to medical advances prolonging life, ensuring those patients can interact with their physicians and other care givers is crucial. Testimony also supported the addition of electronic advanced care planning as a substantive addition to existing policy. Therefore, Your Reference Committee recommends that Board of Trustees Report 6 be adopted, and that the remainder of the Report be filed.

(3) BOARD OF TRUSTEES REPORT 09 — CORPORATE PRACTICE OF MEDICINE PROHIBITION

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Board of Trustees Report 9 be adopted and the remainder of the Report be filed.

HOD ACTION: Recommendations in Board of Trustees Report 9 adopted and the remainder of the Report filed.

The Board of Trustees recommends that in lieu of Resolution 233-I-23, existing AMA Policy H-215.981 entitled, "Corporate Practice of Medicine," be amended by addition and the remainder of the report be filed:

1. Our American Medical Association vigorously opposes any effort to pass federal legislation or regulation preempting state laws prohibiting the corporate practice of medicine. (Reaffirm HOD Policy)

2. Our AMA vigorously opposes any effort to pass legislation or regulation that removes or weakens state laws prohibiting the corporate practice of medicine. (New HOD Policy)

3. Our AMA opposes the corporate practice of medicine and supports the restriction of ownership and operational authority of physician medical practices to physicians or physician-owned groups. (New HOD Policy)

4. At the request of state medical associations, our AMA will provide guidance, consultation, and model legislation regarding the corporate practice of medicine, to ensure the autonomy of hospital medical staffs, employed physicians in non-hospital settings, and physicians contracting with corporately owned management service organizations. (Reaffirm HOD Policy)

5. Our AMA will continue to monitor the evolving corporate practice of medicine with respect to its effect on the patient-physician relationship, financial conflicts of interest, patient centered care and other relevant issues. (Directive to take action)

6. Our AMA will work with interested state medical associations, the federal government, and other interested parties to develop and advocate for regulations and appropriate legislation pertaining to corporate control of practices in the healthcare sector such that physician clinical autonomy ~~in clinical care~~ and operational authority ~~is~~ are preserved and protected. (Modify Current HOD Policy)

7. Our AMA will create a state corporate practice of medicine template to assist state medical associations and national medical specialty societies as they navigate the intricacies of corporate investment in physician practices and health care generally at the state level and develop the most effective means of prohibiting the corporate practice of medicine in ways that are not detrimental to the sustainability of physician practices. (New HOD Policy)

Your Reference Committee heard testimony uniformly in favor of adopting Board of Trustees Report 9. Testimony expressed concern about the detrimental impact that corporate investment has had on physician practices and health care generally, and thus noted that our AMA should do more to oppose the corporate practice of medicine. Testimony also highlighted that the Report should be adopted because, by not calling for a complete prohibition on corporate investment in physician practices, physicians wanting to pursue a partnership with a corporate investor are not prohibited from doing so. Testimony stressed that physicians must always maintain control of practice operations and clinical decision-making and emphasized the value of additional resources on the corporate practice of medicine doctrine to be developed by our AMA. Therefore, your Reference Committee recommends that Board of Trustees Report 9 be adopted, and that the remainder of the Report be filed.

(4) RESOLUTION 205 — NATIVE AMERICAN MEDICAL DEBT

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 205 be adopted.

HOD ACTION: Resolution 205 adopted.

RESOLVED, that our American Medical Association support federal legislation requiring credit reporting agencies to remove information on the credit reports of Indian Health Service (IHS) beneficiaries that relate to debts or collections activities for medical services that should have been paid by the IHS. (New HOD Policy)

Your Reference Committee heard overwhelming testimony in favor of Resolution 205, with only one comment against adoption. Your Reference Committee heard that Resolution 205 would call on our AMA to advocate for federal legislation that would protect Native American patients from credit report penalties arising from unpaid medical bills that should have been covered by the Indian Health Service (IHS). Testimony noted that Native Americans are disproportionately affected by medical debt, which negatively impacts their credit scores and leads to increased reliance on high-risk loans. Your Reference Committee also heard that the IHS Purchased and Referred Care (PRC) program often fails to pay medical bills on time, leaving IHS patients burdened with medical debt that the agency is responsible for covering. This issue forces Indigenous patients to cover costs that should be federally funded, leading to both personal and financial harm. Further testimony highlighted that supporting policy changes for IHS beneficiaries would align with protections currently provided to veterans receiving care through the Department of Veterans Affairs, thereby fostering greater equity in credit reporting practices. Therefore, your Reference Committee recommends that Resolution 205 be adopted.

(5) RESOLUTION 218 — TIME SENSITIVE CREDENTIALING OF NEW PROVIDERS WITH AN INSURANCE CARRIER

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 218 be adopted.

HOD ACTION: Resolution 218 adopted.

RESOLVED, that our American Medical Association urge the US Department of Labor to establish uniform provider credentialing standards for Third Party Administrator's (TPA's) serving ERISA Plans to include the following : that when a credentialing application is submitted, the insurance carrier must respond in writing within five business days whether the application is complete and acceptable, and if incomplete the carrier must send notice to the provider indicating what additional information is needed for completion of the process, and acknowledge the completion of a successfully completed application within ten business (Directive to Take Action); and be it further

RESOLVED, that our AMA urge the US Department of Labor to require Third Party Administrators to send a written notice to applicants within 45 days, regarding their credentialing decision and after 45 days, an applicant is deemed to have been automatically credentialled and enrolled to be eligible for payment of services, even if the payer fails to acknowledge the applicant. (Directive to Take Action)

Your Reference Committee heard unanimous support for Resolution 218. Testimony highlighted the need for timely, uniform credentialing processes as described in the resolution. Your Reference Committee heard testimony that highlighted arbitrary and variable standards imposed by insurance companies, evidenced by delays of up to 9 months despite timely submission of all required documents. Your Reference Committee heard that current delays from varied carrier policies are detrimental to private practice viability and patient care. Testimony also emphasized the importance of credentialing for providers to establish a financial relationship with insurance carriers. Therefore, your Reference Committee recommends that Resolution 218 be adopted.

RECOMMENDED FOR ADOPTION AS AMENDED

(6) BOARD OF TRUSTEES REPORT 01 — AUGMENTED INTELLIGENCE DEVELOPMENT, DEPLOYMENT, AND USE IN HEALTH CARE

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Section "1) a)" be amended by addition and deletion to read as follows:

a) Health care AI must be designed, developed, and deployed in a manner which is ethical, equitable, responsible, accurate, ~~and~~ transparent, and evidence-based.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Section "1) g)" be amended by addition to read as follows:

g) Clinical decisions influenced by AI must be made with specified qualified human intervention points during the decision-making process. A qualified human is defined as a licensed physician with the necessary qualifications and training to independently provide the same medical service without the aid of AI. As the potential for patient harm increases, the point in time when a physician should utilize their clinical judgment to interpret or act on an AI recommendation should occur earlier in the care plan. With few exceptions, there generally should be a qualified human in the loop when it comes to medical decision making capable of intervening or overriding the output of an AI model.

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Section "4) d)" be amended by addition to read as follows:

d) Use of generative AI should incorporate physician and staff education about the appropriate use, risks, and benefits of engaging with generative AI. Additionally, physicians and healthcare organizations should engage with generative AI tools only when adequate information regarding the product is provided to physicians and other users by the developers of those tools.

RECOMMENDATION D:

Madam Speaker, your Reference Committee recommends that Section 5 be amended by addition to read as follows:

c) Liability protections for physicians using AI-enabled technologies should align with both current and future AMA medical liability reform policies.

RECOMMENDATION E:

Madam Speaker, your Reference Committee recommends that Board of Trustees Report 01 be adopted as amended and the remainder of the Report be filed.

HOD ACTION: Section 4(f) referred for decision and the remainder of the recommendations in Board of Trustees Report 01 adopted as amended and the remainder of the Report filed.

The Board of Trustees recommends that the following be adopted as new policy in lieu of Resolution 206-I-23 and that the remainder of the report be filed:

AUGMENTED INTELLIGENCE DEVELOPMENT, DEPLOYMENT, AND USE IN HEALTH CARE

1. General Governance
    a. Health care AI must be designed, developed, and deployed in a manner which is ethical, equitable, responsible, accurate, and transparent.
    b. Use of AI in health care delivery requires clear national governance policies to regulate its adoption and utilization, ensuring patient safety, and mitigating inequities. Development of national governance policies should include interdepartmental and interagency collaboration.
    c. Compliance with national governance policies is necessary to develop AI in an ethical and responsible manner to ensure patient safety, quality, and continued access to care. Voluntary agreements or voluntary compliance is not sufficient.
    d. AI systems should be developed and evaluated with a specific focus on mitigating bias and promoting health equity, ensuring that the deployment of these technologies does not exacerbate existing disparities in health care access, treatment, or outcomes.

e. Health care AI requires a risk-based approach where the level of scrutiny, validation, and oversight should be proportionate to the overall potential of disparate harm and consequences the AI system might introduce. [See also Augmented Intelligence in Health Care H-480.939 at (1)]
f. AI risk management should minimize potential negative impacts of health care AI systems while providing opportunities to maximize positive impacts.
g. Clinical decisions influenced by AI must be made with specified human intervention points during the decision-making process. As the potential for patient harm increases, the point in time when a physician should utilize their clinical judgment to interpret or act on an AI recommendation should occur earlier in the care plan. With few exceptions, there generally should be a human in the loop when it comes to medical decision making capable of intervening or overriding the output of an AI model.
h. Health care practices and institutions should not utilize AI systems or technologies that introduce overall or disparate risk that is beyond their capabilities to mitigate. Implementation and utilization of AI should avoid exacerbating clinician burden and should be designed and deployed in harmony with the clinical workflow and, in institutional settings, consistent with AMA Policy H-225.940 - Augmented Intelligence and Organized Medical Staff.
i. Medical specialty societies, clinical experts, and informaticists are best positioned and should identify the most appropriate uses of AI-enabled technologies relevant to their clinical expertise and set the standards for AI use in their specific domain. [See Augmented Intelligence in Health Care H-480.940 at (2)]

2. When to Disclose: Transparency in Use of Augmented Intelligence-Enabled Systems and Technologies That Impact Medical Decision Making at the Point of Care
    a. Decisions regarding transparency and disclosure of the use of AI should be based upon a risk- and impact-based approach that considers the unique circumstance of AI and its use case. The need for transparency and disclosure is greater where the performance of an AI-enabled technology has a greater risk of causing harm to a patient.
        i. AI disclosure should align and meet ethical standards or norms.
        ii. Transparency requirements should be designed to meet the needs of the end users. Documentation and disclosure should enhance patient and physician knowledge without increasing administrative burden.
        iii. When AI is used in a manner which impacts access to care or impacts medical decision making at the point of care, that use of AI should be disclosed and documented to both physicians and/or patients in a culturally and linguistically appropriate manner. The opportunity for a patient or their caregiver to request additional review from a licensed clinician should be made available upon request.

iv. When AI is used in a manner which directly impacts patient care, access to care, medical decision making, or the medical record, that use of AI should be documented in the medical record.

b. AI tools or systems cannot augment, create, or otherwise generate records, communications, or other content on behalf of a physician without that physician's consent and final review.

c. When AI or other algorithmic-based systems or programs are utilized in ways that impact patient access to care, such as by payors to make claims determinations or set coverage limitations, use of those systems or programs must be disclosed to impacted parties.

d. The use of AI-enabled technologies by hospitals, health systems, physician practices, or other entities, where patients engage directly with AI, should be clearly disclosed to patients at the beginning of the encounter or interaction with the AI-enabled technology. Where patient-facing content is generated by AI, the use of AI in generating that content should be disclosed or otherwise noted within the content.

3. What to Disclose: Required Disclosures by Health Care Augmented Intelligence-Enabled Systems and Technologies

a. When AI-enabled systems and technologies are utilized in health care, the following information should be disclosed by the AI developer to allow the purchaser and/or user (physician) to appropriately evaluate the system or technology prior to purchase or utilization:

i. Regulatory approval status.

ii. Applicable consensus standards and clinical guidelines utilized in design, development, deployment, and continued use of the technology.

iii. Clear description of problem formulation and intended use accompanied by clear and detailed instructions for use.

iv. Intended population and intended practice setting.

v. Clear description of any limitations or risks for use, including possible disparate impact.

vi. Description of how impacted populations were engaged during the AI lifecycle.

vii. Detailed information regarding data used to train the model:

1. Data provenance.
2. Data size and completeness.
3. Data timeframes.
4. Data diversity.
5. Data labeling accuracy.

viii. Validation Data/Information and evidence of:

1. Clinical expert validation in intended population and practice setting and intended clinical outcomes.
2. Constraint to evidence-based outcomes and mitigation of "hallucination"/"confabulation" or other output error.
3. Algorithmic validation.
4. External validation processes for ongoing evaluation of the model performance, e.g., accounting for AI model drift and degradation.

5. Comprehensiveness of data and steps taken to mitigate biased outcomes.
6. Other relevant performance characteristics, including but not limited to performance characteristics at peer institutions/similar practice settings.
7. Post-market surveillance activities aimed at ensuring continued safety, performance, and equity.

ix. Data Use Policy:
1. Privacy.
2. Security.
3. Special considerations for protected populations or groups put at increased risk.

x. Information regarding maintenance of the algorithm, including any use of active patient data for ongoing training.

xi. Disclosures regarding the composition of design and development team, including diversity and conflicts of interest, and points of physician involvement and review.

b. Purchasers and/or users (physicians) should carefully consider whether or not to engage with AI-enabled health care technologies if this information is not disclosed by the developer. As the risk of AI being incorrect increases risks to patients (such as with clinical applications of AI that impact medical decision making), disclosure of this information becomes increasingly important. [See also Augmented Intelligence in Health Care H-480.939]

4. Generative Augmented Intelligence
   a. Generative AI should: (a) only be used where appropriate policies are in place within the practice or other health care organization to govern its use and help mitigate associated risks; and (b) follow applicable state and federal laws and regulations (e.g., HIPAA-compliant Business Associate Agreement).
   b. Appropriate governance policies should be developed by health care organizations and account for and mitigate risks of:
      i. Incorrect or falsified responses; lack of ability to readily verify the accuracy of responses or the sources used to generate the response.
      ii. Training data set limitations that could result in responses that are out of date or otherwise incomplete or inaccurate for all patients or specific populations.
      iii. Lack of regulatory or clinical oversight to ensure performance of the tool.
      iv. Bias, discrimination, promotion of stereotypes, and disparate impacts on access or outcomes.
      v. Data privacy.
      vi. Cybersecurity.
      vii. Physician liability associated with the use of generative AI tools.
   c. Health care organizations should work with their AI and other health information technology (health IT) system developers to implement rigorous data validation and verification protocols to ensure that only accurate, comprehensive, and bias managed datasets inform generative

AI models, thereby safeguarding equitable patient care and medical outcomes. [See Augmented Intelligence in Health Care H-480.940 at (3)(d)]

d. Use of generative AI should incorporate physician and staff education about the appropriate use, risks, and benefits of engaging with generative AI. Additionally, physicians should engage with generative AI tools only when adequate information regarding the product is provided to physicians and other users by the developers of those tools.
e. Clinicians should be aware of the risks of patients engaging with generative AI products that produce inaccurate or harmful medical information (e.g., patients asking chatbots about symptoms) and should be prepared to counsel patients on the limitations of AI-driven medical advice.
f. Governance policies should prohibit the use of confidential, regulated, or proprietary information as prompts for generative AI to generate content.
g. Data and prompts contributed by users should primarily be used by developers to improve the user experience and AI tool quality and not simply increase the AI tool's market value or revenue generating potential.

5. Physician Liability for Use of Augmented Intelligence-Enabled Technologies
    a. Current AMA policy states that liability and incentives should be aligned so that the individual(s) or entity(ies) best positioned to know the AI system risks and best positioned to avert or mitigate harm do so through design, development, validation, and implementation. [See Augmented Intelligence in Health Care H-480.939]
        i. Where a mandated use of AI systems prevents mitigation of risk and harm, the individual or entity issuing the mandate must be assigned all applicable liability.
        ii. Developers of autonomous AI systems with clinical applications (screening, diagnosis, treatment) are in the best position to manage issues of liability arising directly from system failure or misdiagnosis and must accept this liability with measures such as maintaining appropriate medical liability insurance and in their agreements with users.
        iii. Health care AI systems that are subject to non-disclosure agreements concerning flaws, malfunctions, or patient harm (referred to as gag clauses) must not be covered or paid and the party initiating or enforcing the gag clause assumes liability for any harm.
    b. When physicians do not know or have reason to know that there are concerns about the quality and safety of an AI-enabled technology, they should not be held liable for the performance of the technology in question.

6. Data Privacy and Augmented Intelligence
    a. Entity Responsibility:
        i. Entities, e.g., AI developers, should make information available about the intended use of generative AI in health care and identify

the purpose of its use. Individuals should know how their data will be used or reused, and the potential risks and benefits.

ii. Individuals should have the right to opt-out, update, or request deletion of their data from generative AI tools. These rights should encompass AI training data and disclosure to other users of the tool.

iii. Generative AI tools should not reverse engineer, reconstruct, or reidentify an individual's originally identifiable data or use identifiable data for nonpermitted uses, e.g., when data are permitted to conduct quality and safety evaluations. Preventive measures should include both legal frameworks and data model protections, e.g., secure enclaves, federated learning, and differential privacy.

b. User Education:

i. Users should be provided with training specifically on generative AI. Education should address:

1. Legal, ethical, and equity considerations.
2. Risks such as data breaches and re-identification.
3. Potential pitfalls of inputting sensitive and personal data.
4. The importance of transparency with patients regarding the use of generative AI and their data.

[See H-480.940, Augmented Intelligence in Health Care, at (4) and (5)]

7. Augmented Intelligence Cybersecurity
   a. AI systems must have strong protections against input manipulation and malicious attacks.
   b. Entities developing or deploying health care AI should regularly monitor for anomalies or performance deviations, comparing AI outputs against known and normal behavior.
   c. Independent of an entity's legal responsibility to notify a health care provider or organization of a data breach, that entity should also act diligently in identifying and notifying the individuals themselves of breaches that impact their personal information.
   d. Users should be provided education on AI cybersecurity fundamentals, including specific cybersecurity risks that AI systems can face, evolving tactics of AI cyber attackers, and the user's role in mitigating threats and reporting suspicious AI behavior or outputs.

8. Mitigating Misinformation in AI-Enabled Technologies
   a. AI developers should ensure transparency and accountability by disclosing how their models are trained and the sources of their training data. Clear disclosures are necessary to build trust in the accuracy and reliability of the information produced by AI systems.
   b. Algorithms should be developed to detect and flag potentially false and misleading content before it is widely disseminated.
   c. Developers of AI should have mechanisms in place to allow for reporting of mis- and disinformation generated or propagated by AI-enabled systems.

d. Developers of AI systems should be guided by policies that emphasize rigorous validation and accountability for the content their tools generate, and, consistent with AMA Policy H-480.939(7), are in the best position to manage issues of liability arising directly from system failure or misdiagnosis and must accept this liability with measures such as maintaining appropriate medical liability insurance and in their agreements with users.
e. Academic publications and journals should establish clear guidelines to regulate the use of AI in manuscript submissions. These guidelines should include requiring the disclosure that AI was used in research methods and data collection, requiring the exclusion of AI systems as authors, and should outline the responsibility of the authors to validate the veracity of any referenced content generated by AI.
f. Education programs are needed to enhance digital literacy, helping individuals critically assess the information they encounter online, particularly in the medical field where mis- and disinformation can have severe consequences.

9. Payor Use of Augmented Intelligence and Automated Decision-Making Systems
    a. Use of automated decision-making systems that determine coverage limits, make claim determinations, and engage in benefit design should be publicly reported, based on easily accessible evidence-based clinical guidelines (as opposed to proprietary payor criteria), and disclosed to both patients and their physician in a way that is easy to understand.
    b. Payors should only use automated decision-making systems to improve or enhance efficiencies in coverage and payment automation, facilitate administrative simplification, and reduce workflow burdens. Automated decision-making systems should never create or exacerbate overall or disparate access barriers to needed benefits by increasing denials, coverage limitations, or limiting benefit offerings. Use of automated decision-making systems should not replace the individualized assessment of a patient's specific medical and social circumstances and payors' use of such systems should allow for flexibility to override automated decisions. Payors should always make determinations based on particular patient care needs and not base decisions on algorithms developed on "similar" or "like" patients.
    c. Payors using automated decision-making systems should disclose information about any algorithm training and reference data, including where data were sourced and attributes about individuals contained within the training data set (e.g., age, race, gender). Payors should provide clear evidence that their systems do not discriminate, increase inequities, and that protections are in place to mitigate bias.
    d. Payors using automated decision-making systems should identify and cite peer-reviewed studies assessing the system's accuracy measured against the outcomes of patients and the validity of the system's predictions.
    e. Any automated decision-making system recommendation that indicates limitations or denials of care, at both the initial review and appeal levels, should be automatically referred for review to a physician (a) possessing a current and valid non-restricted license to practice medicine in the state

in which the proposed services would be provided if authorized and (b) be of the same specialty as the physician who typically manages the medical condition or disease or provides the health care service involved in the request prior to issuance of any final determination. Prior to issuing an adverse determination, the treating physician must have the opportunity to discuss the medical necessity of the care directly with the physician who will be responsible for determining if the care is authorized.

f. Individuals impacted by a payor's automated decision-making system, including patients and their physicians, must have access to all relevant information (including the coverage criteria, results that led to the coverage determination, and clinical guidelines used).

g. Payors using automated decision-making systems should be required to engage in regular system audits to ensure use of the system is not increasing overall or disparate claims denials or coverage limitations, or otherwise decreasing access to care. Payors using automated decision-making systems should make statistics regarding systems' approval, denial, and appeal rates available on their website (or another publicly available website) in a readily accessible format with patient population demographics to report and contextualize equity implications of automated decisions. Insurance regulators should consider requiring reporting of payor use of automated decision-making systems so that they can be monitored for negative and disparate impacts on access to care. Payor use of automated decision-making systems must conform to all relevant state and federal laws.

(New HOD Policy)

Your Reference Committee heard testimony largely in support of Board of Trustees Report 01. Testimony covered the report's comprehensive focus areas, including healthcare AI governance, transparency in AI applications, oversight of generative AI tools, physician liability, and AI-related privacy and security issues. Your Reference Committee has considered that this is a highly vetted report and includes amendments made in response to previous comments and concerns from prior AMA meetings. Several amendments were proposed, most of which your Reference Committee believes are consistent with the recommendations in the report and would provide additional clarity. These include amendments that would clarify that: clinical decisions influenced by AI must be made with a specified human who is qualified; the deployment of AI tools be evidence-based; and healthcare organizations, in addition to physicians, should engage with generative AI tools only when adequate information regarding the product is provided by the developers of those tools. In addition, your Reference Committee recommends including an amendment that would provide greater focus on addressing additional liability protections for physicians using AI-enabled technologies, as well as an amendment that would modify Recommendation B in the Preliminary Report to clarify the definition of "qualified human," per testimony received. While additional testimony was heard regarding disclosure to patients and physicians when AI is used in medical decision making, the use of confidential or proprietary information as prompts, and advocacy for the development of expert consensus guidelines, your Reference Committee recommends deferring to the language in the report at this time given that the current language has been well vetted. In making this recommendation, your Reference Committee considered that our AMA House of Delegates adopted Policy G-615.998 at the 2024 Annual Meeting, and that under

this policy a task force is being formed that will focus on digital health, technology, informatics, and augmented/artificial intelligence. This task force, along with our AMA Councils, will be well positioned to consider these and other evolving and complex issues regarding AI and propose to the HOD revised or new policy as necessary to ensure that our AMA's advocacy on behalf of physicians and our patients remains impactful. Therefore, your Reference Committee recommends that Board of Trustees Report 01 be adopted as amended and that the remainder of the Report be filed.

(7) BOARD OF TRUSTEES REPORT 04 — ADDRESSING WORK REQUIREMENTS FOR J-1 VISA WAIVER PHYSICIANS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Board of Trustees Report 4 be amended by addition and deletion to read as follows:

Our American Medical Association ~~supports~~ advocate for federal visa and visa waiver policies ~~that~~ to include time for administrative tasks, professional development opportunities, and other professional responsibilities within the federally mandated work week requirements for direct patient care~~, administrative tasks, professional development opportunities, and other professional responsibilities~~.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Board of Trustees Report 4 be adopted as amended and the remainder of the Report be filed.

HOD ACTION: Recommendation in Board of Trustees Report 4 adopted as amended and the remainder of the Report filed.

The Board of Trustees recommends that the following policy be adopted in lieu of Resolution 217-I-23, and the remainder of the report be filed:

Our American Medical Association supports federal visa and visa waiver policies that include time within the federally mandated work week requirements for direct patient care, administrative tasks, professional development opportunities, and other professional responsibilities. (New HOD Policy)

Your Reference Committee heard supportive testimony on Board of Trustees Report 4. Your Reference Committee heard that International Medical Graduates (IMGs) are working significant hours to ensure that they can provide patient care as well as gain professional development. Testimony noted that it was very difficult for IMGs to find enough time to accomplish all the personal and professional goals that they have due to

their work hour requirements. Your Reference Committee heard that the work hour requirements that apply to J-1 waivers vary by state, regional commission, and federal agency. An amendment was provided and was supported by some commentors. However, testimony from the Board of Trustees emphasized the importance of maintaining the term support in this resolution. Testimony stated that maintaining the word support will provide staff with the ability to strategically advocate on this topic when the time is ripe to ensure that we do not negatively impact the passage of the Conrad 30 legislation, which must be renewed yearly. Therefore, the Reference Committee recommends that Board of Trustees Report 4 be adopted as amended, and that the remainder of the Report be filed.

(8) RESOLUTION 202 — ILLICIT DRUGS: CALLING FOR A MULTIFACETED APPROACH TO THE "FENTANYL" CRISIS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first resolve of Resolution 202 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association continue to support ~~advocate for~~ public education and awareness about the rapidly evolving US illicit drug epidemic ~~crisis~~ due to dangers of illegally made fentanyl and other toxic substances ~~carfentanil-laced products (Directive to Take Action)~~; and be it further

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the second resolve of Resolution 202 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA continue to support efforts by ~~advocate that~~ federal, state and local government officials and agencies ~~implement measures~~ to curb and/or stop the manufacturing, importation, and distribution of illicit drugs and related chemical compounds (Directive to Take Action).~~;~~ ~~and be it further~~

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Resolves three through six of Resolution 202 be deleted.

~~RESOLVED, that our AMA support federal legislation that would help Customs and Border Protection (CBP) stop the flow of illicit goods, including fentanyl and counterfeit medications (New HOD Policy); and be it further~~

~~RESOLVED, that our AMA, based on the Public Health Security and Bioterrorism Preparedness and Response Act of 2002 (which criminalizes the use of a biological agents to cause death, disease, or other harm), request our government to determine if expansion should include illicit chemicals and drugs such as fentanyl, carfentanil, 3-methylfentanyl, Xylazine, etc. (Directive to Take Action); and be it further~~

~~RESOLVED, that our AMA encourage our government to clarify if, and in what circumstances, these types of illicit drugs (e.g. fentanyl, carfentanil, etc.), or their precursors, should be considered chemical weapons as defined by The Chemical Weapons Convention and/or a WMD as defined by the DHS (New HOD Policy); and be it further~~

~~RESOLVED, that our AMA assess the likelihood that illicit drugs such as carfentanil may be used as a WMD and what steps healthcare workers, hospital systems and first-responders should take to prepare for such an event. (Directive to Take Action)~~

RECOMMENDATION D:

Madam Speaker, your Reference Committee recommends that Resolution 202 be adopted as amended.

RECOMMENDATION E:

Madam Speaker, your Reference Committee recommends that the title of Resolution 202 be changed to read as follows:

CALLING FOR A MULTIFACETED APPROACH TO THE ILLICIT FENTANYL CRISIS

HOD ACTION: The second resolve of Resolution 202 referred and the remainder of Resolution 202 adopted as amended with a change of title.

CALLING FOR A MULTIFACETED APPROACH TO THE ILLICIT FENTANYL CRISIS

RESOLVED, that our American Medical Association advocate for public education and awareness about the rapidly evolving US illicit drug crisis due to dangers of fentanyl and carfentanil-laced products (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate that federal, state and local government officials and agencies implement measures to curb and/or stop the manufacturing, importation, and distribution of illicit drugs and related chemical compounds (Directive to Take Action); and be it further

RESOLVED, that our AMA support federal legislation that would help Customs and Border Protection (CBP) stop the flow of illicit goods, including fentanyl and counterfeit medications (New HOD Policy); and be it further

RESOLVED, that our AMA, based on the Public Health Security and Bioterrorism Preparedness and Response Act of 2002 (which criminalizes the use of a biological agents to cause death, disease, or other harm), request our government to determine if

expansion should include illicit chemicals and drugs such as fentanyl, carfentanil, 3-methylfentanyl, Xylazine, etc. (Directive to Take Action); and be it further

RESOLVED, that our AMA encourage our government to clarify if, and in what circumstances, these types of illicit drugs (e.g. fentanyl, carfentanil, etc.), or their precursors, should be considered chemical weapons as defined by The Chemical Weapons Convention and/or a WMD as defined by the DHS (New HOD Policy); and be it further

RESOLVED, that our AMA assess the likelihood that illicit drugs such as carfentanil may be used as a WMD and what steps healthcare workers, hospital systems and first-responders should take to prepare for such an event. (Directive to Take Action)

Your Reference Committee heard mixed testimony on Resolution 202. Your Reference Committee heard that our AMA has considerable, existing policy advocating for a public health focus to combat the drug overdose and death epidemic, including strong support for increased education, research, prevention, treatment, harm reduction efforts, and removing the stigma associated with drug use and substance use disorders (SUDs). Testimony highlighted the need for our AMA to take a public health approach to this Resolution to avoid stigmatizing drug use and to increase support for harm reduction initiatives such as naloxone access. Testimony emphasized that our AMA's most appropriate role is to support public health efforts and that law enforcement should be left to law enforcement. Testimony also noted the ongoing nature of the epidemic, including how there are multiple, toxic substances in the nation's illicit drug supply. Testimony noted that AMA advocacy is incredibly broad and effectively addresses the polysubstance nature of the epidemic without having to name every new substance. Therefore, your Reference Committee recommends that Resolution 202 be adopted as amended.

(9) RESOLUTION 203 — ALTERNATIVE PATHWAYS FOR INTERNATIONAL MEDICAL GRADUATES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first resolve of Resolution 203 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association provides an informational report about the ongoing work around alternate licensing pathways and currently introduced laws and regulations being introduced around the country and their status during the ~~A-25~~ I-25 meeting (Directive to Take Action); and be it further

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the second resolve of Resolution 203 be amended by addition and deletion to read as follows:

RESOLVED, that, following the conclusion of the work of the Advisory Commission on Alternate Licensing Models, our AMA develop educational resources related to alternate licensing models for the AMA HOD and other interested parties ~~stakeholders~~ (Directive to Take Action); and be it further

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the third resolve of Resolution 203 be amended by deletion to read as follows:

RESOLVED, that our AMA widely distribute the Commission's report and relevant educational content to all AMA members ~~and other interested stakeholders~~ (Directive to Take Action)~~; and be it further~~

RECOMMENDATION D:

Madam Speaker, your Reference Committee recommends that the fourth resolve of Resolution 203 be deleted.

~~RESOLVED, that, following the conclusion of the work of the Advisory Commission on Alternate Licensing Models, our AMA study our existing policy pertaining to state licensure processes, including alternate licensing pathways, and recommend updates to such policies, as appropriate, to help inform advocacy efforts by state medical societies. (Directive to Take Action)~~

RECOMMENDATION E:

Madam Speaker, your Reference Committee recommends that Resolution 203 be adopted as amended.

HOD ACTION: Resolution 203 adopted as amended.

RESOLVED, that our American Medical Association provides an informational report about the ongoing work around alternate licensing pathways and currently introduced laws and regulations being introduced around the country and their status during the A-25 meeting (Directive to Take Action); and be it further

RESOLVED, that, following the conclusion of the work of the Advisory Commission on Alternate Licensing Models, our AMA develop educational resources related to alternate licensing models for the AMA HOD and other interested stakeholders (Directive to Take Action); and be it further

RESOLVED, that our AMA widely distribute the Commission's report and relevant educational content to all AMA members and other interested stakeholders (Directive to Take Action); and be it further

RESOLVED, that, following the conclusion of the work of the Advisory Commission on Alternate Licensing Models, our AMA study our existing policy pertaining to state licensure processes, including alternate licensing pathways, and recommend updates to such policies, as appropriate, to help inform advocacy efforts by state medical societies. (Directive to Take Action)

Your Reference Committee heard about the importance of the Advisory Commission on Additional Licensing Models and the work that it is undertaking to try and unify and ease the licensure pathway for international medical graduates (IMGs). Testimony noted how difficult it can be for IMGs to receive a license to practice medicine in the United States, even if they have already received extensive training abroad. Testimony also noted the importance of a more uniform approach to this licensure pathway among the states. However, your Reference Committee also heard that it is the undertaking of the Commission to provide information about the Commission and its ongoing work to interested parties and states. Moreover, testimony noted that since the recommendations of the Commission are not complete and will continue to be developed over the course of multiple years, our AMA should not commit to changing our existing policies based on the work of the Commission. Further testimony noted that due to the ongoing work of the Commission, an informational report would be more beneficial to our House if it were presented at the Interim 2025 meeting of the House of Delegates to provide more time for the Commission to develop their recommendations and for staff to appropriately review

the work of the Commission in alignment with our existing AMA policy. Therefore, your Reference Committee recommends that Resolution 203 be adopted as amended.

(10) RESOLUTION 204 — SUPPORT FOR PHYSICIAN-SUPERVISED COMMUNITY PARAMEDICINE PROGRAMS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 204 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association support federal and state efforts to strengthen ~~establish, expand,~~ and provide coverage for community paramedicine programs ~~supervised by physicians~~, especially in rural or underserved areas, so long as these programs do not decrease funding for physician payment. (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 204 be amended by addition of a second resolve clause to read as follows:

RESOLVED, that our American Medical Association only support community paramedicine programs that preserve physician-led team-based care.

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Resolution 204 be adopted as amended.

HOD ACTION: Resolution 204 adopted as amended.

RESOLVED, that our American Medical Association support federal and state efforts to establish, expand, and provide coverage for community paramedicine programs supervised by physicians, especially in rural areas. (New HOD Policy)

Your Reference Committee heard unanimous testimony in support of Resolution 204. Your Reference Committee received testimony that highlighted the important role of community paramedicine programs in improving access to care and limiting unnecessary trips to emergency departments. However, some testimony highlighted the need to preserve physician-led teams in these programs. Additionally, amendments were proffered to ensure that funding for physician payment was not decreased because of the establishment of these programs. Further testimony noted the importance of guaranteeing

that other underserved communities were included in this advocacy work. Therefore, your Reference Committee recommends that Resolution 204 be adopted as amended.

(11) RESOLUTION 206 — PROTECT INFANT AND YOUNG CHILD FEEDING

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Resolve of Resolution 206 be amended by addition to read as follows:

RESOLVED, that our American Medical Association support public and private payer coverage of medically necessary donor human breast milk (New HOD Policy); and be it further

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 206 be adopted as amended.

HOD ACTION: Resolution 206 adopted as amended.

RESOLVED, that our American Medical Association support Medicaid coverage of donor human breast milk (New HOD Policy); and be it further

RESOLVED, that our AMA advocate for an adequate supply and consistent sources of infant milk formula. (Directive to Take Action)

Your Reference Committee heard overwhelming testimony in support of Resolution 206, with no opposing testimony offered. Your Reference Committee heard that AMA policy recognizes that breastfeeding is the optimal form of nutrition for most infants and promotes strategies to increase breastfeeding, and further, that in alignment with this policy, the American Academy of Pediatrics supports the use of donor human milk for high-risk infants and calls for policies to provide high-risk infants access to donor human milk based on medical necessity, not financial status. Your Reference Committee further heard that in 2011, the U.S. Surgeon General called for strategies to address obstacles to the availability of safe, banked, donor human milk for fragile infants. Your Reference Committee heard support for having mechanisms in place that allow for the accessibility of safe and sufficient nutrition for infants and that our AMA should advocate for such a supply. An amendment was offered to support coverage of donor human milk only in cases of medical necessity. Testimony noted that this was an important addition due to supplier concerns. Additional testimony emphasized the importance of requiring this benefit from all payers. Therefore, your Reference Committee recommends that Resolution 206 be adopted as amended.

(12) RESOLUTION 207 — ACCOUNTABILITY FOR G-605.009: REQUESTING A TASK FORCE TO PRESERVE THE PATIENT-PHYSICIAN RELATIONSHIP TASK FORCE UPDATE AND GUIDANCE

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the second resolve of Resolution 207 be deleted.

~~RESOLVED, that our AMA's work on the Task Force continues for a minimum of three years with reevaluation of need and relevance at I-29 (Directive to Take Action); and be it further~~

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the third Resolve of Resolution 207 be amended by addition and deletion to read as follows:

2h. Work with interested parties to encourage the development of institution-level guidance and protection ~~publish public-facing guidance for what is medically allowable~~ for physicians practicing in states with restrictions potentially ~~impeding on~~ interfering with the patient-physician relationship. (Modify Current HOD Policy)

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Resolution 207 be adopted as amended.

HOD ACTION: Resolution 207 adopted as amended.

RESOLVED, that our American Medical Association's Task Force to Preserve the Patient-Physician Relationship will present annual updates on their findings at AMA Annual Meetings until the objectives have been completed (Directive to Take Action); and be it further

RESOLVED, that our AMA's work on the Task Force continues for a minimum of three years with reevaluation of need and relevance at I-29 (Directive to Take Action); and be it further

RESOLVED, that our AMA amend G-605.009 with the addition of text as follows:

2h. Work with interested parties to publish public-facing guidance for what is medically allowable for physicians practicing in states with restrictions potentially impeding on the patient-physician relationship. (Modify Current HOD Policy)

Your Reference Committee heard testimony that was overall supportive of the Task Force to Preserve the Patient-Physician Relationship and of efforts to protect the patient-physician relationship from laws that restrict medical care. Your Reference Committee heard testimony in support of the Reference Committee recommendation to require the Task Force to report annually on its progress and in support of an amendment to direct the Task Force to encourage the development of institution-level guidance for physicians practicing in states that restrict medical care.

Your Reference Committee also heard testimony that provided information on the Task Force activities. For example, your Reference Committee heard about informational report (BOT 21-I-24) that has been provided to this House. Informational report (BOT 09-I-23) was also provided at last year's Interim Meeting, and – as directed by policy – updates will be provided annually. As outlined in its report, the Task Force has been working diligently to carry out the directives adopted by this House. The Task Force has met virtually and in-person and has tapped national experts and government officials to help examine key issues for the Task Force to focus its efforts on – including legal issues, EMTALA, shield laws, workforce, and education issues, and more.

In addition, testimony noted existing resources, including "Know your State's Abortion Laws" guides for medical providers from the Abortion Defense Network. These guides align with the ask in Resolution 207 that our AMA publish state specific guidance about the legal boundaries of state abortion laws. Our AMA has supported the development of these resources and a hotline for medical professionals to ask additional questions about the current state of the law, seek individualized legal advice, or find representation in civil or criminal cases. Our AMA is also in the process of conducting research and producing resources on the impact of abortion laws on the physician workforce and on strategy and message development. The Task Force is in the process of developing additional deliverables as well.

Your Reference Committee heard testimony that opposed requiring the Task Force to operate for a certain number of years and an amendment was offered to strike the second resolved clause accordingly. The testimony emphasized that it would be premature to extend the Task Force mandate to 2029 and that such a directive would be overly prescriptive. Your Reference Committee agrees that the Task Force should be able to continue its important work and that a timeline for the Task Force should be evaluated at a later time after the Task Force has reported on its progress. Therefore, your Reference Committee recommends that Resolution 207 be adopted as amended.

(13) RESOLUTION 208 — MEDICARE PART B ENROLLMENT AND PENALTY AWARENESS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the fourth resolve of Resolution 208 be deleted.

~~RESOLVED, that our AMA explore with AARP and other interested organizations a mechanism for auto enrollment in Medicare Part B for those who take Social Security benefits before age 65 that would include additional premium support for those making less than $1,000 in monthly Social Security benefits. (Directive to Take Action)~~

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 208 be adopted as amended.

HOD ACTION: Resolution 208 adopted as amended.

RESOLVED, that our American Medical Association review the current penalties for declining Medicare Part B coverage with the Centers for Medicare and Medicaid Services (CMS), and advocate for changes to improve awareness of the risk and financial burdens associated with discontinuing coverage before reaching age 65 (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate to CMS for the creation of a comprehensive checklist for seniors approaching age 65 to facilitate Medicare enrollment and avoid gaps in insurance coverage or permanent increases in Part B premiums (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for enhanced public awareness regarding the risks of not enrolling in Medicare Part B, and support making information about these risks more accessible and widely available to prevent lifetime penalties (Directive to Take Action); and be it further

RESOLVED, that our AMA explore with AARP and other interested organizations a mechanism for auto enrollment in Medicare Part B for those who take Social Security benefits before age 65 that would include additional premium support for those making less than $1,000 in monthly Social Security benefits. (Directive to Take Action)

Your Reference Committee heard mostly supportive testimony on Resolution 208. Your Reference Committee heard testimony that emphasized the need to increase awareness and simplify Medicare Part B enrollment to prevent lifelong penalties and support for seniors receiving necessary healthcare coverage. Testimony noted that the current Medicare enrollment process is complex and that penalties for late enrollment can place significant financial strain on seniors, especially those with limited incomes. An amendment was offered stemming from concerns about the legal and logistical

complexities of auto-enrolling individuals in a program that requires premium payments, as this could unintentionally impact financial autonomy and create additional costs for those not wishing to participate. Your Reference Committee heard that our AMA's framework for auto-enrollment advocacy has historically been aligned with Medicaid programs, where individuals are auto-enrolled only if they are eligible for coverage options that come at no cost to them after the application of subsidies, as exemplified in AMA Policy H-165.823, Options to Maximize Coverage under the AMA Proposal for Reform. Therefore, your Reference Committee recommends that Resolution 208 be adopted as amended.

(14) RESOLUTION 210 — LASER SURGERY

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first resolve of Resolution 210 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association amend policy H-475.989, "Laser Surgery" to read that laser surgery should be performed only by ~~individuals licensed to practice medicine and surgery or by those categories of practitioners appropriately trained~~ licensed physicians or by individuals who are appropriately trained, under the supervision of a physician, and currently licensed by the state to perform surgical services (Modify Current HOD Policy); and be it further

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 210 be adopted as amended.

HOD ACTION: Resolution 210 referred.

RESOLVED, that our American Medical Association amend policy H-475.989, "Laser Surgery" to read that laser surgery should be performed only by individuals licensed to practice medicine and surgery or by those categories of practitioners appropriately trained and currently licensed by the state to perform surgical services (Modify Current HOD Policy); and be it further

RESOLVED, that our AMA amend policy H-475.980 Addressing Surgery Performed by Optometrists to read:

1. Our AMA will support legislation prohibiting optometrists from performing surgical procedures as defined by AMA policies H-475.983, "Definition of Surgery," and H-475.989 ~~H-475.988~~, "Laser Surgery."

2. Our AMA encourages state medical associations to support state legislation and rulemaking prohibiting optometrists from performing surgical procedures as defined by AMA policies H-475.983, "Definition of Surgery," and H-475.989 ~~H-475.988~~, "Laser Surgery". (Modify Current HOD Policy)

Your Reference Committee heard testimony in support of Resolution 210, however several amendments were offered. One amendment aimed to clarify that only licensed physicians are considered appropriately trained clinicians licensed by the state to perform surgical services. Your Reference Committee believes that this amendment creates redundancy within policy H-475.989, which already specifies that "laser surgery should be performed only by individuals licensed to practice medicine and surgery." Another amendment, recognizing that Resolution 210 was proposed with ophthalmology in mind, suggested specifying that policy H-475.989 only applies to laser surgery "of the eyeball." However, because policy H-475.989 was crafted to apply to all forms of laser surgery, your Reference Committee believes that this amendment would inappropriately narrow its scope. A final amendment proposed specifying that laser surgery may be performed by "appropriately trained licensed physicians or individuals appropriately trained and under the supervision of a physician." Your Reference Committee understands that laser surgery is used by many different medical specialties and that some non-physicians practicing on physician-led teams within certain specialties may be trained to perform laser surgery under the supervision of a physician. This amendment avoids redundancy and aligns with the intent of the existing policy while creating safeguards to ensure and clarify that AMA can only support laser surgery done by non-physicians if the individual is appropriately trained and practicing on a physician-led team. Therefore, your Reference Committee recommends that Resolution 210 be adopted as amended.

(15) RESOLUTION 211 — WATER BEAD INJURIES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the second resolve of Resolution 211 be amended by deletion to read as follows:

RESOLVED, that our AMA ~~continue to~~ urge Congress to enact legislation to classify water bead products as banned hazardous items to protect consumers, particularly children, from associated risks (New HOD Policy); and be it further

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 211 be adopted as amended.

HOD ACTION: Resolution 211 adopted as amended.

RESOLVED, that our American Medical Association urge the U.S. Consumer Product Safety Commission (CPSC) to promptly promulgate and enforce stringent performance

and labeling requirements for water bead toys and toys containing water beads to effectively mitigate associated health hazards (New HOD Policy); and be it further

RESOLVED, that our AMA continue to urge Congress to enact legislation to classify water bead products as banned hazardous items to protect consumers, particularly children, from associated risks (New HOD Policy); and be it further

RESOLVED, that our AMA encourage businesses that sell gel blasters to make appropriate and safe protective eye wear available and encourage its use to their customers and to distribute educational materials on the safe use of gel guns (New HOD Policy); and be it further

RESOLVED, that our AMA advocate for the development of national safety standards for gel blasters that include requirements for product design modifications such as lower velocity limits, safer projectile designs, or integrated safety mechanisms to reduce the risk of eye injuries. (Directive to Take Action)

Your Reference Committee heard strong testimony in support of Resolution 211. Your Reference Committee heard that water beads can be dangerous for children and have the potential to cause significant damage if they expand inside the body after ingestion, inhalation or insertion into ears, and can cause potential bowel obstruction, choking, or other injuries. Testimony also noted the significant dangers associated with water beads being used as projectiles, including eye injuries. Your Reference Committee heard that adoption of Resolution 211 would be a welcome addition to our AMA's broad range of public health policies, especially with respect to protecting children and young adults. An amendment was proposed to correct a misstatement in the second resolve with respect to our AMA continuing to support pending legislation in Congress that would classify water bead products as banned hazardous items, but our AMA has not supported such legislation; your Reference Committee agrees with this amendment. Therefore, your Reference Committee recommends that Resolution 211 be adopted as amended.

(16) RESOLUTION 212 — ADDRESSING THE UNREGULATED BODY BROKERAGE INDUSTRY

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 212 be amended by addition and deletion to read as follows:

Our AMA: (1) recognizes the need for ethical, transparent, and consistent body and body part donation regulations; (2) will support ~~collaborate with interested organizations to actively advocate for the passage of~~ federal legislation to provide necessary minimum standards, oversight, and authority over body broker entities that receive donated human bodies and body parts for education and research; (3) will develop model state legislation to provide necessary minimum standards, oversight, and authority over body broker entities that receive donated human bodies and body parts for education and research; and (4) encourages state medical societies to advocate for legislation or regulations in their state that are consistent with the AMA model state legislation. (Modify Current HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 212 be adopted as amended.

HOD ACTION: Resolution 212 referred.

RESOLVED, that our American Medical Association amend existing policy H-460.890, "Improving Body Donation Regulation," by addition to read as follows:

Our AMA: (1) recognizes the need for ethical, transparent, and consistent body and body part donation regulations~~.~~; (2) will collaborate with interested organizations to actively advocate for the passage of federal legislation to provide necessary minimum standards, oversight, and authority over body broker entities that receive donated human bodies and body parts for education and research; (3) will develop model state legislation to provide necessary minimum standards, oversight, and authority over body broker entities that receive donated human bodies and body parts for education and research; and (4) encourages state medical societies to advocate legislation or regulations in their state that are consistent with the AMA model state legislation. (Modify Current HOD Policy)

Your Reference Committee heard strong supportive testimony on Resolution 212. Testimony highlighted current gaps in federal and state oversight that allow body brokers to operate with minimal accountability, raising significant ethical concerns and public health risks. Testimony strongly supported our AMA's role in aiding states in enforcing minimum standards that would prevent the misuse and exploitation of donor bodies. Testimony particularly addressed the unregulated practices of non-living tissue body

banks. A minor amendment was offered to support the passage of federal legislation to broaden our AMA's advocacy on this issue. Therefore, your Reference Committee recommends that Resolution 212 be adopted as amended.

(17) RESOLUTION 213 — SUSTAINABLE LONG-TERM FUNDING FOR CHILD PSYCHIATRY ACCESS PROGRAMS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 213 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association advocate that the federal government work to achieve adequate and sustained funding for ~~of~~ access to child psychiatry consultation programs~~, such as Child Psychiatry Access Programs and Pediatric Mental Health Care Access Program~~. (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 213 be adopted as amended.

HOD ACTION: Resolution 213 adopted as amended.

RESOLVED, that our American Medical Association advocate that the federal government work to achieve adequate sustained funding of child psychiatry consultation programs, such as Child Psychiatry Access Programs and Pediatric Mental Health Care Access Program. (Directive to Take Action)

Your Reference Committee heard testimony in support of Resolution 213. Your Reference Committee heard that the Child Psychiatry Access Programs (CPAP) model helps to meet the needs of, and support primary care providers in, managing pediatric patients with psychiatric illnesses. Testimony noted that despite strong efforts to increase the number of child and adolescent psychiatrists, the demand exceeds the supply. Your Reference Committee heard that due to the success of CPAPs, Health Resources and Services Administration (HRSA) issued several grants for states to develop and implement these programs, however, it was noted that funding will run out for many states in 2026. Your Reference Committee also heard that Resolution 213 should be adopted with an amendment to delete reference to specific programs funded under discretionary appropriations and to make the language broader to provide flexibility to support more comprehensive physician workforce policy and to prevent conflicts with efforts to increase residency slots in mental health. Your Reference Committee agrees that the proffered amendment would provide more flexibility to AMA staff in working with Congress and should be adopted. Therefore, your Reference Committee recommends that Resolution 213 be adopted as amended.

(18) RESOLUTION 214 — ADVOCATING FOR EVIDENCE-BASED STRATEGIES TO IMPROVE RURAL OBSTETRIC HEALTH CARE AND ACCESS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that third resolve of Resolution 214 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA encourages academic medical centers and health systems to actively participate in obstetric telementoring/teleconsultation models to support rural physicians and nonphysician practitioners who provide obstetric care as part of a physician-led team ~~advanced practice providers~~ and improve perinatal health outcomes in rural communities (New HOD Policy); and be it further

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 214 be adopted as amended.

HOD ACTION: Resolution 214 adopted as amended.

RESOLVED, that our American Medical Association strongly supports federal legislation that provides funding for the creation and implementation of a national obstetric emergency training program for rural health care facilities with and without a dedicated labor and delivery unit (New HOD Policy); and be it further

RESOLVED, that our AMA supports the expansion and implementation of innovative obstetric telementoring/teleconsultation models to address perinatal health disparities and improve access to evidence-informed perinatal care in rural communities (New HOD Policy); and be it further

RESOLVED, that our AMA encourages academic medical centers and health systems to actively participate in obstetric telementoring/teleconsultation models to support rural physicians and advanced practice providers and improve perinatal health outcomes in rural communities (New HOD Policy); and be it further

RESOLVED, that our AMA supports ongoing research to evaluate the effectiveness of national implementation of obstetric telementoring/teleconsultation models to improve rural perinatal health outcomes and reduce rural-urban health disparities (New HOD Policy).

Your Reference Committee heard strong supportive testimony in favor of Resolution 214. Your Reference Committee heard that patients may seek obstetric care in a number of non-obstetric settings and therefore, it is important to ensure that the larger physician workforce, especially those physicians who are often required to provide prenatal and postpartum care in rural facilities, are trained and prepared to provide this medical care.

Testimony also noted that in many rural areas that lack regular and reliable access to physician specialists and subspecialists, non-specialist physicians must manage this care and thus need access to teleconsultations. Your Reference Committee also heard that this Resolution aligns with ongoing AMA advocacy in this space and that our AMA put out maternal health recommendations to Congress and the Administration acknowledging the importance of increased training and access to teleconsultations within the context of a physician led team. However, your Reference Committee also heard about the importance of aligning the terminology that we use for nonphysician practitioners with our policy compendium. Further testimony noted the importance of ensuring that this care takes place as part of a physician led team. Therefore, your Reference Committee recommends that Resolution 214 be adopted as amended.

(19) RESOLUTION 216 — CLEARING FEDERAL OBSTACLES FOR SUPERVISED INJECTION SITES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 216 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association advocate for elimination of federal obstacles ~~policies that empower states to determine the legality of~~ to the development of overdose prevention sites ~~supervised injection facilities (SIFs)~~.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 216 be adopted as amended.

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the title of Resolution 216 be changed to read as follows:

CLEARING FEDERAL OBSTACLES FOR OVERDOSE PREVENTION SITES

HOD ACTION: Resolution 216 adopted as amended with a change of title.

CLEARING FEDERAL OBSTACLES FOR OVERDOSE PREVENTION SITES

RESOLVED, that our American Medical Association advocate for federal policies that empower states to determine the legality of supervised injection facilities (SIFs). (Directive to Take Action)

Your Reference Committee heard mixed testimony on Resolution 216. Your Reference Committee heard that it is important to help remove barriers to more states being able to implement a pilot overdose prevention site. Testimony noted that decisions about overdose prevention sites should be left to the states and that the federal government should not be able to dictate the existence of these sites. Additional testimony noted that these sites are an important harm reduction measure, and that this resolution addresses a gap in existing AMA policy. However, one commentator suggested that adopting the resolution would create the appearance of AMA suggesting that illicit drug use can be done safely. Nevertheless, significantly more testimony was in favor of the resolution. Moreover, an amendment was offered that suggested a change in terminology from "supervised injection facility" to "overdose prevention site." Therefore, your Reference Committee recommends that Resolution 216 be adopted as amended.

(20) RESOLUTION 222 — ROLLBACK ON PHYSICIAN PERFORMANCE MEASURES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first resolve of Resolution 222 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association will continue to advocate ~~make public statements calling~~ for a removal of any/all unproven outcomes measures and associated mandates placed on physicians, practices, licensed clinics, nursing homes, hospitals and other places of healthcare (Directive to Take Action); and be it further

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the second resolve of Resolution 222 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA will support ~~seek~~ legislation or regulation removing any/all unproven outcomes measures and associated mandates placed on physicians, practices, licensed clinics, nursing homes, hospitals and other places of healthcare (Directive to Take Action); and be it further

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the third resolve of Resolution 222 be deleted.

~~RESOLVED, that our AMA will include the following action on a national level, including but not limited to:~~

~~-AMA statements calling for a removal of any/all unproven outcomes measures and associated mandates placed on physicians, practices, licensed clinics, nursing homes, hospitals and other places of healthcare; and legislation and regulation seeking the same, and~~

~~-AMA seeking legislation or regulation mandating the removal of any/all unproven outcomes measures and associated mandates placed on physicians, practices, licensed clinics, nursing homes, hospitals and other places of healthcare. (Directive to Take Action)~~

RECOMMENDATION D:

Madam Speaker, your Reference Committee recommends that Resolution 222 be adopted as amended.

HOD ACTION: Resolution 222 adopted as amended.

RESOLVED, that our American Medical Association will make public statements calling for a removal of any/all unproven outcomes measures and associated mandates placed on physicians, practices, licensed clinics, nursing homes, hospitals and other places of healthcare (Directive to Take Action); and be it further

RESOLVED, that our AMA will seek legislation or regulation removing any/all unproven outcomes measures and associated mandates placed on physicians, practices, licensed clinics, nursing homes, hospitals and other places of healthcare (Directive to Take Action); and be it further

RESOLVED, that our AMA will include the following action on a national level, including but not limited to:

-AMA statements calling for a removal of any/all unproven outcomes measures and associated mandates placed on physicians, practices, licensed clinics, nursing homes, hospitals and other places of healthcare; and legislation and regulation seeking the same, and

-AMA seeking legislation or regulation mandating the removal of any/all unproven outcomes measures and associated mandates placed on physicians, practices, licensed clinics, nursing homes, hospitals and other places of healthcare. (Directive to Take Action)

Your Reference Committee heard support for Resolution 222. Your Reference Committee heard that many existing performance measures lack scientific validation and burden physicians without improving patient care. Testimony argued that these mandates often redirect resources away from patient interaction. Further testimony noted that many current measures for quality reporting do not accurately capture the true quality of patient care. An amendment was offered that provided a more focused and strategic approach to addressing concerns regarding unproven performance measures that negatively impact physicians. The amendment captures our AMA's ongoing role in supporting legislative efforts that address unproven performance measures in the Merit-based Incentive Payment System (MIPS) and includes significant reforms, such as freezing performance thresholds, eliminating punitive payment penalties, requiring timely quarterly feedback from the Centers for Medicaid and Medicare Services, and simplifying reporting processes to reduce administrative burdens on physicians. Therefore, your Reference Committee recommends that Resolution 222 be adopted as amended.

(21) RESOLUTION 229 - SUPPORTING PENALTIES ON INSURERS WHO FAIL TO PAY DOCTORS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 229 be amended by deletion to read as follows:

RESOLVED, that our American Medical Association will advocate for passage of legislation that imposes penalties on insurers that fail to pay doctors within 30 days when doctors win for a claim brought to the federal Independent Dispute Resolution (IDR) process ~~(i.e. No Surprises Enforcement Act that has currently been introduced to the U.S. House of Representatives)~~.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 229 be adopted as amended.

HOD ACTION: Resolution 229 adopted as amended.

RESOLVED, that our American Medical Association will advocate for passage of legislation that imposes penalties on insurers that fail to pay doctors within 30 days when doctors win for a claim brought to the federal Independent Dispute Resolution (IDR) process (i.e. No Surprises Enforcement Act that has currently been introduced to the U.S. House of Representatives)

Your Reference Committee heard support for Resolution 229. Your Reference Committee heard about the need for both Congress and the Administration to ensure that the Independent Dispute Resolution (IDR) process under the No Surprises Act (NSA) functions as Congress intended. However, your Reference Committee heard that the

reference to specific legislation should be removed since the legislation referenced in the Resolution has already been changed to the Enhanced Enforcement of Health Coverage Act. Therefore, your Reference Committee recommends that Resolution 229 be adopted as amended.

RECOMMENDED FOR ADOPTION IN LIEU OF

(22) RESOLUTION 201 — BOARDING PATIENTS IN THE EMERGENCY ROOM
RESOLUTION 230 — ADDRESSING AND REDUCING PATIENT BOARDING IN EMERGENCY DEPARTMENTS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Alternate Resolution 201 be adopted in lieu of Resolutions 201 and 230.

ADDRESSING AND REDUCING PATIENT BOARDING IN EMERGENCY DEPARTMENTS

RESOLVED, that our American Medical Association (AMA) collaborate with interested parties, such as hospitals, insurance companies, the Centers for Medicare & Medicaid Services (CMS), and accrediting bodies such as the Joint Commission, to address and reduce emergency department boarding and overcrowding (Directive to Take Action); and be it further

RESOLVED, that our AMA support appropriate staffing and standards of care for all patients admitted to the hospital or awaiting transfer, including emergency department patients and admitted patients physically located in the emergency department, to mitigate patient harm and physician burnout (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for increased state and federal assistance to address the systemic factors contributing to emergency department boarding (Directive to Take Action); and be it further

RESOLVED, that our AMA support other medical societies, hospital associations, accrediting organizations, and patient advocacy groups to raise awareness of the impacts of emergency department boarding and to identify and propose solutions (Directive to Take Action); and be it further

RESOLVED, that our AMA will continue to monitor the development of CMS quality measures related to patient boarding and work in collaboration with relevant medical specialty associations to support improvements in quality standards related to emergency department care (Directive to Take Action).

RESOLVED, that our AMA will report back to the House of Delegates at the 2025 Interim Meeting on progress addressing and reducing patient boarding in emergency departments (Directive to Take Action).

HOD ACTION: Alternate Resolution 201 adopted in lieu of Resolutions 201 and 230.

RESOLUTION 201

RESOLVED, that our American Medical Association immediately collaborate with stakeholders such as hospitals, insurance companies, CMS, and joint commission to resolve this issue (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate strongly for appropriate staffing ratios and appropriate care for patients and the emergency room and those admitted but still physically located in the emergency room to decrease patient harm and physician and nurse burnout. (Directive to Take Action)

RESOLUTION 230

RESOLVED, that our American Medical Association strongly advocate that hospitals and health systems prioritize strategies to reduce emergency department boarding (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for increased state and federal funding to address the underlying causes of emergency department boarding (Directive to Take Action); and be it further

RESOLVED, that our AMA collaborate with other medical societies, hospital associations, accrediting organizations, and patient advocacy groups to raise awareness about the negative impacts of emergency department boarding and propose solutions (Directive to Take Action); and be it further

RESOLVED, that our AMA encourage the inclusion of emergency department boarding metrics in hospital quality measures and accreditation standards (New HOD Policy); and be it further

RESOLVED, that our AMA will report back to the House of Delegates at the 2025 Annual Meeting on progress addressing and reducing patient boarding in emergency departments (Directive to Take Action).

Your Reference Committee heard testimony in support of the spirit of Resolutions 201 and 230. Your Reference Committee heard that boarding patients in emergency rooms is a systemic problem that has a detrimental impact on both patients and physicians. Multiple amendments were offered. Additional testimony highlighted concerns about prescriptive staffing ratios and offered amendments to negate this issue. Testimony stressed that boarding patients in emergency rooms is an emergent problem that harms patients and contributes to physician burnout. Testimony also supported the joint consideration of

Resolution 201 and Resolution 230 given their similarities and a well-supported Alternate Resolution was offered that combined the content in both Resolutions. Therefore, your Reference Committee recommends that Alternate Resolution 201 be adopted in lieu of Resolutions 201 and 230.

RECOMMENDED FOR REFERRAL

(23) BOARD OF TRUSTEES REPORT 03 — STARK LAW SELF-REFERRAL BAN

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Board of Trustees Report 3 be referred.

HOD ACTION: Board of Trustees Report 3 referred.

The Board of Trustees recommends that the following policy be adopted in lieu of Resolution 227-I-23, and the remainder of the report be filed.

1. That our American Medical Association reaffirm AMA Policies H-140.861, "Physicians Self-Referral," D-270.995, "Physician Ownership and Referral for Imaging Services," and H-385.914, "Stark Law and Physician Compensation," be reaffirmed. (Reaffirm HOD Policy)

2. That our American Medical Association supports initiatives to expand Stark law waivers to allow independent physicians, in addition to employed or affiliated physicians, to work with hospitals or health entities on quality improvement initiatives to address issues including care coordination and efficiency. (New HOD Policy)

Your Reference Committee heard mixed testimony on Board of Trustees Report 3. Your Reference Committee heard that the Stark law has contributed to creating an uneven playing field for physician practices who must go to great lengths to avoid violating the Stark law's prohibition on self-referral. Other testimony noted that the Report should go further to remove burdens on physician practices that large, consolidated entities do not face. Testimony recommended referral for stronger support to eliminate the Stark law's unfair barrier to competition on physician practices. Therefore, your Reference Committee recommends that Board of Trustees Report 3 be referred.

(24) RESOLUTION 226 — INFORMATION BLOCKING RULE

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 226 be referred.

HOD ACTION: Resolution 226 referred.

RESOLVED, that our American Medical Association supports the use of short-term embargo of reports or results and individual tailoring of preferences for release of information as part of the harm exception to the Information Blocking Rule (New HOD Policy); and be it further

RESOLVED, that our AMA supports the requirement of review of report and result information by the ordering physician or physician surrogate prior to release of medical information to the patient (New HOD Policy); and be it further

RESOLVED, that our AMA supports expansion of the harm exception to the Information Blocking Rule to include harassment or potential harm of medical staff or others (New HOD Policy); and be it further

RESOLVED, that our AMA advocates for expansions to the harm exception to the Information Blocking Rule and for the requirement of review by the ordering physician or surrogate prior to the application of the Information Blocking Rule provisions. (Directive to Take Action).

Your Reference Committee heard mixed testimony on Resolution 226. Testimony indicated that any limits on patients' access to their medical records must be undertaken only at the request of the patient to avoid violation of the HIPAA patient right of access and the Information Blocking Rules. However, testimony also noted that requiring physician review of every result would unnecessarily increase physician burden. Testimony emphasized the need to differentiate between delay of normal results versus abnormal results with serious implications. Some testimony opposed the delay of results only when directed by a patient. Your Reference Committee believes that given the level of complexity and variety of concerns heard throughout testimony, further study is the most appropriate course of action to sufficiently address this issue. Therefore, your Reference Committee recommends that Resolution 226 be referred.

RECOMMENDED FOR REFERRAL FOR DECISION

(25) RESOLUTION 228 – CODIFICATION OF THE CHEVRON DEFERENCE DOCTRINE

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 228 be referred for decision.

HOD ACTION: Resolution 228 referred.

RESOLVED, that our American Medical Association support codification of the Chevron deference doctrine at the federal and state levels, which would:

a. generally leave reasonable interpretation of ambiguous regulatory statutes to the purview of the executive branch, including agencies comprised of scientific and medical experts evaluating robust evidence and

b. generally prioritize legislative oversight and modification of ambiguous regulatory statutes and agency rules, instead of deferring to the judicial branch for this function.

Your Reference Committee heard mixed testimony on Resolution 228. In support, your Reference Committee heard that in June 2024, the U.S. Supreme Court overturned the 40-year-old Chevron Deference Doctrine, under which courts would defer to Agency interpretation of ambiguous legislation. Moreover, your Reference Committee heard that healthcare, public health, scientific, and technological regulations are best left to subject-matter and technical experts within the Agencies. Further testimony was heard that noted that the demise of Chevron sets a dangerous precedent for the gradual erosion of regulations governing environmental, healthcare, public health, and civil rights policy. Testimony noted that this legal change could threaten our AMA's advocacy on a myriad of healthcare and public health priorities.

However, your Reference Committee also heard that this resolution could have negative consequences for our AMA's advocacy efforts. Your Reference Committee heard that the Supreme Court's decision may present opportunities for our AMA to challenge certain regulations, especially under Medicare, that negatively impact physician payment. Further testimony noted that our AMA is currently examining various regulations where legal challenges might be possible. Your Reference Committee heard that calling for the codification of the Chevron Deference Doctrine is too vague since Chevron deference is a judicial doctrine, not a legislative mandate, and codifying "deference" itself seems to contradict its purpose. . Your Reference Committee also heard concerns that establishing a statutory requirement that ambiguous statutes should always be decided by Executive Branch Agencies could result in unchecked Executive authority, which might not align with our AMA's advocacy in opposition to certain Agency interpretations or implementation of rules.

Your Reference Committee considered testimony that offered alternative language than what is in the resolution, as well as testimony raising concerns that adopting Resolution 228 would have significant implications for our AMA's advocacy agenda and strategy.

Your Reference Committee agrees with testimony that our Board is in a better position to weigh the pros and cons of this resolution and should be referred for study or referred for decision. Having heard testimony that this issue is urgent, your Reference Committee recommends that a referral for decision would be a more expedient way to address this matter. Therefore, your Reference Committee recommends that Resolution 228 be referred for decision.

RECOMMENDED FOR NOT ADOPTION

(26) RESOLUTION 221 — MEDICARE COVERAGE FOR NON-PAR PHYSICIANS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 221 not be adopted.

HOD ACTION: Resolution 221 not adopted.

RESOLVED, that our American Medical Association support federal legislation that would provide Medicare enrollees with the ability to receive partial reimbursement towards the cost of receiving treatment from the physician of their choice, regardless of whether that physician participates in Medicare. (New HOD Policy)

Your Reference Committee heard considerable testimony in opposition to Resolution 221. Your Reference Committee heard support for the intent to increase patient choice, but testimony raised concerns about potential redundancy with existing policies. Additional testimony noted that our AMA already has policies supporting patient choice, including the Medicare Patient Empowerment Act, and recommended that our AMA continue our advocacy with our existing policies rather than adopting new ones. Further testimony expressed opposition based on Medicare's current allowances for non-participating providers, and noted concerns that the resolution may not reflect current Medicare rules and limits around non-PAR physician reimbursement, as outlined by CMS. For additional information on this issue please see our AMA's Medicare Participation Options Toolkit and our AMA's Medicare Participation Guide, and our AMA's Frequently Asked Questions Regarding Medicare Participation Options. Therefore, your Reference Committee recommends that Resolution 221 not be adopted.

RECOMMENDED FOR REAFFIRMATION IN LIEU OF

(27) RESOLUTION 215 — ADVOCATING FOR FEDERAL AND STATE INCENTIVES FOR RECRUITMENT AND RETENTION OF PHYSICIANS TO PRACTICE IN RURAL AREAS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that AMA policies H-465.988, H-465.981, H-305.925, and D-305.958 be reaffirmed in lieu of Resolution 215.

HOD ACTION: AMA policies H-465.988, H-465.981, H-305.925, and D-305.958 reaffirmed in lieu of Resolution 215.

RESOLVED, that our American Medical Association advocate for increased federal and state funding for loan forgiveness for physicians who commit to practice and reside in rural and underserved areas for a meaningful period of time (Directive to Take Action); and be it further

RESOLVED, that our AMA urge Congress and State legislatures to establish retention bonus programs for physicians who maintain practice in rural areas for extended periods, with increasing bonuses for longer commitments (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for the expansion and sustainable funding of residency and graduate medical education slots in rural areas, as well as opportunities for exposure to rural health care such as through clinical rotations in rural areas, to increase the likelihood of physicians practicing in these communities after training. (Directive to Take Action)

Your Reference Committee heard mixed testimony on Resolution 215. Your Reference Committee heard that it is extremely important to ensure that physicians who work in rural and underserved communities are properly supported and provided with the resources necessary to practice in these communities. Testimony noted the cost of medical school and the importance of loan forgiveness programs as well as the need to ensure that medical students and residents are provided rotations and residency positions in rural communities to help build a connection to the work and ensure that these areas have access to physicians. However, your Reference Committee also heard that our AMA has consistently advocated for additional loan forgiveness avenues and increased funding for residency slots. Testimony also highlighted that our AMA is consistently advocating for sustainable working environments for physicians across the board, including those that practice in rural areas. This advocacy includes requests for proper payment, access to needed resources, pipeline programs and more. Additionally, your Reference Committee heard that more providers are needed in the Indian Health Service and notes that our AMA recently passed policy that addresses helping to create sustainable pipelines for physicians in the Indian Health Service. Your Reference Committee also notes that our AMA has actively worked on this issue and has sent multiple advocacy letters out on this topic. (See some of our AMA advocacy work on this topic here, here, here, here, here,

here, here, and here). Further testimony noted that Resolution 215 is already abundantly covered by existing AMA policy and advocacy work. Therefore, your Reference Committee recommends that existing AMA policies H-465.988, H-465.981, H-305.925, and D-305.958 be reaffirmed in lieu of Resolution 215.

H-465.988 - Educational Strategies for Meeting Rural Health Physician Shortage

1. In light of the data available from the current literature as well as ongoing studies being conducted by staff, our American Medical Association recommends that:

a. Our AMA encourage medical schools and residency programs to develop educationally sound rural clinical preceptorships and rotations consistent with educational and training requirements, and to provide early and continuing exposure to those programs for medical students and residents.

b. Our AMA encourage medical schools to develop educationally sound primary care residencies in smaller communities with the goal of educating and recruiting more rural physicians.

c. Our AMA encourage state and county medical societies to support state legislative efforts toward developing scholarship and loan programs for future rural physicians.

d. Our AMA encourage state and county medical societies and local medical schools to develop outreach and recruitment programs in rural counties to attract promising high school and college students to medicine and the other health professions.

e. Our AMA urge continued federal and state legislative support for funding of Area Health Education Centers (AHECs) for rural and other underserved areas.

f. Our AMA continue to support full appropriation for the National Health Service Corps Scholarship Program, with the proviso that medical schools serving states with large rural underserved populations have a priority and significant voice in the selection of recipients for those scholarships.

g. Our AMA support full funding of the new federal National Health Service Corps loan repayment program.

h. Our AMA encourage continued legislative support of the research studies being conducted by the Rural Health Research Centers funded by the National Office of Rural Health in the Department of Health and Human Services.

i. Our AMA continue its research investigation into the impact of educational programs on the supply of rural physicians.

j. Our AMA continue to conduct research and monitor other progress in development of educational strategies for alleviating rural physician shortages.

k. Our AMA reaffirm its support for legislation making interest payments on student debt tax deductible.

l. Our AMA encourage state and county medical societies to develop programs to enhance work opportunities and social support systems for spouses of rural practitioners.

2. Our AMA will work with state and specialty societies, medical schools, teaching hospitals, the Accreditation Council for Graduate Medical Education (ACGME), the Centers for Medicare and Medicaid Services (CMS) and other interested

stakeholders to identify, encourage and incentivize qualified rural physicians to serve as preceptors and volunteer faculty for rural rotations in residency.
3. Our AMA will:
    a. work with interested stakeholders to identify strategies to increase residency training opportunities in rural areas with a report back to the House of Delegates; and
    b. work with interested stakeholders to formulate an actionable plan of advocacy with the goal of increasing residency training in rural areas.
4. Our AMA will encourage ACGME review committees to consider adding exposure to rural medicine as appropriate, to encourage the development of rural program tracks in training programs and increase physician awareness of the conditions that pose challenges and lack of resources in rural areas.
5. Our AMA will encourage adding educational webinars, workshops and other didactics via remote learning formats to enhance the educational needs of smaller training programs.

H-465.981 - Enhancing Rural Physician Practices

1. Our American Medical Association supports legislation to extend the 10% Medicare payment bonus to physicians practicing in rural counties and other areas where the poverty rate exceeds a certain threshold, regardless of the areas' Health Professional Shortage Area (HPSA) status.
2. Our AMA encourages federal and state governments to make available low interest loans and other financial assistance to assist physicians with shortage area practices in defraying their costs of compliance with requirements of the Occupational Safety and Health Administration, Americans with Disabilities Act and other national or state regulatory requirements.
3. Our AMA will explore the feasibility of supporting the legislative and/or regulatory changes necessary to establish a waiver process through which shortage area practices can seek exemption from specific elements of regulatory requirements when improved access, without significant detriment to quality, will result.
4. Our AMA supports legislation that would allow shortage area physician practices to qualify as Rural Health Clinics without the need to employ one or more physician extenders.
5. Our AMA will undertake a study of structural urbanism, federal payment polices, and the impact on rural workforce disparities.

H-305.925 - Principles of and Actions to Address Medical Education Costs and Student Debt

The costs of medical education should never be a barrier to the pursuit of a career in medicine nor to the decision to practice in a given specialty. To help address this issue, our American Medical Association (AMA) will:
1. Collaborate with members of the Federation and the medical education community, and with other interested organizations, to address the cost of medical education and medical student debt through public- and private-sector advocacy.
2. Vigorously advocate for and support expansion of and adequate funding for federal scholarship and loan repayment programs--such as those from the National Health Service Corps, Indian Health Service, Armed Forces, and Department of Veterans Affairs, and for comparable programs from states and the

private sector--to promote practice in underserved areas, the military, and academic medicine or clinical research.

3. Encourage the expansion of National Institutes of Health programs that provide loan repayment in exchange for a commitment to conduct targeted research.

4. Advocate for increased funding for the National Health Service Corps Loan Repayment Program to assure adequate funding of primary care within the National Health Service Corps, as well as to permit:

a. inclusion of all medical specialties in need, and

b. service in clinical settings that care for the underserved but are not necessarily located in health professions shortage areas.

5. Encourage the National Health Service Corps to have repayment policies that are consistent with other federal loan forgiveness programs, thereby decreasing the amount of loans in default and increasing the number of physicians practicing in underserved areas.

6. Work to reinstate the economic hardship deferment qualification criterion known as the “20/220 pathway,” and support alternate mechanisms that better address the financial needs of trainees with educational debt.

7. Advocate for federal legislation to support the creation of student loan savings accounts that allow for pre-tax dollars to be used to pay for student loans.

8. Work with other concerned organizations to advocate for legislation and regulation that would result in favorable terms and conditions for borrowing and for loan repayment, and would permit 100% tax deductibility of interest on student loans and elimination of taxes on aid from service-based programs.

9. Encourage the creation of private-sector financial aid programs with favorable interest rates or service obligations (such as community- or institution-based loan repayment programs or state medical society loan programs).

10. Support stable funding for medical education programs to limit excessive tuition increases, and collect and disseminate information on medical school programs that cap medical education debt, including the types of debt management education that are provided.

11. Work with state medical societies to advocate for the creation of either tuition caps or, if caps are not feasible, pre-defined tuition increases, so that medical students will be aware of their tuition and fee costs for the total period of their enrollment.

12. Encourage medical schools to:

a. study the costs and benefits associated with non-traditional instructional formats (such as online and distance learning, and combined baccalaureate/MD or DO programs) to determine if cost savings to medical schools and to medical students could be realized without jeopardizing the quality of medical education;

b. engage in fundraising activities to increase the availability of scholarship support, with the support of the Federation, medical schools, and state and specialty medical societies, and develop or enhance financial aid opportunities for medical students, such as self-managed, low-interest loan programs;

c. cooperate with postsecondary institutions to establish collaborative debt counseling for entering first-year medical students;

d. allow for flexible scheduling for medical students who encounter financial difficulties that can be remedied only by employment, and consider creating opportunities for paid employment for medical students;

e. counsel individual medical student borrowers on the status of their indebtedness and payment schedules prior to their graduation;
f. inform students of all government loan opportunities and disclose the reasons that preferred lenders were chosen;
g. ensure that all medical student fees are earmarked for specific and well-defined purposes, and avoid charging any overly broad and ill-defined fees, such as but not limited to professional fees;
h. use their collective purchasing power to obtain discounts for their students on necessary medical equipment, textbooks, and other educational supplies;
i. work to ensure stable funding, to eliminate the need for increases in tuition and fees to compensate for unanticipated decreases in other sources of revenue; mid-year and retroactive tuition increases should be opposed.

13. Support and encourage state medical societies to support further expansion of state loan repayment programs, particularly those that encompass physicians in non-primary care specialties.

14. Take an active advocacy role during reauthorization of the Higher Education Act and similar legislation, to achieve the following goals:

a. Eliminating the single holder rule.
b. Making the availability of loan deferment more flexible, including broadening the definition of economic hardship and expanding the period for loan deferment to include the entire length of residency and fellowship training.
c. Retaining the option of loan forbearance for residents ineligible for loan deferment.
d. Including, explicitly, dependent care expenses in the definition of the "cost of attendance".
e. Including room and board expenses in the definition of tax-exempt scholarship income.
f. Continuing the federal Direct Loan Consolidation program, including the ability to "lock in" a fixed interest rate, and giving consideration to grace periods in renewals of federal loan programs.
g. Adding the ability to refinance Federal Consolidation Loans.
h. Eliminating the cap on the student loan interest deduction.
i. Increasing the income limits for taking the interest deduction.
j. Making permanent the education tax incentives that our AMA successfully lobbied for as part of Economic Growth and Tax Relief Reconciliation Act of 2001.
k. Ensuring that loan repayment programs do not place greater burdens upon married couples than for similarly situated couples who are cohabitating.
l. Increasing efforts to collect overdue debts from the present medical student loan programs in a manner that would not interfere with the provision of future loan funds to medical students.

15. Continue to work with state and county medical societies to advocate for adequate levels of medical school funding and to oppose legislative or regulatory provisions that would result in significant or unplanned tuition increases.

16. Continue to study medical education financing, so as to identify long-term strategies to mitigate the debt burden of medical students, and monitor the short-

and long-term impact of the economic environment on the availability of institutional and external sources of financial aid for medical students, as well as on choice of specialty and practice location.

17. Collect and disseminate information on successful strategies used by medical schools to cap or reduce tuition.

18. Continue to monitor the availability of and encourage medical schools and residency/fellowship programs to:

a. provide financial aid opportunities and financial planning/debt management counseling to medical students and resident/fellow physicians;

b. work with key stakeholders to develop and disseminate standardized information on these topics for use by medical students, resident/fellow physicians, and young physicians; and

c. share innovative approaches with the medical education community.

19. Seek federal legislation or rule changes that would stop Medicare and Medicaid decertification of physicians due to unpaid student loan debt. Our AMA believes that it is improper for physicians not to repay their educational loans, but assistance should be available to those physicians who are experiencing hardship in meeting their obligations.

20. Related to the Public Service Loan Forgiveness (PSLF) Program, our AMA supports increased medical student and physician participation in the program, and will:

a. Advocate that all resident/fellow physicians have access to PSLF during their training years.

b. Advocate against a monetary cap on PSLF and other federal loan forgiveness programs.

c. Work with the United States Department of Education to ensure that any cap on loan forgiveness under PSLF be at least equal to the principal amount borrowed.

d. Ask the United States Department of Education to include all terms of PSLF in the contractual obligations of the Master Promissory Note.

e. Encourage the Accreditation Council for Graduate Medical Education (ACGME) to require residency/fellowship programs to include within the terms, conditions, and benefits of program appointment information on the employer's PSLF program qualifying status.

f. Advocate that the profit status of a physician's training institution not be a factor for PSLF eligibility,

g. Encourage medical school financial advisors to counsel wise borrowing by medical students, in the event that the PSLF program is eliminated or severely curtailed.

h. Encourage medical school financial advisors to increase medical student engagement in service-based loan repayment options, and other federal and military programs, as an attractive alternative to the PSLF in terms of financial prospects as well as providing the opportunity to provide care in medically underserved areas.

i. Strongly advocate that the terms of the PSLF that existed at the time of the agreement remain unchanged for any program participant in the event of any future restrictive changes.

j. Monitor the denial rates for physician applicants to the PSLF.

k. Undertake expanded federal advocacy, in the event denial rates for physician applicants are unexpectedly high, to encourage release of information on the basis for the high denial rates, increased transparency and streamlining of program requirements, consistent and accurate communication between loan servicers and borrowers, and clear expectations regarding oversight and accountability of the loan servicers responsible for the program.

l. Work with the United States Department of Education to ensure that applicants to the PSLF and its supplemental extensions, such as Temporary Expanded Public Service Loan Forgiveness (TEPSLF), are provided with the necessary information to successfully complete the program(s) in a timely manner.

m. Work with the United States Department of Education to ensure that individuals who would otherwise qualify for PSLF and its supplemental extensions, such as TEPSLF, are not disqualified from the program(s).

21. Advocate for continued funding of programs including Income-Driven Repayment plans for the benefit of reducing medical student load burden.

22. Strongly advocate for the passage of legislation to allow medical students, residents and fellows who have education loans to qualify for interest-free deferment on their student loans while serving in a medical internship, residency, or fellowship program, as well as permitting the conversion of currently unsubsidized Stafford and Graduate Plus loans to interest free status for the duration of undergraduate and graduate medical education.

23. Continue to monitor opportunities to reduce additional expense burden upon medical students including reduced-cost or free programs for residency applications, virtual or hybrid interviews, and other cost-reduction initiatives aimed at reducing non-educational debt.

24. Encourage medical students, residents, fellows and physicians in practice to take advantage of available loan forgiveness programs and grants and scholarships that have been historically underutilized, as well as financial information and resources available through the Association of American Medical Colleges and American Association of Colleges of Osteopathic Medicine, as required by the Liaison Committee on Medical Education and Commission on Osteopathic College Accreditation, and resources available at the federal, state and local levels.

25. Support federal efforts to forgive debt incurred during medical school and other higher education by physicians and medical students, including educational and cost of attendance debt.

26. Support that residency and fellowship application services grant fee assistance to applicants who previously received fee assistance from medical school application services or are determined to have financial need through another formal mechanism.

D-305.958 - Increasing Graduate Medical Education Positions as a Component to any Federal Health Care Reform Policy

1. Our American Medical Association will ensure that actions to bolster the physician workforce must be part of any comprehensive federal health care reform.

2. Our AMA will work with the Centers for Medicare and Medicaid Services to explore ways to increase graduate medical education slots to accommodate the need for more physicians in the US.
3. Our AMA will work actively and in collaboration with the Association of American Medical Colleges and other interested stakeholders to rescind funding caps for GME imposed by the Balanced Budget Act of 1997.
4. Our AMA will actively advocate for expanded funding for entry and continued training positions in specialties and geographic regions with documented medical workforce shortages.
5. Our AMA will lobby Congress to find ways to increase graduate medical education funding to accommodate the projected need for more physicians.
6. Our AMA will work with key organizations, such as the US Health Resources and Services Administration, the Robert Graham Center, and the Cecil G. Sheps Center for Health Services Research, to:
    a. Support development of reports on the economic multiplier effect of each residency slot by geographic region and specialty.
    b. Investigate the impact of GME funding on each state and its impact on that state's health care workforce and health outcomes.

(28) RESOLUTION 217 — EXPAND ACCESS TO SKILLED NURSING FACILITY SERVICES FOR PATIENTS WITH OPIOID USE DISORDER

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that AMA policy D-95.955 be reaffirmed in lieu of Resolution 217.

HOD ACTION: AMA policy D-95.955 reaffirmed in lieu of Resolution 217.

RESOLVED, that our American Medical Association advocate for legislative and regulatory action to ensure patients are not being denied appropriate admission to skilled nursing facilities based on practices of denying admission solely on the diagnosis of opioid use disorder or prescriptions for active medications for opioid use disorder (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for and support legislation and regulatory action to ensure adequate reimbursement of skilled nursing facilities that recognizes the complexity of care, treatment and resources required for opioid use disorder treatment (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for increased access to medications for opioid use disorder in long-term care pharmacies and address the barriers to access to methadone in long-term care for use in the treatment of opioid use disorder. (Directive to Take Action)

Minimal but mixed testimony was received for Resolution 217. Your Reference Committee heard that there has been a consistent struggle for patients with opioid use disorder (OUD)

when admission to a skilled nursing facility (SNF) is recommended. Testimony noted that a history of OUD or being prescribed appropriate medical treatment for OUD should not be a barrier to receiving necessary care at a SNF. Further testimony highlighted the fact that denying admission to these facilities based solely on an OUD diagnosis, or actively taking medications for OUD, exacerbates the stigma surrounding addiction and denies patients access to the comprehensive care they need. Your Reference Committee received one suggestion to refer this resolution for further study however, opposing testimony noted that this issue does not need to be studied and noted that not accepting a patient needing physical rehabilitation services because they are on medication for OUD is discrimination. Further testimony noted that our AMA already has existing policy that addresses caring for individual with OUD in SNFs. Therefore, your Reference Committee recommends that existing AMA policy D-95.955 be reaffirmed in lieu of Resolution 217.

Improving Access to Post-Acute Medical Care for Patients with Substance Use Disorder (SUD) D-95.955

1. Our American Medical Association advocates to ensure that patients who require a post-acute medical care setting are not discriminated against because of their history of substance use disorder.
2. Our AMA advocates that our federal, state, and local governments remove barriers to evidence-based treatment for substance use disorders, including medications for opioid use disorder, at skilled nursing facilities.
3. Our AMA advocates that Medicare and Medicaid, including managed care organizations, remove barriers to coverage and treatment for substance use and opioid use disorder, including medications for opioid use disorder, in skilled nursing facilities.

(29) RESOLUTION 219 — ADVOCATE TO CONTINUE REIMBURSEMENT FOR TELEHEALTH / TELEMEDICINE VISITS PERMANENTLY

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that AMA policies D-480.965 and D-480.963 be reaffirmed in lieu of Resolution 219.

HOD ACTION: AMA policies D-480.965 and D-480.963 reaffirmed in lieu of Resolution 219.

RESOLVED, that our American Medical Association advocate for making telehealth reimbursement permanent for Medicare and for all health insurance providers. (Directive to Take Action)

Your Reference Committee heard testimony in support of the spirit of Resolution 219. Your Reference Committee heard testimony that emphasized telehealth's role in improving access to care, particularly for rural and underserved communities, and highlighted its sustained value since the COVID-19 pandemic. Testimony also reflected the increasing importance of advocating for a permanent telehealth solution for Medicare beneficiaries

and patients with private insurance plans, as the COVID-19 telehealth waivers are set to expire on December 31st of this year. However, strong testimony, that was supported by others, recommended reaffirmation of existing AMA policy. This testimony noted that our AMA already has policy that directly addresses the concerns raised by Resolution 219 concerning access and reimbursement for telehealth. Your Reference Committee also heard about our AMA's tireless advocacy efforts in this realm in the form of supporting bi-partisan legislation and commenting, when appropriate, through the regulatory rule making process. Therefore, Your Reference Committee recommends that existing AMA Policies D-480.965 and D-480.963 be reaffirmed in lieu of Resolution 219.

D-480.965 - Reimbursement for Telehealth

Our American Medical Association will work with third-party payers, the Centers for Medicare and Medicaid Services, Congress and interested state medical associations to provide coverage and reimbursement for telehealth to ensure increased access and use of these services by patients and physicians.

D-480.963 -COVID-19 Emergency and Expanded Telemedicine Regulations

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

(30) RESOLUTION 220 — MIPS REFORM

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that AMA policies D-400.982, H-385.905, and D-395.999 be reaffirmed in lieu of Resolution 220.

HOD ACTION: AMA policies D-400.982, H-385.905, and D-395.999 reaffirmed in lieu of Resolution 220.

RESOLVED, that our American Medical Association advocate for the repeal of the Medicare Merit-Based Incentive Payment System (MIPS) and replacement with 1) a practicing physician-designed program that has far less administrative burdens and 2) only adopts measures that have been shown to measurably improve patient outcomes. (Directive to Take Action)

Your Reference Committee heard mixed testimony on Resolution 220. Your Reference Committee heard that MIPS has become overly complex, placing excessive administrative demands on physicians and detracting from direct patient care. Testimony noted that the existing Surgical Care MIPS Value Pathway (MVP) demonstrates the system's flaws, as it groups unrelated specialties together and lacks relevant, clinically meaningful measures. However, your Reference Committee also heard strong testimony noting that our AMA already has policy that addresses the concerns raised in this resolution. Existing AMA policy already focuses on securing sufficient Medicare physician payment to ensure access to care and emphasizes reducing the financial and reporting burdens that MIPS places on physicians. These existing AMA policies advocate for reforms such as positive payment updates, eliminating budget neutrality, and reducing the administrative load associated with MIPS reporting. Your Reference Committee also heard that our AMA is actively advocating in this area. For example, our AMA, in collaboration with 50 state medical associations, the District of Columbia, and 76 national medical specialty societies, has developed legislation to replace key elements of MIPS with a new Data-Driven Performance Payment System (DPPS). This includes freezing performance thresholds, eliminating the tournament model, and simplifying reporting to reduce the negative impacts on small and rural practices (see here and here). Therefore, your Reference Committee recommends that existing AMA policies D-400.982, H-385.905, and D-395.999 be reaffirmed in lieu of Resolution 220.

D-400.982 – AMA Efforts on Medicare Payment Reform

1. Our American Medical Association will increase media awareness around the 2024 AMA Annual meeting about the need for Medicare Payment Reform, eliminating budget neutrality reductions, and instituting annual cost of living increases.
2. Our AMA will step up its public relations campaign to get more buy-in from the general public about the need for Medicare payment reform.
3. Our AMA will increase awareness to all physicians about the efforts of our AMA on Medicare Payment Reform.
4. Our AMA will advocate for abolition of all MIPS penalties in light of the current inadequacies of Medicare payments.

H-385.905 - Merit-based Incentive Payment System (MIPS)

Our American Medical Association supports legislation that ensures Medicare physician payment is sufficient to safeguard beneficiary access to care, replaces or supplements budget neutrality in MIPS with incentive payments, or implements positive annual physician payment updates.

D-395.999 - Reducing MIPS Reporting Burden

Our AMA will work with the Centers for Medicare and Medicaid Services (CMS) to advocate for improvements to Merit-Based Incentive Payment System (MIPS) that have significant input from practicing physicians and reduce regulatory and paperwork burdens on physicians. In the interim, our AMA will work with CMS to shorten the yearly MIPS data reporting period from one-year to a minimum of 90-days (of the physician's choosing) within the calendar year.

(31) RESOLUTION 223 — MANDATED ECONOMIC ESCALATORS IN INSURANCE CONTRACTS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that AMA policy D-400.990 be reaffirmed in lieu of Resolution 223.

HOD ACTION: AMA policy D-400.990 reaffirmed in lieu of Resolution 223.

RESOLVED, that our American Medical Association advocates through legislation or regulation for the mandatory insertion of an economic escalator provision in all commercial insurance contracts to account for economic inflation or a decline in Medicare Physician Fee Schedule (PFS). (Directive to Take Action)

Your Reference Committee heard mixed testimony on Resolution 223. Your Reference Committee heard that linking commercial reimbursement to Medicare's declining rates without adjustments for inflation creates financial strain for physician practices, particularly as operational costs continue to rise. Additional testimony argued that economic escalators could perpetuate unsustainable cost-shifting and fail to address underlying reimbursement issues and recommended that instead innovative reimbursement models such as value-based care and bundled payments, which align payments with patient outcomes, should be promoted. Your Reference Committee also heard strong testimony in favor of reaffirming existing AMA policy. This testimony noted that existing AMA policy already supports uncoupling commercial fee schedules from Medicare's declining payment rates and advocates for inflation-based adjustments to ensure physician payment schedules reflect both the rising costs of care and the value of services provided. Testimony also highlighted the work that our AMA is already doing in this space including advocating to ensure that commercial payers adopt payment models that better align with the costs and value of care, rather than relying solely on Medicare's outdated fee structure. Therefore, your Reference Committee recommends that existing AMA Policy D-400.990 be reaffirmed in lieu of Resolution 223.

D-400.990 - Uncoupling Commercial Fee Schedules from the Medicare Physician Payment Schedule

1. Our American Medical Association shall use every means available to convince health insurance companies and managed care organizations to immediately

uncouple fee schedules from the Medicare Physician Payment Schedule and to maintain a level of payment that is sustainable, reflects the full cost of practice, and the value of the care provided, and includes inflation-based updates.
2. Our AMA will seek legislation and/or regulation to prevent managed care companies from utilizing a physician payment schedule below the updated Medicare Physician Payment Schedule.

(32) RESOLUTION 225 — ELIMINATION OF MEDICARE 14-DAY RULE

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that AMA policy D-330.903 be reaffirmed in lieu of Resolution 225.

HOD ACTION: Resolution 225 adopted.

RESOLVED, that our American Medical Association actively lobby the federal government to readdress and change laboratory date of service rules under Medicare, e.g. the Medicare 14-Day Laboratory Date of Service Rule (Medicare 14-Day Rule), such that complex laboratory services performed on pathologic specimens collected from an inpatient hospital procedure be paid separately from inpatient bundled payments, consistent with Outpatient rules. (Directive to Take Action).

Your Reference Committee heard minimal but mixed testimony on Resolution 225. Your Reference Committee heard testimony in support of reaffirming existing policy. Testimony reflected that existing policy on this subject accomplishes the spirit of this resolution and the testimony noted that the resolution's slightly modified language does not provide any substantive changes to our existing policy. Your Reference Committee would like to encourage interested parties to contact our AMA staff who would be happy to help state or specialty societies address this issue. Therefore, your Reference Committee recommends that existing AMA policy D-330.903 be reaffirmed in lieu of Resolution 225.

D-330.903 - Elimination of Laboratory 14-Day Rules Under Medicare

Our AMA will actively lobby the federal government to change laboratory Date of Service rules under Medicare such that complex diagnostic laboratory services performed on pathologic specimens collected from a hospital procedure be paid separately from inpatient and outpatient bundled payments.

(33) RESOLUTION 227 — MEDICARE PAYMENT PARITY FOR TELEMEDICINE SERVICES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that AMA policies D-480.969 and D-480.965 be reaffirmed in lieu of Resolution 227.

HOD ACTION: AMA policies D-480.969 and D-480.965 reaffirmed in lieu of Resolution 227.

RESOLVED, that our American Medical Association advocate for Medicare to reimburse providers for telemedicine-provided services at an equal rate as if the services were provided in-person. (Directive to Take Action)

Your Reference Committee heard testimony in support of the spirit of Resolution 227. Your Reference Committee heard about telemedicine's role in expanding access to care and promoting continuity across various care settings. Testimony noted that Medicare payment parity is essential for sustaining telemedicine services and fairly compensating physicians. However, additional testimony suggested exploring flexible reimbursement models to account for telemedicine's unique cost structure while still recognizing the value of physician expertise and time. Your Reference Committee also heard testimony that clarified that the value of telehealth services paid for by Medicare is something that cannot be advocated for by AMA staff since discussions related to the value of those codes occur at the AMA/Specialty Society RVS Update Committee (RUC) meetings following deliberations by the various specialty society members that utilize those services. Testimony further noted the strong existing policy that our AMA already has that addresses the heart of Resolution 227. Therefore, your Reference Committee recommends that existing AMA Policies D-480.969 and D-480.965 be reaffirmed in lieu of Resolution 227.

D-480.969 - Insurance Coverage Parity for Telemedicine Service

1. Our American Medical Association will advocate for telemedicine parity laws that require private insurers to cover telemedicine-provided services comparable to that of in-person services, and not limit coverage only to services provided by select corporate telemedicine providers.
2. Our AMA will develop model legislation to support states' efforts to achieve parity in telemedicine coverage policies.
3. Our AMA will work with the Federation of State Medical Boards to draft model state legislation to ensure telemedicine is appropriately defined in each state's medical practice statutes and its regulation falls under the jurisdiction of the state medical board.

D-480.965 - Reimbursement for Telehealth

Our American Medical Association will work with third-party payers, the Centers for Medicare and Medicaid Services, Congress and interested state medical

associations to provide coverage and reimbursement for telehealth to ensure increased access and use of these services by patients and physicians.

(34) RESOLUTION 231 - ESTABLISH PREGNANCY AS A FEDERAL QUALIFYING LIFE EVENT TRIGGERING A SPECIAL ENROLLMENT PERIOD

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that AMA policy H-165.828 be reaffirmed in lieu of Resolution 231.

HOD ACTION: Resolution 231 adopted.

RESOLVED, that our American Medical Association actively advocate that the United States Department of Health and Human Services and Congress establish pregnancy as a qualifying life event for a Special Enrollment Period in the Affordable Care Act Marketplace. (Directive to Take Action)

Your Reference Committee heard strong testimony in favor of adoption of Resolution 231. Your Reference Committee heard that in light of the U.S.'s high maternal mortality rate and the gaps in access to maternal care, a woman needs immediate access to pregnancy care when she becomes pregnant, but the U.S. Department of Health and Human Services (HHS) has declined to change current regulations to allow this, and that active advocacy efforts by our AMA are needed. However, your Reference Committee also heard testimony that Resolution 231 should not be adopted because our AMA already has policy supporting inclusion of pregnancy as a qualifying life event for special enrollment in the health insurance marketplace. Your Reference Committee heard that this policy was adopted in 2021 and is included in policy H-165.828 as subparagraph 8. Your Reference Committee notes that this existing AMA policy is broader and more flexible because it allows for appropriate advocacy to take place across a range of entities instead of restricting this advocacy to HHS. Further, your Reference Committee heard that our AMA has actively advocated for this policy. For example, in a 2023 letter to the Administrator of the Centers for Medicare & Medicaid, our AMA stated that pregnancy should be a qualifying life event. In addition, your Reference Committee heard that in a 2022 letter, our AMA stated that "our AMA supports the inclusion of pregnancy as a qualifying life event for special enrollment in the health insurance marketplace." While acknowledging the importance of this issue, in light of existing policy H-165.828 and the actions to implement this policy that our AMA has already taken, your Reference Committee recommends that existing AMA policy H-165.828 be reaffirmed in lieu of Resolution 231.

Health Insurance Affordability H-165.828

1. Our American Medical Association supports modifying the eligibility criteria for premium credits and cost-sharing subsidies for those offered employer-sponsored coverage by lowering the threshold that determines whether an employee's premium contribution is affordable to the level at which premiums are capped for

individuals with the highest incomes eligible for subsidized coverage in Affordable Care Act (ACA) marketplaces.

2. Our AMA supports legislation or regulation, whichever is relevant, to fix the ACA's "family glitch," thus determining the eligibility of family members of workers for premium tax credits and cost-sharing reductions based on the affordability of family employer-sponsored coverage and household income.
3. Our AMA encourages the development of demonstration projects to allow individuals eligible for cost-sharing subsidies, who forego these subsidies by enrolling in a bronze plan, to have access to a health savings account (HSA) partially funded by an amount determined to be equivalent to the cost-sharing subsidy.
4. Our AMA supports capping the tax exclusion for employment-based health insurance as a funding stream to improve health insurance affordability, including for individuals impacted by the inconsistency in affordability definitions, individuals impacted by the "family glitch," and individuals who forego cost-sharing subsidies despite being eligible.
5. Our AMA supports additional education regarding deductibles and cost-sharing at the time of health plan enrollment, including through the use of online prompts and the provision of examples of patient cost-sharing responsibilities for common procedures and services.
6. Our AMA supports efforts to ensure clear and meaningful differences between plans offered on health insurance exchanges.
7. Our AMA supports clear labeling of exchange plans that are eligible to be paired with a Health Savings Account (HSA) with information on how to set up an HSA.
8. Our AMA supports the inclusion of pregnancy as a qualifying life event for special enrollment in the health insurance marketplace.

Madam Speaker, this concludes the report of Reference Committee B. I would like to thank Rachel Kyllo, MD, Robert Dannenhoffer, MD, Anuradha Reddy, MD, Michael Medlock, MD, Deborah Fuller, MD, Rebekah Bernard, MD, and all those who testified before the Committee.

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American Society for Dermatologic Surgery Association

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Oregon

Anuradha Reddy, MD (Alternate)
Maryland

Michael Medlock, MD (Alternate)
Massachusetts

Deborah Fuller, MD (Alternate)
Texas

Rebekah Bernard, MD
Florida

Dale Mandel, MD
Pennsylvania
Chair

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (I-24)

Final Report of Reference Committee C

Cheryl Gibson Fountain, MD, Chair

Your Reference Committee recommends the following consent calendar for acceptance:

RECOMMENDED FOR ADOPTION

1. Council on Medical Education Report 1 - Medication Reconciliation Education

2. Council on Medical Education Report 2 - Updates to Recommendations for Future Directions for Medical Education

3. Resolution 302 - Strengthening Parental Leave Policies for Medical Trainees and Recent Graduates

RECOMMENDED FOR ADOPTION AS AMENDED

4. Resolution 304 - Payment and Benefit Parity for Fellows

5. Resolution 306 - Streamlining Continuing Medical Education Across States and Medical Specialties

RECOMMENDED FOR REFERRAL

6. Resolution 305 - Removing Board Certification as a Requirement for Billing for Home Sleep Studies

Amendments:
If you wish to propose an amendment to an item of business, click here: Submit New Amendment

RECOMMENDED FOR ADOPTION

(1) COUNCIL ON MEDICAL EDUCATION REPORT 1 - MEDICATION RECONCILIATION EDUCATION

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Council on Medical Education Report 1 be adopted and the remainder of the report be filed.

HOD ACTION: Recommendations in Council on Medical Education Report 1 be adopted and the remainder of the report be filed.

1. Amend AMA Policy D-120.965 "Pharmacy Review of First Dose Medication" by addition of a new third clause to read as follows:

   3. Our AMA a) recognizes that medication reconciliation is a multidisciplinary process and b) supports education of physicians-in-training about the physician's role and responsibilities in medication reconciliation and management within a physician-led team in relevant clinical settings, to minimize medical errors and promote patient safety and quality of care.

2. Amend AMA Policy D-120.965 with a change in title to read as follows:

   MEDICATION RECONCILIATION TO IMPROVE PATIENT SAFETY

3. Reaffirm AMA Policy H-160.902 "Hospital Discharge Communications"

The recommendations in Council on Medical Education Report 1 received supportive online testimony from the author as well as the Council on Medical Education and others. The only live testimony was from the Council in support of their report. Continuing education on medication reconciliation was also addressed in the remainder of Resolution 805-I-23, which is now AMA Policy D-300.973 "Medication Reconciliation Education". There was no opposing testimony. Your Reference Committee appreciates the Council's work and recommends that CME 1-I-24 be adopted.

(2) COUNCIL ON MEDICAL EDUCATION REPORT 2 - RECOMMENDATIONS FOR FUTURE DIRECTIONS FOR MEDICAL EDUCATION

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Council on Medical Education Report 2 be adopted and the remainder of the report be filed.

HOD ACTION: Recommendations in Council on Medical Education Report 2 be adopted and the remainder of the report be filed.

1. Study the restructuring of AMA Policy H-295.995, "Recommendations for Future Directions for Medical Education" in a series of seven future reports based on the topics of 1) mission of medical education, 2) professional regulation, 3) entry into and transition through the medical education continuum, 4) medical education curricula, 5) physician as medical professional, 6) medical education systems, and 7) obligations to students and trainees, to consolidate existing AMA policies in these areas where appropriate and to recommend new language for the future of medical education. (Directive to Take Action)

2. Policy H-295.995, "Recommendations for Future Directions for Medical Education," be amended by deletion of items 19, 20, 31 and 33 and appropriately renumbered to read as follows (Modify Current HOD Policy):

(19) ~~The first year of postdoctoral medical education for all graduates should consist of a broad year of general training. (a) For physicians entering residencies in internal medicine, pediatrics, and general surgery, postdoctoral medical education should include at least four months of training in a specialty or specialties other than the one in which the resident has been appointed. (A residency in family practice provides a broad education in medicine because it includes training in several fields.) (b) For physicians entering residencies in specialties other than internal medicine, pediatrics, general surgery, and family practice, the first postdoctoral year of medical education should be devoted to one of the four above-named specialties or to a program following the general requirements of a transitional year stipulated in the "General Requirements" section of the "Essentials of Accredited Residencies." (c) A program for the transitional year should be planned, designed, administered, conducted, and evaluated as an entity by the sponsoring institution rather than one or more departments. Responsibility for the executive direction of the program should be assigned to one physician whose responsibility is the administration of the program. Educational programs for a transitional year should be subjected to thorough surveillance by the appropriate accrediting body as a means of assuring that the content, conduct, and internal evaluation of the educational program conform to national standards. The impact of the transitional year should not be deleterious to the educational programs of the specialty disciplines.~~

(20) ~~The ACGME, individual specialty boards, and respective residency review committees should improve communication with directors of residency programs because of their shared responsibility for programs in graduate medical education.~~

(31) ~~The Educational Commission for Foreign Medical Graduates should be encouraged to study the feasibility of including in its procedures for certification of graduates of foreign medical schools a period of observation adequate for the evaluation of clinical skills and the application of knowledge to clinical problems.~~

(33) ~~The AMA, when appropriate, supports the use of selected consultants from the public and from the professions for consideration of special issues related to medical education.~~

The recommendations in Council on Medical Education Report 2 received supportive online and live testimony, including from the Council on Medical Education as the author, and others. There was no opposing testimony. An amendment was offered requesting an additional recommendation in support of increasing and retaining Black and African American learners in medical school, as well as other marginalized groups. Your Reference Committee acknowledges the deep importance of this work and existing AMA policy Minorities in the Health Professions H-350.978, which states: "(7) The AMA reaffirms its support of: (a) efforts to increase the number of black Americans and other minority Americans entering and graduating from U.S. medical schools; and (b) increased financial aid from public and private sources for students from low income, minority and socioeconomically disadvantaged backgrounds." Additional relevant AMA policies include Underrepresented Student Access to US Medical Schools H-350.960 and Racial and Ethnic Disparities in Health Care H-350.974. The Council on Medical Education noted that CME 2-I-24 proposes a framework to consolidate and modernize AMA medical education policy via future reports, and seeks approval to utilize staff time and resources to do so. The body of CME 2-I-24 described a future report category of "mission of medical education" that explicitly includes consideration of the history of harms against Black physicians and patients, and work towards a diverse workforce. Your Reference Committee urges the Council to address this issue as intended in that future report to the HOD.

Your Reference Committee is grateful to the Council for this self-led report and its initiative to further address these important issues in future reports, and recommends that CME 2-I-24 be adopted.

(3) RESOLUTION 302 - STRENGTHENING PARENTAL LEAVE POLICIES FOR MEDICAL TRAINEES AND RECENT GRADUATES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 302 be adopted.

HOD ACTION: Resolution 302 adopted.

RESOLVED, that our American Medical Association (AMA) amend "Increasing Practice Viability For Physicians Through Increased Employer And Employee Awareness Of Protected Leave Policies" H-405.960 by addition and deletion to read as follows:

4. Our AMA recommends that medical practices, departments and training programs strive to provide 12 weeks of paid parental, family and medical necessity leave in a 12-month period for their attending and trainee physicians as needed, with the understanding that no parent be required to take a minimum leave~~.~~, and with eligibility beginning at the start of employment without a waiting period.

Your Reference Committee received supportive online and live testimony, including from the co-authors, Resident and Fellow Section (RFS) and Lesbian, Gay, Bisexual, Transgender, Queer+ (LGBTQ+) Section, as well as the Council on Medical Education, and others. There was individual testimony raising concern that many physicians do not get 12 weeks of leave, but there was no testimony opposing the resolution.

Your Reference Committee acknowledged possible challenges and practical considerations associated with any leave, regardless of immediacy of timing, and concurred with the online testimony that the elimination of the waiting period better aligns with the health of trainee physicians and their families. Your Reference Committee also noted that this change better aligns with current ACGME leave policies, which do not include a waiting period. Thus, your Reference Committee recommends that Resolution 302 be adopted.

RECOMMENDED FOR ADOPTION AS AMENDED

(4) RESOLUTION 304 - PAYMENT AND BENEFIT PARITY FOR FELLOWS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 304 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association (AMA) amend Residents and Fellows' Bill of Rights H-310.912 by addition to read as follows:

5. Our AMA will partner with ACGME and other relevant stakeholders to encourage training programs to reduce financial burdens on residents and fellows by providing employee benefits including, but not limited to, on-call meal allowances, transportation support, relocation stipends, and childcare services~~, and will encourage institutions to provide parity in salary and benefits between residents and follows at a level that is at minimum commensurate with their postgraduate year~~.

8. Our AMA adopts the following "Residents and Fellows' Bill of Rights" as applicable to all residents and fellow physicians in ACGME-accredited training programs:

E. Adequate compensation and benefits that provide for resident well-being and health.

2. With regard to compensation, residents and fellows should receive:

a. Compensation for time at orientation.

b. ~~Salaries~~ Compensation, including salary and benefits, commensurate with their level of training and experience. Compensation should reflect cost of living differences based on local economic factors, such as housing, transportation, and energy costs (which affect the purchasing power of wages), and include appropriate adjustments for changes in the cost of living.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 304 be adopted as amended.

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the title of Resolution 304 be changed to read as follows:

COMPENSATION PARITY FOR RESIDENTS AND FELLOWS

HOD ACTION: Resolution 304 adopted as amended.

RESOLVED, that our American Medical Association (AMA) amend Residents and Fellows' Bill of Rights H-310.912 by addition to read as follows:

5. Our AMA will partner with ACGME and other relevant stakeholders to encourage training programs to reduce financial burdens on residents and fellows by providing employee benefits including, but not limited to, on-call meal allowances, transportation support, relocation stipends, and childcare services, and will encourage institutions to provide parity in salary and benefits between residents and fellows at a level that is at minimum commensurate with their postgraduate year.

Your Reference Committee received mixed testimony in the online reference committee. Online testimony also noted that financial funding structures differ between resident and fellowship training, and that GME programs face funding challenges. Your Reference Committee is sensitive to this issue, particularly as it relates to government funding and accreditation. The Council on Medical Education recommended that Policies H-310.929, H-310.912, and H-225.950 be reaffirmed in lieu of this resolution. Your Reference Committee also discussed concern about the use of the term “postgraduate”, given residents may have different numbers of postgraduate years prior to starting a fellowship. Your Reference Committee proposed an amendment by addition and deletion to Policy H-310.912 clause 8.E.2.b. to include “compensation” and “benefits” in the Preliminary Report recommendation. Your Reference Committee also recommended a change in title to more accurately reflect the intent of the resolution and amendments.

Live testimony was broadly supportive of the Preliminary Report recommendation including from the authors. Thus, your Reference Committee recommends that Resolution 304 be adopted as amended.

(5) RESOLUTION 306 - STREAMLINING CONTINUING MEDICAL EDUCATION ACROSS STATES AND MEDICAL SPECIALTIES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the third resolve of Resolution 306 be deleted:

~~**RESOLVED, our AMA work with relevant stakeholders to examine the feasibility of a single common continuing medical education requirement for maintaining state licensure; and be it further**~~

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the fourth resolve of Resolution 306 be deleted:

~~**RESOLVED, our AMA advocate any continuing medical education that requires answering questions to be categorized as "Self-Assessment continuing medical education."**~~

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Resolution 306 be amended by addition of a new resolve clause to read as follows:

RESOLVED, our AMA advocate that all entities, including licensing and specialty boards, should recognize all AMA PRA credit equally.

RECOMMENDATION D:

Madam Speaker, your Reference Committee recommends that Resolution 306 be adopted as amended.

HOD ACTION: Resolution 306 adopted as amended.

RESOLVED, our AMA work with relevant stakeholders to minimize the financial and time burden of reporting continuing medical education, including but not limited to participation in a common reporting standard; and be it further

RESOLVED, our AMA advocate for medical specialty and state medical boards to continue to allow manual entry of continuing medical education until all boards and

continuing medical education providers participate in a common reporting standard; and be it further

RESOLVED, our AMA work with relevant stakeholders to examine the feasibility of a single common continuing medical education requirement for maintaining state licensure; and be it further

RESOLVED, our AMA advocate any continuing medical education that requires answering questions to be categorized as “Self-Assessment continuing medical education.”

Your Reference Committee received mixed online testimony on this item in the online reference committee. While most testimony supported the first and second resolves, there was a variance in testimony on the latter. The Council on Medical Education recommended that the first and second resolves be adopted, the third resolve not be adopted, and they offered alternate language in lieu of the fourth resolve, which was supported by additional testimony. Testimony about the third resolve noted that it conflicts with Policy H-275.917(2B) “An Update on Maintenance of Licensure” (MOL), which states that MOL requirements are under the purview of state medical boards. Also, online and live testimony pointed out that many states have laws which mandate state-specific educational requirements. Regarding the fourth resolve, testimony from the Council noted that the AMA is the owner of the AMA PRA Credit System and defines AMA PRA credit; thus, concern was raised about other bodies self-designating subcategories of AMA PRA credit for recognition (e.g., “self-assessment”) while not accepting other AMA PRA credit. Further online testimony suggested the fourth resolve over-generalizes CME questions. Your Reference Committee was informed that the AMA initiated the “Reimagining PRA” project, which will address some of these points including data reporting and the role of the AMA, as owner of the AMA PRA credit system, and AOA and AAFP credit systems in defining what is recognized as continuing medical education by other entities.

Live testimony was broadly supportive of the Preliminary Report recommendations. Testimony also emphasized that staff from continuing medical education offices should be considered when collaborating with interested parties.

Your Reference Committee believes the testimony offered by the Council provides a sound compromise to the testimony offered and addresses the concerns about the fourth resolve, for which there was broad support in live testimony. Therefore, your Reference Committee recommends that Resolution 306 be adopted as amended.

RECOMMENDED FOR REFERRAL

(6) RESOLUTION 305 - REMOVING BOARD CERTIFICATION AS A REQUIREMENT FOR BILLING FOR HOME SLEEP STUDIES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 305 be referred.

HOD ACTION: Resolution 305 referred for decision.

RESOLVED, that our American Medical Association advocate that the appropriate bodies in United States government to remove Sleep Board Certification and facility accreditation as a requirement for the approval of and payment for home sleep studies.

Your Reference Committee received mixed online and live testimony on this item. Testimony from the author supported the resolution, centered on lack of patient access to home sleep studies. The primary concern expressed by several delegations in support of referral focused on insufficient access to sleep studies. Testimony from one individual also supported the resolution, citing the growth in home sleep devices (e.g., Watchpat, Apple watch), and advocated that licensed physicians be able to offer home sleep testing and receive payment for it. Members testified to their frustration related to not being able to order sleep studies for their patients, be reimbursed for these sleep studies and expressed comfort in being able to refer patients to sleep medicine specialists. The Council on Medical Education, American Board of Medical Specialties, and a delegation also recommended referral of this item in the online reference committee, raising concerns about possible consequences from removing board certification and facility accreditation requirements and favoring study of the latest evidence on access to polysomnography services and patient outcomes.

The American Academy of Sleep Medicine, Chest Caucus and Thoracic Society all testified in opposition to referral citing concerns that this would lower quality of care, while increasing the cost of care in populations with sleep disorders. The linkage between diagnosis of sleep apnea and treatment of sleep apnea was highlighted as potential area where costs would increase. A specialty delegation testified that the issue of access is more about obtaining insurance approval rather than board certification. Testimony also expressed concern regarding ensuring that individuals ordering sleep tests and interpreting the results have been effectively trained. One delegation and one individual recommended to not adopt, noting concerns about the accuracy of the information provided in Resolution 305 as well as the importance of sleep center accreditation to ensure quality sleep services. Testimony also cited AMA policy “Medical Specialty Board Certification Standards” H-275.926 that “opposes discrimination against physicians based solely on lack of ABMS or equivalent AOA-BOS board certification, or where board certification is one of the criteria considered for purposes of measuring quality of care, determining eligibility to contract with managed care entities, eligibility to receive hospital staff or other clinical privileges, ascertaining competence to practice medicine, or for other purposes."

Your Reference Committee recognizes this is a complex issue involving quality and access to care and is sensitive to how this issue may intersect with the AMA's current efforts to prevent scope creep. Given the many concerns about access to care, reimbursement for home sleep studies and removal of both facility accreditation and board certification requirements brought forward in testimony, your Reference Committee recommends that Resolution 305 be referred for study.

Madam Speaker, this concludes the report of Reference Committee C. I would like to thank Brandon Francis, MD; Rebecca Hayes, MD, MBA, FAAFP; Jayme Looper, MD, MSE; Bhushan H. Pandya, MD, FACP; Scott H. Pasichow, MD, MPH, FACEP; and Charles W. Van Way III, MD. I'd also like to thank staff persons Tanya Lopez, MS; Lena Drake; Richard Pan, MD, MPH; and Amber Ryan, MEd; as well as all those who testified before the Committee.

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American College of Obstetricians and Gynecologists
Chair

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (I-24)

Final Report of Reference Committee F

Michael B. Simon, MD, MBA, Chair

Your Reference Committee recommends the following consent calendar for acceptance:

RECOMMENDED FOR ADOPTION

1. Report of the House of Delegates Committee on the Compensation of the Officers

2. Council on Long Range Planning and Development Report 1 - Academic Physicians Section Five-Year Review

3. Board of Trustees Report 25 - World Medical Association Observer Status in the House of Delegates

4. Resolution 608 - Direct Election of Resident/Fellow Members of the AMA Board of Trustees and Various AMA Councils

RECOMMENDED FOR ADOPTION AS AMENDED

5. Speakers' Report 1 - Report of the Election Task Force 2

RECOMMENDED FOR ADOPTION IN LIEU OF

6. Board of Trustees Report 16 - AMA Reimbursement of Necessary HOD Business Meeting Expenses for Delegates and Alternates
   Resolution 605 - AMA House of Delegates Expenses
   Resolution 609 - Restoring Annual and Interim Meeting Schedule

RECOMMENDED FOR NOT ADOPTION

7. Resolution 601 - Expanding AMA Meeting Venue Options

8. Resolution 602 - Delaying the ETF Endorsement Timeline Revision for Section IOP Revisions

9. Resolution 607 - AMA House of Delegates Venues

RECOMMENDED FOR REAFFIRMATION IN LIEU OF

10. Resolution 604 - Opposing Discrimination and Protecting Free Speech Among Member Organizations of Organized Medical Associations

11. Resolution 606 - Protecting Free Speech and Encouraging Respectful Discourse Among Member Organizations of Organized Medical Associations

RECOMMENDED FOR ADOPTION

(1) REPORT OF THE HOUSE OF DELEGATES COMMITTEE ON THE COMPENSATION OF THE OFFICERS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the Report of the House of Delegates Committee on the Compensation of the Officers be adopted and the remainder of the Report be filed.

HOD ACTION: Report of the House of Delegates Committee on the Compensation of the Officers adopted and the remainder of the Report filed.

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

1. That there be no change to the current Definitions effective July 1, 2018 as they appear in the Travel and Expenses Standing Rules for AMA Officers for the Governance Honorarium, Per Diem for Representation and Telephonic Per Diem except for the Governance Honorarium and Per Diem amounts as recommended in 2, 3 and 4 below.

   - Definition of Governance Honorarium effective July 1, 2017:
     The purpose of this payment is to compensate Officers, excluding Board Chair, Chair-Elect and Presidents, for all Chair-assigned internal AMA work and related travel. This payment is intended to cover all currently scheduled Board meetings, special Board or Board committee, subcommittee and task force meetings, Board orientation, Board development and media training, and Board conference calls, and any associated review or preparatory work, and all travel days related to all such meetings. The Governance Honorarium also covers Internal Representation, such as section and council liaison meetings (and associated travel) or calls, up to eleven (11) Internal Representation days.

   - Definition of Per Diem for Representation effective July 1, 2017:
     The purpose of this payment is to compensate for Board Chair-assigned representation day(s) and related travel for Officers, excluding Board Chair, Chair-Elect and Presidents. Representation is either external to the AMA, or for participation in a group or organization with which the AMA has a key role in creating/partnering/facilitating achievement of the respective organization goals such as the AMA Foundation, PCPI, etc., or for Internal Representation days above eleven (11). The Board Chair may also approve a per diem for special circumstances that cannot be anticipated such as weather-related travel delays.

   - Definition of Telephonic Per Diem for Representation effective July 1, 2017:
     Officers, excluding the Board Chair, Chair-Elect and Presidents, who are assigned as the AMA representative to outside groups as one of their specific Board assignments or assigned Internal Representation days above eleven (11), receive

a per diem rate for teleconference meetings when the total of all teleconference meetings of 30 minutes or longer during a calendar day equal 2 or more hours. Payment for these meetings would require approval of the Chair of the Board.

2. That the Governance Honorarium for all Board members excluding, Board Chair, President, President-elect, and Immediate Past President be increased effective July 1, 2025 to $68,500. (Directive to Take Action)

3. That the Per Diem for Chair-assigned representation for all Board members excluding the Board Chair, and Presidents and related travel be increased effective July 1, 2025 to $1,550 per day. (Directive to Take Action)

4. That the Per Diem for Chair-assigned Telephonic Per Diem for Representation be increased effective July 1, 2025 to $775 as defined. (Directive to Take Action)

Limited, yet supportive, testimony was provided. Your Reference Committee recommends adoption of the Report of the House of Delegates Committee on the Compensation of the Officers.

(2) COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT REPORT 1 - ACADEMIC PHYSICIANS SECTION FIVE-YEAR REVIEW

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the Council on Long Range Planning and Development Report 1 be adopted and the remainder of the Report be filed.

HOD ACTION: Council on Long Range Planning and Development Report 1 adopted and the remainder of the Report filed.

The Council on Long Range Planning and Development recommends that our American Medical Association renew delineated section status for the Academic Physicians Section through 2029 with the next review no later than the 2029 Interim Meeting.

Your Reference Committee received no negative testimony in response to the Council's report and appreciates the Academic Physicians Section's cooperation with the Council, which allowed for a thorough review. Your Reference Committee supports the recommendation of the Council.

(3) BOARD OF TRUSTEES REPORT 25 - WORLD MEDICAL ASSOCIATION OBSERVER STATUS IN THE HOUSE OF DELEGATES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Board of Trustees 25 be adopted and the remainder of the Report be filed.

HOD ACTION: Board of Trustees 25 adopted and the remainder of the Report filed.

The Board of Trustees recommends that the World Medical Association be admitted as an Official Observer in the House of Delegates, and that the remainder of this report be filed.

The testimony was supportive of granting the World Medical Association's Official Observer status in our AMA House of Delegates.

(4) RESOLUTION 608 - DIRECT ELECTION OF RESIDENT/FELLOW MEMBERS OF THE AMA BOARD OF TRUSTEES AND VARIOUS AMA COUNCILS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 608 be adopted.

HOD ACTION: Alternate Resolution adopted in lieu of Resolution 608.

RESOLVED, that our American Medical Association amend existing policy and election rules to permit an exception to the endorsement timeline for the Resident and Fellow Section, allowing endorsements to be obtained no later than six months before the election, applicable only to candidates for resident- and fellow-designated seats on the Board of Trustees and AMA Councils.

RESOLVED, that our American Medical Association (AMA) modify its Constitution and Bylaws to allow the Resident and Fellow Section (RFS) to directly elect the resident/fellow member of our AMA Board of Trustees as well as modify its Bylaws to allow the RFS to directly elect the resident/fellow member of our AMA Council on Constitution and Bylaws (CCB), our AMA Council on Medical Education (CME), our AMA Council on Medical Service (CMS), and our AMA Council on Science and Public Health (CSAPH).

Opposing testimony indicated that members of our AMA Board of Trustee represent the entire House of Delegates and should be voted on by the larger body. Supportive testimony spoke to the impact of endorsement and election rule changes that are making

it disproportionately difficult for a resident in a three year residency program (e.g., family medicine, internal medicine, emergency medicine) to plan for, be endorsed, run, be elected, and serve a full term for the resident and fellow trustee position due to the extended timeline spanning more than three years.

RECOMMENDED FOR ADOPTION AS AMENDED

(5) SPEAKERS' REPORT 1 - REPORT OF THE ELECTION TASK FORCE 2

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Speakers' Report 1 be amended by addition and deletion to read as follows:

1. That the following "Glossary of Election Terms" be added to our AMA Election Policy (New HOD Policy):

Glossary

Active campaign window - period of time after the Speaker's notice of the opening of active campaigning until the Election Session during the House of Delegates meeting at which elections are being held.

Active campaigning - Outreach by candidates or their surrogate(s), including but not limited to, members of their campaign team, to members of the House of Delegates with the goal of being elected by the AMA House of Delegates.

Announced candidate - person who has indicated their intention to run for elected position; announcement can be made only by sending an electronic announcement card to the Speakers via the HOD office by email to hod@ama-assn.org.

Campaign manager(s) - person(s) identified by the candidate to the HOD Office as the person(s) responsible for running the campaign.

Campaign team - campaign manager(s) and/or staff identified by the candidate to the HOD Office.

Campaign-related - any content that includes reference to an announced candidate in the context of their candidacy for an elected position within the AMA.

Digital - relating to, using, or storing data or information in the form of digital signals; involving or relating to the use of computer technology; this includes, but is not limited to, social media and communication platforms.

Elected position(s) - Council or Officer position within the AMA elected by the House of Delegates of the AMA.

Endorsing group - Any group that wishes to endorse candidates other than the candidates they are eligible to sponsor. See definition of "Sponsoring Group."

Endorse - any public acknowledgement by a candidate or members of a group of the group's support of a candidate~~, other than from the sponsoring group~~. Internal discussions of support in a closed session of the group are not considered public for the purpose of this definition.

Featured - identification of a candidate at an event by the host or organizer of the event, including but not limited to, written or verbal announcement of the candidate or their candidacy.

Sponsoring group

- Sponsoring group is an endorsing group that may offer endorsements to the delegate(s) and/or alternate delegate(s) representing that sponsoring group without the need to provide their endorsement process to the HOD Office.
- The association, society, AMA section, or other entity for which a prospective candidate serves as an AMA HOD delegate or alternate delegate as certified with the HOD office.
- The Section delegate and alternate delegate are the only individuals who may be sponsored by their respective AMA Section.
- Current trustees or Council members seeking re-election ~~as a trustee~~ or election to president-elect may be sponsored by the delegation for which they served as an AMA HOD delegate or alternate delegate immediately prior to their election~~ to the board~~.
- Individuals may self sponsor ~~act as their own sponsoring group~~ (self-~~sponsor~~nomination).

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Speakers' Report 1 be amended by addition of a recommendation to read as follows:

7. Policy G-610.090 Section VI item 7 be amended by addition and deletion to read as follows (Modify HOD Policy):

VI. Interview Rules

Candidates and interviewers must comply with the following rules:

7. Virtual interviews are subject to the following constraints:
   a. Interviews may be conducted only during a ~~4-7-day~~9-14 day window (preferably across two separate weekends) as designated by the Speaker beginning at least two weeks but not more than ~~4~~ six (6) weeks prior to the scheduled Opening Session of the House of Delegates meeting at which elections will take place.
   b. Interviews conducted on weeknights must be scheduled between 5 pm and 10 pm or on weekends between 8 am and 10 pm based on the candidate's local time, unless another mutually acceptable time outside these hours is arranged.
   c. Caucuses and delegations scheduling interviews for candidates within the parameters above must offer alternatives to those candidates who have conflicts with the scheduled time.

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Speakers' Report 1 be adopted as amended and the remainder of the Report be filed.

HOD ACTION: Speakers' Report 1 adopted as amended and the remainder of the Report filed.

Recommendations adopted from this report will be in effect at the close of Interim 2024. For clarification purposes only, additions within existing policy language are shown in red.

1. That the following "Glossary of Election Terms" be added to our AMA Election Policy (New HOD Policy):

Glossary

Active campaign window - period of time after the Speaker's notice of the opening of active campaigning until the Election Session during the House of Delegates meeting at which elections are being held.

Active campaigning - Outreach by candidates or their surrogate(s), including but not limited to, members of their campaign team, to members of the House of Delegates with the goal of being elected by the AMA House of Delegates.

Announced candidate - person who has indicated their intention to run for elected position; announcement can be made only by sending an electronic announcement card to the Speakers via the HOD office by email to hod@ama-assn.org.

Campaign manager(s) - person(s) identified by the candidate to the HOD Office as the person(s) responsible for running the campaign.

Campaign team - campaign manager(s) and/or staff identified by the candidate to the HOD Office.

Campaign-related - any content that includes reference to an announced candidate in the context of their candidacy for an elected position within the AMA.

Digital - relating to, using, or storing data or information in the form of digital signals; involving or relating to the use of computer technology; this includes, but is not limited to, social media and communication platforms.

Elected position(s) - Council or Officer position within the AMA elected by the House of Delegates of the AMA.

Endorsing group - Any group that wishes to endorse candidates other than the candidates they are eligible to sponsor. See definition of "Sponsoring Group."

Endorse - any public acknowledgement by a candidate or members of a group of the group's support of a candidate, other than from the sponsoring group. Internal discussions of support in a closed session of the group are not considered public for the purpose of this definition.

Featured - identification of a candidate at an event by the host or organizer of the event, including but not limited to, written or verbal announcement of the candidate or their candidacy.

Sponsoring group

- The association, society, AMA section, or other entity for which a prospective candidate serves as an AMA HOD delegate or alternate delegate as certified with the HOD office.
- The Section delegate and alternate delegate are the only individuals who may be sponsored by their respective AMA Section.

- Current trustees seeking re-election as a trustee or election to president-elect may be sponsored by the delegation for which they served as an AMA HOD delegate or alternate delegate immediately prior to their election to the board.
- Individuals may act as their own sponsoring group (self-sponsor).

2. Policy G-610.090 Section II be amended by addition and deletion to read as follows (Modify HOD Policy):

II. Guidelines for Candidacy ~~for Nominations~~ for AMA Offices

1. Every effort should be made to have two or more candidates ~~nominate two or more eligible members~~ for each ~~Council~~ vacancy.
2. The Federation (in ~~nominating or~~ sponsoring candidates for leadership positions), the House of Delegates (in electing Council and Board members), and the Board, the Speakers, and the President (in appointing or nominating physicians for service on AMA Councils or in other leadership positions) should consider the need to enhance and promote diversity.

3. Policy G-610.090 Section III items 1 and 6 be amended by addition and deletion to read as follows (Modify HOD Policy):

III. Candidate Announcement, Nominations and Open Positions

1. Individuals intending to seek election at the next Annual Meeting should make their intentions known to the Speakers by providing the Speaker's office with an electronic announcement "card" that includes any or all of the following elements and no more: the candidate's name, photograph, ~~email address,~~ the office sought, the sponsoring group, if any, and a list of endorsing groups, if any~~societies~~. The Speakers will ensure that the information is posted on our AMA website in a timely fashion, generally on the morning of the last day of a House of Delegates meeting or upon adjournment of the meeting. Announcements that include additional information (e.g., a brief resume) will not be posted to the website. Printed announcements may not be distributed to members of the House by any method.

6. Our AMA believes that:
   a. specialty society candidates for our AMA House of Delegates elected offices should be listed in the pre-election materials available to the House as the representative of that society and not by the state in which the candidate resides.
   b. elected specialty society members should be identified in that capacity while serving their term of office.
   c. nothing in the above recommendations should preclude formal co-endorsement by any state delegation of the national specialty society candidate, if that state delegation should so choose.

4. Policy G-610.090 Section IV items 1, 6, and 7 be amended by addition and deletion to read as follows (Modify HOD Policy):

IV. Communications, Campaign Memorabilia and Literature

1. Active campaigning for ~~our AMA elective office~~ an elected AMA position may not begin until the active campaign window opens as announced by the Speaker following the Spring Board of Trustees meeting immediately preceding the meeting at which the election is scheduled to take place. ~~Board of Trustees, after its April meeting, announces the candidates for council seats. Active campaigning includes mass outreach activities directed to all or a significant portion of the members of the House of Delegates and communicated by or on behalf of the candidate. If in the judgment of the Speaker of the House of Delegates circumstances warrant an earlier date by which campaigns may formally begin, the Speaker shall communicate the earlier date to all known candidates.~~

6. Active campaigning via mass outreach to delegates by candidates or on behalf of a candidate by any method is prohibited. A reduction in the volume of telephone calls and personal electronic communication from candidates and on behalf of candidates is encouraged. No part of this rule shall be interpreted to limit developing or communicating within a campaign team. ~~The Office of House of Delegates Affairs does not provide email addresses for any purpose. The use of~~ Eelectronic messages ~~to contact electors should be minimized, and if used~~ must include a simple mechanism to allow recipients to opt out of receiving future messages.

7. Printed and digital ~~C~~campaign materials may not be distributed to members of the House other than by the HOD office candidate email and on the AMA Candidates' Page. ~~by postal mail or its equivalent. The AMA Office of House of Delegates Affairs will not longer furnish a file containing the names and mailing addresses of members of the AMA HOD. Printed campaign materials may not be distributed in the House of Delegates. Candidates are encouraged to eliminate printed campaign materials.~~

5. Policy G-610.090 Section IV be amended by the addition of a new second and final item with appropriate renumbering to read as follows (New HOD Policy):

2. An announced candidate may discuss their candidacy on an individual basis in private conversations after the announcement of candidacy until the active campaigning period begins. Prior to the active campaigning period, no other individual may discuss the candidacy except in private conversations with the announced candidate on an individual basis. This rule does not prohibit any candidate from discussions for the purpose of forming a campaign team or from a campaign team discussing a candidate or campaign strategy. This rule also does not prohibit persons not associated with a campaign from discussing candidates in private conversations.

9. Candidates and campaigns may not produce a personal campaign-related website or other digital campaign-related content. Candidates may not direct to personal or professional websites as a method of campaigning other than to the AMA Candidates' Page.

6. Policy G-610.090 Section VI item 4 be amended by addition and deletion to read as follows (Modify HOD Policy):

VI. Interview Rules

Candidates and interviewers must comply with the following rules:

4. Groups conducting interviews with announced candidates for a given office must offer an interview to all ~~individuals that have officially announced their candidacy~~ announced candidates at the time the group's interview schedule is finalized.
    a. A sponsoring group may meet with an announced candidate who is a member of their group during the active campaign window without meeting with ~~interviewing~~ other candidates for the same office.
    b. Interviewing groups may, but are not required to, interview ~~late announcing candidates~~persons who become announced candidates during the active campaign window. Should an interview be offered to such a ~~late~~ candidate, all other announced candidates for the same office (even those previously interviewed) must be afforded the same opportunity and medium.
    c. Any ~~appearance by a candidate before an organized meeting of a caucus or delegation, other than their own, will be considered an interview and fall under the rules for interviews~~campaign-related presentation to an assembly by an announced candidate, with or without being followed by a discussion, question and answer session, or a vote of the assembly regarding the candidate, is an interview and subject to the rules on in-person interviews. No portion of this rule shall be interpreted to mean that a candidate acting in their current formal capacity would be unable to present or discuss matters pertaining to that formal capacity with any group.

Testimony provided by the author stated that the Election Task Force Report was updated to reflect feedback offered during an open forum at the 2024 Annual Meeting.

Further testimony highlighted that:

- the proposed sponsorship process may potentially place some members at a disadvantage with respect to the overall endorsement process. Your Reference Committee proffered an amendment to the definition for a Sponsoring group to clarify that a Sponsoring group is an Endorsing group that is not required to submit their endorsing procedures to the House of Delegates Office because the House of Delegates Office can verify delegate / alternate delegate status based on its credentialling information.

- greater flexibility is needed for virtual candidate interviews and an amendment was proffered for the Interview Rules to address this concern.

Finally, your Reference Committee received limited, yet disparate, testimony on the timeline for the campaign window. Concerns were raised about costs and equity if the campaign window was extended.

RECOMMENDED FOR ADOPTION IN LIEU OF

(6) BOARD OF TRUSTEES REPORT 16 - AMA REIMBURSEMENT OF NECESSARY HOD BUSINESS MEETING EXPENSES FOR DELEGATES AND ALTERNATES
RESOLUTION 605 - AMA HOUSE OF DELEGATES EXPENSES
RESOLUTION 609 - RESTORING ANNUAL AND INTERIM MEETING SCHEDULE

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the Recommendations in Board of Trustees Report 16 be amended by an additional recommendation to read as follows:

2. That our AMA will issue a report at the 2025 Annual Meeting, and each meeting thereafter, identifying the number of delegates and alternate delegates supported by the grants and the total amount provided under our AMA House of Delegates Emergency Assistance Program;

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the Recommendations in Board of Trustees Report 16 be amended by an additional recommendation to read as follows:

3. That our AMA will provide the House of Delegates with reports on a regular cadence detailing ongoing work regarding House of Delegates meetings to mitigate costs, explore solutions, and maintain participation while reducing the financial burden on all parties over the long term.

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the Recommendations in Board of Trustees Report 16 be amended by an additional recommendation to read as follows:

4. That our AMA will not reduce by one day the 2025 Annual and Interim Meetings and will issue a report for consideration at the 2025 Annual Meeting outlining details for potential changes to the length and format of future House of Delegates meetings; and that

RECOMMENDATION D:

Madam Speaker, your Reference Committee recommends that Board of Trustees Report 16 as amended be adopted in lieu of Resolutions 605 and 609 and the remainder of Report be filed.

HOD ACTION: Board of Trustees Report 16 as amended adopted in lieu of Resolutions 605 and 609 and the remainder of Report filed.

Board of Trustees Report 16
The AMA recognizes that engagement by the organizations who send representatives to our HOD meetings to participate in the policy-making process is essential to the strength of organized medicine. Your Board of Trustees is committed to supporting attendance at AMA HOD meetings, providing immediate financial relief on a short-term emergency basis, and developing a plan for long-term sustainable participation. Therefore, your Board of Trustees recommends that Resolution 606-A-23 not be adopted and the remainder of this report be filed.

Resolution 605
RESOLVED, that our American Medical Association provide $1000, in 2024 dollars, per designated delegate and alternate delegate that attends the Annual and/or Interim meetings of our AMA (Directive to Take Action)

RESOLVED, that our AMA give the meeting stipend to the delegate or alternate delegate themselves, rather than to the state or subspecialty society that they represent. (Directive to Take Action)

Resolution 609
RESOLVED, that our American Medical Association Board of Trustees restore the length of the Regular Meetings (Annual and Interim) of the House of Delegates to the length that occurred in 2024, and shall do so at the Annual Meeting of the House of Delegates in 2025 and continuing (Directive to Take Action)

RESOLVED, that any proposed changes to the structure or format of the Regular Meetings of the House of Delegates, including but not limited to duration, composition, or

apportionment, be brought before the House for open discussion and approval by vote prior to implementation. (Directive to Take Action)

Your Reference Committee wishes to highlight that testimony reflected consensus around the fact that Federation members and societies, as well as our AMA, are impacted by rising and exorbitant meeting costs. All recognize that this plan is needed to address the growing financial barrier to participation in the policymaking process of our AMA House of Delegates. Further consensus reflected that such a plan is complex. Our Board of Trustees indicate in their report that three listening sessions with members of the House of Delegates and Federation staff were convened in which 100+ state and specialty society delegates and executives participated.

Our Board of Trustees has established a two-year Emergency Assistance Program, beginning at A-25. The purpose of this temporary assistance program will be to offer financial relief to Federation organizations to support the funding of delegates and alternates, including medical student and resident and fellow physician delegates elected from their sections and allocated to be supported by their societies to attend the AMA Annual and Interim HOD meetings. The funding will be made available as a grant to societies who are deemed to spend a greater percentage of their annual revenue to support their AMA delegation (based on an average cost estimate per delegate for all societies and using each state and specialty society's most recent Form 990 available) than the AMA spends on the Annual and Interim meetings (approximately 2.6%). The AMA will provide the society with the IRS per diem allowable rate per delegate and alternate delegate that will be required to be used for expenses related to the AMA HOD meetings. Each society that is deemed eligible to receive assistance will need to provide a formal request to the AMA to receive funding. The funds will be paid directly to the society, not to the individual delegates and alternate delegates, but will be limited to use for defraying the costs for delegates and alternate delegates to attend the AMA House of Delegates meetings. The AMA has already acquired the necessary documentation to issue the grants if requested by qualifying societies and there is no administrative reporting or support needed from state and specialty societies, residents, fellows or medical students.

Your Reference Committee noted an additional concern raised in the testimony, which is further clarity and transparency is needed for the financial assistance provided under our AMA House of Delegates Emergency Assistance Program. Your Reference Committee believes both clarity and transparency will be achieved with the ongoing reports requested in Recommendation B.

Additional testimony on issuing grants without means testing was offered. Your Reference Committee wishes to note that means testing is an important aspect of fiduciary responsibility and preservation of tax-exempt status. In order to evaluate the pilot grant program, your Reference Committee recommends information on recipients be reported at an aggregate level.

As noted in Board of Trustees Report 16, the "AMA's tax-exempt status and the regulations under which it operates to maintain that status is a key consideration when determining if or how to provide benefits or contributions to individuals or organizations." Accordingly, the Board of Trustees sought counsel to protect the tax-exempt status of our Association while ensuring compliance with Internal Revenue Service guidelines for providing grants to societies. The AMA House of Delegates Emergency Assistance

Program minimizes the risk to the AMA's tax-exempt status. Other alternatives proposed would expose the AMA to unacceptable levels of IRS risk and scrutiny.

Testimony was heard regarding the desire of the House of Delegates to have input regarding any substantial changes to the House of Delegates meeting, including what was proposed by the Board in this report to shorten the meeting by one day.

Those expressing concerns about Board of Trustees Report 16 and Resolution 609 identified that our Board of Trustees proactively shortened our House of Delegates meetings by one day. There were questions as to whether the decision is within the purview of our Board of Trustees. Your Reference Committee determined that our AMA Bylaws establish our Board of Trustees as fiduciaries, which provides for broad discretion regarding venue negotiations. The Board of Trustees Report further indicates, "It is estimated that this [shortening the meeting by one day] will reduce the cost to societies by a minimum of $1.4 million per year and benefit many delegates and alternates by requiring less time away from their practices." To be clear, the $1.4 million per year in cost savings is a benefit to Federation members and societies. Further, the AMA House of Delegates Emergency Assistance Program is not dependent on shortening our AMA meetings. Our Board of Trustees opted to shorten the 2025 Annual Meeting by one day due to these anticipated cost savings, but the action is reversible. Your Reference Committee heard overwhelming testimony supporting reinstatement of the meeting day and therefore recommends restoring the original timeline to our House of Delegates meetings.

RECOMMENDED FOR NOT ADOPTION

(7) RESOLUTION 601 - EXPANDING AMA MEETING VENUE OPTIONS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 601 not be adopted.

HOD ACTION: Resolution 601 not adopted.

RESOLVED, that our American Medical Association rescind Policy G-630.140 Item 4. (Rescind HOD Policy)

Your Reference Committee received mixed, but predominantly negative, testimony in response to Resolution 601. Those who support the resolution do not believe our AMA Policy G-630.140, Item 4 has achieved any legislative changes or made any significant political statement, and boycotts are not effective in changing legislation. It is believed that the policy has resulted in increased meeting costs due to the limiting of meeting venues. Those opposed to Resolution 601 do not believe our AMA Policy G-630.140, Item 4 exists simply to make a political statement. Opposing testimony further indicated that medical professionals have an obligation to not support discrimination, and the adoption of Resolution 601 would send a strong message that money means more than principles. Your Reference Committee heard extensive testimony that attendee safety is paramount, and since travel to and from, and meeting events occur outside the venue, the selection of the city and state is important in protecting attendee safety.

While your Reference Committee acknowledges the concerns expressed about exorbitant meeting costs, the issue is being addressed by our AMA via other methods.

G-630.140, "Lodging, Meeting Venues, and Social Functions"
Our American Medical Association's policy on lodging and accommodations includes the following:

1. Our AMA supports choosing hotels for its meetings, conferences, and conventions based on size, service, location, cost, and similar factors.
2. Our AMA shall attempt, when allocating meeting space, to locate the Section Assembly Meetings in the House of Delegates Meeting hotel or in a hotel in close proximity.
3. All meetings and conferences organized and/or primarily sponsored by our AMA will be held in a town, city, county, or state that has enacted comprehensive legislation requiring smoke-free worksites and public places (including restaurants and bars), unless intended or existing contracts or special circumstances justify an exception to this policy, and our AMA encourages state and local medical societies, national medical specialty societies, and other health organizations to adopt a similar policy.
4. It is the policy of our AMA not to hold meetings organized and/or primarily sponsored by our AMA, in cities, counties, or states, or pay

member, officer or employee dues in any club, restaurant, or other institution, that has exclusionary policies, including, but not limited to, policies based on, race, color, religion, national origin, ethnic origin, language, creed, sex, sexual orientation, gender, gender identity and gender expression, disability, or age unless intended or existing contracts or special circumstances justify an exception to this policy.

5. Our AMA staff will work with facilities where AMA meetings are held to designate an area for breastfeeding and breast pumping.
6. All future AMA meetings will be structured to provide accommodations for members and invited attendees who are able to physically attend, but who need assistance in order to meaningfully participate.
7. Our AMA will revisit our criteria for selection of hotels and other venues in order to facilitate maximum participation by members and invited attendees with disabilities.

(8) RESOLUTION 602 - DELAYING THE ETF ENDORSEMENT TIMELINE REVISION FOR SECTION IOP REVISIONS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 602 not be adopted.

HOD ACTION: Resolution 602 not adopted.

RESOLVED, that our American Medical Association House of Delegates candidate endorsement process revisions that were to be implemented for the 2026 election cycle be delayed to allow a thorough evaluation of unintended consequences and for revised State and Society bylaws and Section internal operating procedures to be duly ratified (Directive to Take Action)

RESOLVED, that our AMA Board of Trustees expedite the approval of amendments to Section internal operating procedures as necessary to allow for their nomination and endorsement processes to align with impending changes to AMA House of Delegates procedure for nominations and endorsements. (Directive to Take Action)

Testimony provided by our Board of Trustees noted the conflict between the endorsement rules for the Annual 2026 election cycle and the candidate endorsement processes outlined in the Sections' Internal Operating Procedures (IOP). In response, our Board of Trustees approved a temporary suspension of Section IOP requirements for endorsing candidates for AMA House of Delegates (HOD) elections.

Although the Board of Trustees' action to address this conflict and the Governing Councils' capacity to act on behalf of the Sections between meetings was acknowledged, opposing testimony indicated there were still unintended consequences:

- Section members did not have an opportunity to attain consensus on IOP changes needed to align their candidate endorsement process with the endorsement rules for the 2026 election cycle.

- The current rules may preclude some delegations and sections from implementing their established processes for candidate endorsements while potentially creating inequities for candidates.

It was further noted that adjusting the timing of the endorsement window to conclude after the Interim Meeting would alleviate these concerns for future election cycles. Since Resolution 602 calls for postponing a due date that has passed, your Reference Committee believes Resolution 602 cannot be adopted as written.

(9) RESOLUTION 607 - AMA HOUSE OF DELEGATES VENUES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 607 not be adopted.

HOD ACTION: Resolution 607 not adopted.

RESOLVED, that our American Medical Association retain the ability to choose any location within the continental United States to hold the Annual Meeting (Directive to Take Action)

RESOLVED, that our AMA Policy G630.140 Item 4 be rescinded (Rescind HOD Policy)

RESOLVED, that our AMA Board of Trustees will employ or contract any services that may reduce or alleviate concerns about risk factors related to a particular location venue (Directive to Take Action)

RESOLVED, that our AMA Board of Trustees re-examine previously used and explore potentially new venues for future Interim meetings. (Directive to Take Action)

Your Reference Committee noted, and testimony indicated, that Resolution 607 is similar to Resolution 601 in its intent; consequently, there was overlapping testimony on the two items of business. Extensive testimony was heard against the second Resolve and without rescinding AMA Policy G-630.140, the first Resolve clause is in direct conflict with this existing policy. Limited testimony was provided on the third and fourth Resolve clauses, but previous Board reports in I-23 and A-24 indicate that the third and fourth resolve clauses have been and are continually being accomplished by our Board of Trustees.

RECOMMENDED FOR REAFFIRMATION IN LIEU OF

(10) RESOLUTION 604 - OPPOSING DISCRIMINATION AND PROTECTING FREE SPEECH AMONG MEMBER ORGANIZATIONS OR ORGANIZED MEDICAL ASSOCIATIONS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that AMA Policies H-65.951, H-65.961, and H-140.837 be reaffirmed in lieu of Resolution 604.

HOD ACTION: AMA Policies H-65.951, H-65.961, and H-140.837 reaffirmed in lieu of Resolution 604.

RESOLVED, that our American Medical Association supports that organized medical societies should not discriminate against, suspend, or otherwise punish member societies for the political views or actions of their host city, state, or national governments (New HOD Policy)

RESOLVED, that our AMA supports that members of organized medical societies should not engage in harassment of other members, threats towards other members, or hate speech (New HOD Policy)

RESOLVED, that our AMA support these principles on an international level among international medical organizations. (New HOD Policy)

Initial testimony provided by the author highlighted the need for protections to mitigate discrimination and harassment toward various physician and medical student groups. It was noted that local and international organized medical societies are encouraged to uphold principles that support these protections.

Opposing testimony expressed appreciation for the intent of the resolution. However, the following concerns were mentioned:

- A definition for the term “hate speech” is not well-defined and should be clarified before inclusion in AMA policy. A definition of the term would help provide the necessary perspective.
- The first Resolve clause conflicts with AMA Policy G-630.140, Lodging, Meeting Venues, and Social Functions.
- Existing AMA Policies H-65.951, H-65.961, and H-140.837 address discrimination and harassment.

While our AMA recognizes the need to address discrimination and harassment, as evidenced by existing policy, our AMA does not have the authority to adjudicate membership decisions for other organizations. Therefore, your Reference Committee recommends reaffirmation of current AMA policies and the author of Resolution 604 agreed.

H-65.951, "Healthcare and Organizational Policies and Cultural Changes to Prevent and Address Racism, Discrimination, Bias and Microaggressions"

Our American Medical Association adopted the following guidelines for healthcare organizations and systems, including academic medical centers, to establish policies and an organizational culture to prevent and address systemic racism, explicit and implicit bias and microaggressions in the practice of medicine:

GUIDELINES TO PREVENT AND ADDRESS SYSTEMIC RACISM, EXPLICIT BIAS AND MICROAGGRESSIONS IN THE PRACTICE OF MEDICINE

Health care organizations and systems, including academic medical centers, should establish policies to prevent and address discrimination including systemic racism, explicit and implicit bias and microaggressions in their workplaces.

An effective healthcare anti-discrimination policy should:

- Clearly define discrimination, systemic racism, explicit and implicit bias and microaggressions in the healthcare setting.
- Ensure the policy is prominently displayed and easily accessible.
- Describe the management's commitment to providing a safe and healthy environment that actively seeks to prevent and address systemic racism, explicit and implicit bias and microaggressions.
- Establish training requirements for systemic racism, explicit and implicit bias, and microaggressions for all members of the healthcare system.
- Prioritize safety in both reporting and corrective actions as they relate to discrimination, systemic racism, explicit and implicit bias and microaggressions.
- Create anti-discrimination policies that:
- Specify to whom the policy applies (i.e., medical staff, students, trainees, administration, patients, employees, contractors, vendors, etc.).
- Define expected and prohibited behavior.
- Outline steps for individuals to take when they feel they have experienced discrimination, including racism, explicit and implicit bias and microaggressions.
- Ensure privacy and confidentiality to the reporter.
- Provide a confidential method for documenting and reporting incidents.
- Outline policies and procedures for investigating and addressing complaints and determining necessary interventions or action.

These policies should include:

- Taking every complaint seriously.
- Acting upon every complaint immediately.
- Developing appropriate resources to resolve complaints.
- Creating a procedure to ensure a healthy work environment is maintained for complainants and prohibit and penalize retaliation for reporting.

- Communicating decisions and actions taken by the organization following a complaint to all affected parties.
- Document training requirements to all the members of the healthcare system and establish clear expectations about the training objectives.

In addition to formal policies, organizations should promote a culture in which discrimination, including systemic racism, explicit and implicit bias and microaggressions are mitigated and prevented. Organized medical staff leaders should work with all stakeholders to ensure safe, discrimination-free work environments within their institutions.
Tactics to help create this type of organizational culture include:

- Surveying staff, trainees and medical students, anonymously and confidentially to assess:
- Perceptions of the workplace culture and prevalence of discrimination, systemic racism, explicit and implicit bias and microaggressions.
- Ideas about the impact of this behavior on themselves and patients.
- Integrating lessons learned from surveys into programs and policies.
- Encouraging safe, open discussions for staff and students to talk freely about problems and/or encounters with behavior that may constitute discrimination, including racism, bias or microaggressions.
- Establishing programs for staff, faculty, trainees and students, such as Employee Assistance Programs, Faculty Assistance Programs, and Student Assistance Programs, that provide a place to confidentially address personal experiences of discrimination, systemic racism, explicit or implicit bias or microaggressions.
- Providing designated support person to confidentially accompany the person reporting an event through the process.

H-65.961, "Principles for Advancing Gender Equity in Medicine"
Our AMA:

1. declares it is opposed to any exploitation and discrimination in the workplace based on personal characteristics (i.e., gender);
2. affirms the concept of equal rights for all physicians and that the concept of equality of rights under the law shall not be denied or abridged by the U.S. Government or by any state on account of gender;
3. endorses the principle of equal opportunity of employment and practice in the medical field;
4. affirms its commitment to the full involvement of women in leadership roles throughout the federation, and encourages all components of the federation to vigorously continue their efforts to recruit women members into organized medicine;
5. acknowledges that mentorship and sponsorship are integral components of one's career advancement, and encourages physicians to engage in such activities;
6. declares that compensation should be equitable and based on demonstrated competencies/expertise and not based on personal characteristics;
7. recognizes the importance of part-time work options, job sharing, flexible scheduling, re-entry, and contract negotiations as options for physicians to support work-life balance;

8. affirms that transparency in pay scale and promotion criteria is necessary to promote gender equity, and as such academic medical centers, medical schools, hospitals, group practices and other physician employers should conduct periodic reviews of compensation and promotion rates by gender and evaluate protocols for advancement to determine whether the criteria are discriminatory; and
9. affirms that medical schools, institutions and professional associations should provide training on leadership development, contract and salary negotiations and career advancement strategies that include an analysis of the influence of gender in these skill areas.

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

H-140.837, "Policy on Conduct at AMA Meetings and Events
It is the policy of our American Medical Association that all attendees of AMA hosted meetings, events and other activities are expected to exhibit respectful, professional, and collegial behavior during such meetings, events and activities, including but not limited to dinners, receptions and social gatherings held in conjunction with such AMA hosted meetings, events and other activities. Attendees should exercise consideration and respect in their speech and actions, including while making formal presentations to other attendees, and should be mindful of their surroundings and fellow participants.

Any type of harassment of any attendee of our AMA hosted meeting, event and other activity, including but not limited to dinners, receptions and social gatherings held in conjunction with our AMA hosted meeting, event or activity, is prohibited conduct and is not tolerated. Our AMA is committed to a zero tolerance for harassing conduct at all locations where AMA business is conducted. This zero tolerance policy also applies to meetings of all AMA sections, councils, committees, task forces, and other leadership entities (each, an "AMA Entity"), as well as other AMA-sponsored events. The purpose of the policy is to protect participants in AMA-sponsored events from harm.

DEFINITION
Harassment consists of unwelcome conduct whether verbal, physical or visual that denigrates or shows hostility or aversion toward an individual because of race, color, religion, sex, sexual orientation, gender identity, national origin, age, disability, marital status, citizenship or otherwise, and that:

1. Has the purpose or effect of creating an intimidating, hostile or offensive environment.
2. Has the purpose or effect of unreasonably interfering with an individual's participation in meetings or proceedings of the HOD or any AMA Entity.
3. Otherwise adversely affects an individual's participation in such meetings or proceedings or, in the case of AMA staff, such individual's employment opportunities or tangible job benefits.

Harassing conduct includes, but is not limited to: epithets, slurs or negative stereotyping; threatening, intimidating or hostile acts; denigrating jokes; and written, electronic, or graphic material that denigrates or shows hostility or aversion toward an individual or group and that is placed on walls or elsewhere on our AMA's premises or at the site of any AMA meeting or circulated in connection with any AMA meeting.

Harassing conduct also includes intimidation of participating individuals by a threat of consequences in order to compel actions by individuals or a group of individuals such as casting a particular vote.

SEXUAL HARASSMENT

Sexual harassment also constitutes discrimination, and is unlawful and is absolutely prohibited. For the purposes of this policy, sexual harassment includes:

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

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

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

OPERATIONAL GUIDELINES

Our AMA shall, through the Office of General Counsel, implement and maintain mechanisms for reporting, investigation, and enforcement of the Policy on Conduct at AMA Meetings and Events in accordance with the following:

1. Conduct Liaison and Committee on Conduct at AMA Meetings and Events (CCAM).
The Office of General Counsel will appoint a "Conduct Liaison" for all AMA House of Delegates meetings and all other AMA hosted meetings or activities (such as meetings of AMA councils, sections, the RVS Update Committee (RUC), CPT Editorial Panel, or JAMA Editorial Boards), with responsibility for receiving reports of alleged policy violations, conducting investigations, and initiating both immediate and longer-term consequences for such violations. The Conduct Liaison appointed for any meeting will have the appropriate training and experience to serve in this capacity, and may be a third party or an in-house AMA resource with assigned responsibility for this role. The Conduct Liaison will be:

   i. on-site at all House of Delegates meetings and other large, national AMA meetings and
   ii. on call for smaller meetings and activities. Appointments of the Conduct Liaison for each meeting shall ensure appropriate independence and neutrality, and avoid even the appearance of conflict of interest, in investigation of alleged policy violations and in decisions on consequences for policy violations.

   Our AMA shall establish and maintain a Committee on Conduct at AMA Meetings and Events (CCAM), to be comprised of 5-7 AMA members who are nominated by the Office of General Counsel (or through a nomination process facilitated by the Office of General Counsel) and approved by the Board of Trustees. The CCAM should include one member of the Council on Ethical and Judicial Affairs (CEJA); provided, however, that such CEJA member on the CCAM shall be recused from discussion and vote concerning referral by the CCAM of a matter to CEJA for further review and action. The remaining members may be appointed from AMA membership generally, with emphasis on maximizing the diversity of membership. Appointments to the CCAM shall ensure appropriate independence and neutrality, and avoid even the appearance of conflict of interest, in decisions on consequences for policy violations. Appointments to the CCAM should be multi-year, with staggered terms.

2. Reporting Violations of the Policy
Any persons who believe they have experienced or witnessed conduct in violation of Policy H-140.837, Policy on Conduct at AMA Meetings and Events," during any AMA House of Delegates meeting or other activities associated with the AMA (such as meetings of AMA councils, sections, the RVS Update Committee (RUC), CPT Editorial Panel or JAMA Editorial Boards) should promptly notify the:

   i. Conduct Liaison appointed for such meeting, and/or
   ii. The AMA Office of General Counsel and/or
   iii. the presiding officer(s) of such meeting or activity.

Alternatively, violations may be reported using our AMA reporting hotline (telephone and online) maintained by a third party on behalf of the AMA. The AMA reporting hotline will provide an option to report anonymously, in which case the name of the reporting party will be kept confidential by the vendor and not be released to our AMA. The vendor will advise our AMA of any complaint it receives so that the Conduct Liaison may investigate.

These reporting mechanisms will be publicized to ensure awareness.

3. Investigations

All reported violations of Policy H-140.837, "Policy on Conduct at AMA Meetings and Events," pursuant to Section 2 above (irrespective of the reporting mechanism used) will be investigated by the Conduct Liaison. Each reported violation will be promptly and thoroughly investigated. Whenever possible, the Conduct Liaison should conduct incident investigations on-site during the event. This allows for immediate action at the event to protect the safety of event participants. When this is not possible, the Conduct Liaison may continue to investigate incidents following the event to provide recommendations for action to the CCAM. Investigations should consist of structured interviews with the person reporting the incident (the reporter), the person targeted (if they are not the reporter), any witnesses that the reporter or target identify, and the alleged violator.

Based on this investigation, the Conduct Liaison will determine whether a violation of the Policy on Conduct at AMA Meetings and Events has occurred.

All reported violations of the Policy on Conduct at AMA Meetings and Events, and the outcomes of investigations by the Conduct Liaison, will also be promptly transmitted to the AMA's Office of General Counsel (i.e. irrespective of whether the Conduct Liaison determines that a violation has occurred).

4. Disciplinary Action

If the Conduct Liaison determines that a violation of the Policy on Conduct at AMA Meetings and Events has occurred, the Conduct Liaison may take immediate action to protect the safety of event participants, which may include having the violator removed from the AMA meeting, event or activity, without warning or refund.

Additionally, if the Conduct Liaison determines that a violation of the Policy on Conduct at AMA Meetings and Events has occurred, the Conduct Liaison shall report any such violation to the CCAM, together with recommendations as to whether additional commensurate disciplinary and/or corrective actions (beyond those taken on-site at the meeting, event or activity, if any) are appropriate.

The CCAM will review all incident reports, perform further investigation (if needed) and recommend to the Office of General Counsel any additional commensurate disciplinary and/or corrective action, which may include but is not limited to the following:

- Prohibiting the violator from attending future AMA events or activities.
- Removing the violator from leadership or other roles in AMA activities.
- Prohibiting the violator from assuming a leadership or other role in future AMA activities.
- Notifying the violator's employer and/or sponsoring organization of the actions taken by AMA.
- Referral to the Council on Ethical and Judicial Affairs (CEJA) for further review and action.
- Referral to law enforcement.

The CCAM may, but is not required to, confer with the presiding officer(s) of applicable events activities in making its recommendations as to disciplinary and/or corrective actions. Consequence for policy violations will be commensurate with the nature of the violation(s).

5. Confidentiality
   All proceedings of the CCAM should be kept as confidential as practicable. Reports, investigations, and disciplinary actions under Policy on Conduct at AMA Meetings and Events will be kept confidential to the fullest extent possible, consistent with usual business practices.

6. Assent to Policy
   As a condition of attending and participating in any meeting of the House of Delegates, or any council, section, or other AMA entities, such as the RVS Update Committee (RUC), CPT Editorial Panel and JAMA Editorial Boards, or other AMA hosted meeting or activity, each attendee will be required to acknowledge and accept (i) AMA policies concerning conduct at AMA HOD meetings, including the Policy on Conduct at AMA Meetings and Events and (ii) applicable adjudication and disciplinary processes for violations of such policies (including those implemented pursuant to these Operational Guidelines), and all attendees are expected to conduct themselves in accordance with these policies.

   Additionally, individuals elected or appointed to a leadership role in the AMA or its affiliates will be required to acknowledge and accept the Policy on Conduct at AMA Meetings and Events and these Operational Guidelines.

   [Editor's note: Violations of this Policy on Conduct at AMA Meetings and Events may be reported at 800.398.1496 or online at https://www.lighthouse-services.com/ama. Both are available 24 hours a day, 7 days a week.

Please note that situations unrelated to this Policy on Conduct at AMA Meetings and Events should not be reported here. In particular, patient concerns about a physician should be reported to the state medical board or other appropriate authority.]

(11) RESOLUTION 606 - PROTECTING FREE SPEECH AND ENCOURAGING RESPECTFUL DISCOURSE AMONG MEMBER ORGANIZATIONS OR ORGANIZED MEDICAL ASSOCIATIONS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that AMA Policies H-65.951, H-65.961, and H-140.837 be reaffirmed in lieu of Resolution 606.

HOD ACTION: AMA Policies H-65.951, H-65.961, and H-140.837 reaffirmed in lieu of Resolution 606.

RESOLVED, that our American Medical Association believes that organized medical societies should not suspend or otherwise punish member societies for the political views or military actions of their host governments (New HOD Policy)

RESOLVED, that our AMA believes that members of organized medical societies should not engage in harassment of other members, threats towards other members, or hate speech. (New HOD Policy)

Initial testimony provided by the author emphasizes the need for protections to mitigate discrimination and harassment toward various physician and medical student groups.

As was previously stated in the response to Resolution 604, opposing testimony noted that clarification on the term “hate speech” is needed. Further, testimony indicated that the first Resolve clause conflicts with AMA Policy G-630.140, Lodging, Meeting Venues, and Social Functions. Testimony also noted that AMA has extensive policy to address discrimination and harassment.

Therefore, your Reference Committee recommends reaffirmation of H-65.951, Healthcare and Organizational Policies and Cultural Changes to Prevent and Address Racism, Discrimination, Bias and Microaggressions; H-65.961, Principles for Advancing Gender Equity in Medicine; and H-140.837, Policy on Conduct at AMA Meetings and Events address discrimination and harassment. The author of Resolution 606 concurred with this recommendation.

Madam Speaker, this concludes the report of Reference Committee F. I would like to thank Emily D. Briggs, MD, MPH, Robert A. Gilchick, MD, MPH, Hillary Johnson-Jahangir, MD, PhD, Richard F. Labasky, MD, MBA, Brandi N. Ring, MD, MBA, Jayesh B. Shah, MD, MHA, and all those who testified before the Committee.

Emily D. Briggs, MD, MPH
American Academy of Family Physicians

Robert A. Gilchick, MD, MPH
American College of Preventive Medicine

Hillary Johnson-Jahangir, MD, PhD
American Academy of Dermatology Association

Richard F. Labasky, MD, MBA
Utah Medical Association

Brandi N. Ring, MD, MBA
American College of Obstetricians and Gynecologists

Jayesh B. Shah, MD, MHA
Texas Medical Association

Michael B. Simon, MD, MBA
American Society of Anesthesiologists
Chair

DISCLAIMER

The following is a preliminary report of actions taken by the House of Delegates at its 2024 Annual Meeting and should not be considered final. Only the Official Proceedings of the House of Delegates reflect official policy of the Association.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (I-24)

Final Report of Reference Committee J

Shawn Baca, MD, Chair

Your Reference Committee recommends the following consent calendar for acceptance:

RECOMMENDED FOR ADOPTION

1. Board of Trustees Report 5 – Protecting the Health of Incarcerated People
2. Council on Medical Service Report 2 – Unified Financing Health Care System
3. Council on Medical Service Report 3 – Time-Limited Patient Care
4. Resolution 804 – Improving Public Assistance for People with Disabilities
5. Resolution 808 – Requirement to Communicate Covered Alternatives for Denied Medications
6. Resolution 812 – Advocate for Therapy Cap Exception Process
7. Resolution 813 – Insurance Coverage for Pediatric Positioning Chairs
8. Resolution 822 - Resolution On Medicare Coverage for Non-Emergent Dialysis Transport
9. Resolution 824 – Ophthalmologists Required to Be Available for Level I & II Trauma Centers
10. Resolution 825 – Transparency of Facility Fees for Hospital Outpatient Department Visits

RECOMMENDED FOR ADOPTION AS AMENDED

11. Board of Trustees Report 13 – AMA/Specialty Society RVS Update Committee
12. Board of Trustees Report 15 – Published Metrics for Hospitals and Hospital Systems
13. Council on Medical Service Report 1 – Nonprofit Hospital Charity Care Policies
14. Council on Medical Service Report 4 – Biosimilar Coverage Structures
15. Resolution 805 – Coverage for Sexual Assault Survivors
16. Resolution 810 – Immediate Digital Access to Updated Medication Formulary for Patients
17. Resolution 811 – AMA Practice Expense Survey Geographic Analysis
18. Resolution 815 – Addressing the Crisis of Pediatric Hospital Closures and Impact on Care
19. Resolution 818 – Payment for Pre-Certification/Preauthorization Procedures
20. Resolution 820 – State Medicaid Coverage of Home Sleep Testing
21. Resolution 821 – Patient Access to Asthma Medications
22. Resolution 823 – Reining in Medicare Advantage – Institutional Special Needs Plans

RECOMMENDED FOR REFERRAL

23. Resolution 803 – Healthcare Savings Account Reform
24. Resolution 807 – Expanded Pluralism in Medicaid

25. Resolution 809 – Minimum Requirements for Medication Formularies
26. Resolution 817 – ACA Subsidies for Undocumented Immigrants

RECOMMENDED FOR REFERRAL FOR DECISION

27. Resolution 814 – Legislation for Physician Payment for Prior Authorization

RECOMMENDED FOR REAFFIRMATION IN LIEU OF

28. Resolution 801 – Reimbursement for Managing Portal Messages
29. Resolution 802 – Address Physician Burnout with Inbox Management Resources and Increased Payment
30. Resolution 819 – Establishing a New Office-Based Facility Setting to Pay Separately from the Medicare Physician Fee Schedule for the Technical Reimbursement of Physician Services Using High-Cost Supplies
31. Resolution 826 – Renewing Expansion of Premium Tax Credits

RECOMMENDED FOR ADOPTION

(1) BOT REPORT 5: PROTECTING THE HEALTH OF INCARCERATED PATIENTS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the Recommendations in Board of Trustees Report 5 be adopted and the remainder of the report be filed.

HOD ACTION: Recommendations in Board of Trustees Report 5 adopted and the remainder of the Report filed.

The Board of Trustees recommends that the following recommendations be adopted in lieu of Resolution 202-I-23, and that the remainder of the report be filed.

That our American Medical Association reaffirm existing AMA Policies H-430.986, "Health Care While Incarcerated;" H-430.997, "Standards of Care for Inmates of Correctional Facilities;" and D-430.997, "Support for Health Care Services to Incarcerated Persons." (Reaffirm HOD Policy)

Your Reference Committee heard supportive testimony on Board of Trustees Report 5. One delegation suggested amending the report by addition of two new recommendations, but there was no other support for these amendments in the testimony online and minimal support in-person. The Board of Trustees addressed the proffered amendments and spoke against them citing that they are based on an Executive Order from the current Administration and it cannot be guaranteed that this Executive Order is continued by the incoming Administration. Additionally, the Board highlighted that the AMA should support the health of all inmates, not just those in for-profit facilities. All other testimony supported adoption of the recommendations as written. Therefore, your Reference Committee recommends that the recommendations in Board of Trustees Report 5 be adopted and the remainder of the report be filed.

(2) CMS REPORT 2 – UNIFIED FINANCING HEALTH CARE SYSTEM

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the Recommendations in Council on Medical Service Report 2 be adopted and the remainder of the report be filed.

HOD ACTION: Recommendations in Council on Medical Service Report 2 be adopted and the remainder of the Report filed.

The Council on Medical Service recommends that the following recommendations be adopted in lieu of the second resolve clause of Resolution 818-I-23, and that the remainder of the report be filed.

1. That our American Medical Association (AMA) continue monitoring federal and state health reform proposals, including the development of state plans and/or waiver applications seeking program approval for unified financing. (Directive to Take Action)

2. That our AMA reaffirm Policy D-165.942, which advocates that state governments be given the freedom to develop and test different models for covering the uninsured, provided that proposed alternatives a) meet or exceed the projected percentage of individuals covered under an individual responsibility requirement while maintaining or improving upon established levels of quality of care, b) ensure and maximize patient choice of physician and private health plan, and c) include reforms that eliminate denials for pre-existing conditions. (Reaffirm HOD Policy)

3. That our AMA reaffirm Policy H-165.838, which upholds the AMA's commitment to achieving enactment of health system reforms that include health insurance for all Americans, expand choice of affordable coverage, assure that health care decisions remain in the hands of patients and their physicians, and are consistent with pluralism, freedom of choice, freedom of practice, and universal access. (Reaffirm HOD Policy)

Your Reference Committee heard supportive testimony on Council on Medical Service Report 2. Notably, members of the Council on Medical Service, Council on Legislation, and Board of Trustees spoke in favor of the report's recommendation to continue monitoring federal and state health reform proposals, including waiver applications seeking approval for unified financing, and against a proposed new recommendation asking our AMA support federal waivers that permit states to develop and test unified financing systems. The authors of the proffered new recommendation stated that AMA support for a new waiver program is needed because states that may want to implement unified financing reforms are not currently permitted to reallocate and repurpose federal Medicaid or Affordable Care Act funding to provide universal coverage. A member of the Council on Medical Service countered that it would be premature to support unified financing waivers, given the lack of data and design details, including how physicians will be paid under such systems. An amendment similar in intent to the recommendation offered online was proffered in person. Because in-person testimony was similar to testimony in the online reference committee, your Reference Committee recommends that the recommendations in Council on Medical Service Report 2 be adopted and the remainder of the report filed.

(3) CMS REPORT 3 – TIME-LIMITED PATIENT CARE

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the Recommendations in Council on Medical Service Report 3 be <u>adopted</u> and the remainder of the report be <u>filed</u>.

HOD ACTION: Recommendations in Council on Medical Service Report 3 <u>adopted</u> and the remainder of the Report <u>filed</u>.

The Council on Medical Service recommends that the following recommendations be adopted in lieu of the second resolve clause of Resolution 818-I-23, and that the remainder of the report be filed.

1.That our American Medical Association (AMA) support efforts to ensure that physicians are able to exercise autonomy in the length of patient care visits free from undue influence from

outside entities such as, but not limited to, payers, administrators, and health care systems. (New HOD Policy)

2. That our AMA support efforts to incorporate patient complexities and social determinants of health in calculating appropriate amounts of expected patient care time. (New HOD Policy)

3. That our AMA reaffirm Policy H-70.976 which monitors and seeks to prevent attempts by third-party payers to institute policies that impose time and diagnosis limits. (Reaffirm HOD Policy)

4. That our AMA reaffirm Policy D-225.977 that details support for employed physician involvement in self-governance and leadership. (Reaffirm HOD Policy)
5. That our AMA reaffirm Policy H-405.957 that describes AMA efforts to study, promote, and educate on physician well-being and to prevent physician burnout. (Reaffirm HOD Policy)

6. Rescind Policy D-450.951, as having been completed with this report. (Rescind HOD Policy)

Your Reference Committee heard supportive testimony for Council on Medical Service Report 3. Testimony indicated the importance of ensuring that physicians have autonomy in their practice and do not face undue time pressures in caring for patients. Additionally, support was expressed for the Council's recommendations presented in this report. All in-person testimony expressed support for the adoption of this item. Therefore, your Reference Committee recommends that the recommendations in Council on Medical Service Report 3 be adopted and the remainder of the report filed.

(4) RESOLUTION 804 – IMPROVING PUBLIC ASSISTANCE FOR PEOPLE WITH DISABILITIES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 804 be adopted.

HOD ACTION: Resolution 804 adopted.

RESOLVED, that our American Medical Association support appropriate increased asset limits, income cutoffs, and benefits that are indexed to increase at least by inflation for public assistance programs such as Supplemental Security Income (SSI) (New HOD Policy); and be it further

RESOLVED, that our AMA support eliminating the marriage penalty for SSI benefits, such that married couples do not receive fewer benefits or have more restrictive eligibility requirements than they would have as individuals. (New HOD Policy)

Online testimony on Resolution 804 was overwhelmingly supportive. An amendment was proffered, but testimony expressed serious concern that the amended language could increase confusion around the intent of the resolution. Additional testimony expressed support for the breadth of the original resolution. No additional testimony was provided in-person. Therefore, your Reference Committee recommends that Resolution 804 be adopted.

(5) RESOLUTION 808 – REQUIREMENT TO COMMUNICATE COVERED ALTERNATIVES FOR DENIED MEDICATIONS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 808 be adopted.

HOD ACTION: Resolution 808 be adopted.

RESOLVED, that our American Medical Association advocate that Medicare, Medicaid, and all other insurers provide covered alternatives to the patient and the patient's prescribing physician at the time that coverage for a medication is denied. (Directive to Take Action)

Your Reference Committee heard overwhelmingly supportive testimony of Resolution 808. This item was suggested for reaffirmation; however, testimony indicated that the full ask of the resolution is not covered by existing policy. Testimony indicated the importance of placing the onus of identifying alternative, covered medications on payers and not physicians or their patients. All in-person testimony expressed support for the adoption of this item. Based on the supportive testimony, your Reference Committee recommends that Resolution 808 be adopted.

(6) RESOLUTION 812 – ADVOCATE FOR THERAPY CAP EXCEPTION PROCESS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 812 be adopted.

HOD ACTION: Resolution 812 adopted.

RESOLVED, that our American Medical Association actively advocate for all health plans with therapy caps or thresholds to include an exception process. This process should, at a minimum, follow the Medicare standard for therapy cap exceptions, ensuring that patients can access the necessary services to restore functional abilities and enhance quality of life. (Directive to Take Action)

Online testimony for Resolution 812 was overwhelmingly supportive, stressing the importance of ensuring that patients are not harmed by therapy caps and are able to access the necessary services. The author provided in-person testimony in support of the Reference Committee recommendation. Due to the supportive testimony, your Reference Committee recommends Resolution 812 be adopted.

(7) RESOLUTION 813 – INSURANCE COVERAGE FOR PEDIATRIC POSITIONING CHAIRS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 813 be adopted.

HOD ACTION: Resolution 813 adopted.

RESOLVED, that our American Medical Association advocate that private and public insurance companies pay for a physician prescribed positioning chair for children who need support for sitting for daily activities in the home, in addition to the wheelchair that the patient uses for all mobility in the home and community. (Directive to Take Action)

Online testimony was unanimously in favor of Resolution 813, outlining the importance of ensuring that children with disabilities are able to receive positioning chairs as they can support both physical health and engagement with their community. The author provided in-person testimony in support of the Reference Committee recommendation. Due to the overwhelmingly supportive testimony, your Reference Committee recommends Resolution 813 be adopted.

(8) RESOLUTION 822 – RESOLUTION ON MEDICARE COVERAGE FOR NON-EMERGENT DIALYSIS TRANSPORT

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 822 be adopted.

HOD ACTION: Resolution 822 adopted.

RESOLVED, that our American Medical Association advocate for Medicare coverage of non-emergent medical transportation specifically for patients requiring dialysis treatment (Directive to Take Action); and be it further

RESOLVED, that our AMA partner with Center for Medicare and Medicaid Services (CMS) to develop policies to ensure financial assistance for non-emergent medical transportation for dialysis treatments and to transplant centers for kidney transplant evaluation and related care for Medicare beneficiaries. (Directive to Take Action)

Your Reference Committee heard limited, but supportive, online testimony of Resolution 822, which indicated that it may be covered by existing AMA policy. However, the preponderance of in-person testimony supported adoption rather than reaffirmation. Therefore, your Reference Committee has changed its recommendation from reaffirmation to adoption of Resolution 822.

(9) RESOLUTION 824 – OPHTHALMOLOGISTS REQUIRED TO BE AVAILABLE FOR LEVEL I & II TRAUMA CENTERS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 824 be adopted.

HOD ACTION: Policy H-130.948 reaffirmed in lieu of Resolution 824.

RESOLVED, that our American Medical Association work with the American College of Surgeons and the American Trauma Society to specifically name Ophthalmology as a requirement for Level I & II Trauma Centers (Directive to Take Action); and be it further

RESOLVED, that our AMA work with the American College of Surgeons and the American Trauma Society to ensure that during the verification process it has to be insisted that there is availability of Ophthalmology Trauma coverage. (Directive to Take Action)

Your Reference Committee heard mixed but mostly supportive testimony on this resolution. The authors and two additional delegations supported adoption, and another delegation testified against adoption. Through testimony it was revealed that Resolution 824 was submitted to address an optometrist being called first from the emergency department, rather than an ophthalmologist. The authors conceded that their issue had been addressed but encouraged adoption of the resolution to prevent this situation from happening again. The delegation speaking in favor of not adoption testified that the processes outlined in this resolution are already in place within the American College of Surgeons guidelines ("Grey Book"), rendering this resolution unnecessary. Your Reference Committee believes this is ultimately a scope issue, and it is in the best interest of patients to be treated by an ophthalmologist when care is needed at a Level I and/or Level II Trauma Center. Therefore, your Reference Committee recommends that Resolution 824 be adopted.

(10) RESOLUTION 825 – TRANSPARENCY OF FACILITY FEES FOR HOSPITAL OUTPATIENT DEPARTMENT VISITS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 825 be adopted.

HOD ACTION: Resolution 825 adopted.

RESOLVED, that our American Medical Association advocate for legislation or regulation that mandates the proactive transparency of the added costs to the consumer for health care services rendered at hospital outpatient department designated clinics (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate the additional costs of facility fees over professional services be stated upon scheduling of such services, noting the two are separate and additive charges, as well as prominently displayed at the point of service (Directive to Take Action)

Testimony was limited but supportive of Resolution 825. Speakers noted that transparency empowers patients to make good decisions about their care. Your Reference Committee recommends that Resolution 825 be adopted.

RECOMMENDED FOR ADOPTION AS AMENDED

(11) BOT REPORT 13: AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Recommendation 1 in Board of Trustees Report 13 by addition and deletion.

1. That our American Medical Association (AMA) ~~support the continued efforts of the AMA/Specialty Society RVS Update Committee (RUC) to identify extant data to utilize within the ongoing process to improve the Resource Based Relative Value Scale (RBRVS). (New HOD Policy)~~ collaborate with relevant parties to support the AMA/Specialty Society RVS Update Committee (RUC) and RUC Research Subcommittee's study on how usable extant data, including electronic data, can be collected in order to compare the accuracy of a mixed methodology approach against the current survey methodology. (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Board of Trustees Report 13 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Recommendations in Board of Trustees Report 13 be adopted as amended and the remainder of the report filed.

The Board of Trustees recommends that the following be adopted in lieu of Resolution 821-I-23, and the remainder of the report be filed.

1. That our American Medical Association (AMA) support the continued efforts of the AMA/Specialty Society RVS Update Committee (RUC) to identify extant data to utilize within the ongoing process to improve the Resource Based Relative Value Scale (RBRVS). (New HOD Policy)

2. That our AMA reaffirm Policy D-400.983, which supports the RUC and its ability to implement methodological improvements. (Reaffirm HOD Policy)

3. That our AMA reaffirm Policy H-400.959, which supports the RUC's efforts to improve the validity of the RBRVS through development of methodologies for assessing the relative work of new technologies. (Reaffirm HOD Policy)

4. That our AMA reaffirm Policy H-400.969, which calls on the Centers for Medicare & Medicaid Services to adopt the recommendations of the RUC for work relative values for new and revised Current Procedural Terminology (CPT®) codes, and strongly supports the use of the RUC

process as the principal method of refining and maintaining the Medicare RBRVS. (Reaffirm HOD Policy)

Your Reference Committee heard mixed testimony on Board of Trustees (BOT) Report 13. Testimony supportive of the recommendations as written described the AMA/Specialty Society RVS Update Committee (RUC) process as collaborative, transparent, and striving for continuous improvement in the accuracy of the valuation recommendations it makes to the Centers for Medicare & Medicaid Services.

Critics of BOT Report 13 stated that the recommendations support existing RUC efforts but do not fulfill the intent of referred Resolution 821-I-23, which sought to encourage the use of more comprehensive data sources, beyond physician surveys, in determining relative value units (RVUs). Two delegations spoke against Recommendation 4, which recommends reaffirming Policy H-400.969. These delegations also testified in strong support of proffered substitute Recommendation 1, which asks our AMA to fund a pilot study aimed at modernizing the RUC's process by utilizing extant databases from institutions and systems that own these data, such as Epic, Cerner, and Kaiser, to compare the accuracy of this mixed methodology approach against the current survey methodology.

Testimony opposed to substitute Recommendation 1 emphasized that AMA staff have already explored the use of electronic health record (EHR) data with Epic and Oracle (formerly Cerner) and determined that physician time data that could be utilized by the RUC are not available. Additional testimony against the substitute language cautioned that extant data, such as EHRs and operating logs, frequently fail to capture the nuances and intensity of certain specialty services, highlighting neurosurgery and labor management as examples of care that is not fully captured in such data sources. Testimony further questioned the scope and potential costs of the pilot called for in substitute Recommendation 1.

Your Reference Committee also heard testimony supportive of substitute Recommendation 1. Your Reference Committee notes that the RUC operates independently of our AMA. We recommend compromise language that addresses the intent of the proffered substitute recommendation while recognizing that our AMA plays a supportive role to the RUC and does not offer competing recommendations. Accordingly, your Reference Committee recommends that BOT Report 13 be adopted as amended and the remainder of the report be filed.

(12) BOT REPORT 15: PUBLISHED METRICS FOR HOSPITALS AND HOSPITAL SYSTEMS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the Recommendation in Board of Trustees Report 15 be <u>amended by addition</u> to read as follows:

That our AMA research <u>and develop</u> useful metrics that hospitals and hospital systems can use to improve physicians' experience, engagement, and work environment <u>in a manner accessible to physicians</u>.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the Recommendation in Board of Trustees Report 15 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Recommendations in Board of Trustees Report 15 adopted as amended and the remainder of the report be filed.

That our AMA research and develop useful metrics that hospitals and hospital systems can use to improve physicians~~'~~ experience, engagement, and work environment in a manner accessible to physicians with report back to the House of Delegates no later than Annual 2026.

The Board of Trustees recommends that the following recommendation be adopted in lieu of Resolution 715-A-23 and the remainder of the report be filed.

1. That our AMA research useful metrics that hospitals and hospital systems can use to improve physicians' experience, engagement, and work environment.

Your Reference Committee heard strongly supportive online testimony for Board of Trustees Report 15, which primarily encouraged the adoption of the report's recommendations as written. Additional online testimony provided an amendment which your Reference Committee felt bolstered the report and recommendations. In-person testimony was mixed, with the author supporting the report as written, two additional delegations supportive of a portion of the original amendment, and a third delegation proffering an additional amendment. There was concern surrounding the potential deleterious effect to the physician-organization collaboration and possible misuse of metrics which could result in a reduction of access to care. Therefore, your Reference Committee recommends that the recommendation in Board of Trustees Report 15 be adopted as amended and the remainder of the report be filed.

(13) CMS REPORT 1 – NONPROFIT HOSPITAL CHARITY CARE POLICIES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Recommendations in Council on Medical Service Report 1 be amended by addition and deletion to read as follows:

1. **That our American Medical Association (AMA) ~~support~~ advocate that all nonprofit hospitals be required to screen patients for charity care eligibility and other financial assistance program eligibility prior to billing. (New HOD Policy)**
2. **That our AMA ~~support efforts~~ advocate to encourage debt collectors to ensure a patient has been screened for financial assistance eligibility before pursuing that patient for outstanding debt, provide an appeals process for those patients**

not screened previously or deemed ineligible, and require the hospital to reassume the debt account if an appeal is successful. (New HOD Policy)

3. **That our AMA ~~support~~ advocate for the development of minimum standards for nonprofit hospital financial assistance eligibility programs which are publicly accessible. (New HOD Policy)**
4. **That our AMA ~~support~~ advocate for a standardized definition of what is considered a "community benefit" when evaluating community health improvement activities. (New HOD Policy)**
5. **That our AMA ~~support~~ advocate for the development of a transparent, publicly available, standardized data set on community benefit including consideration of charity care-to-expense ratios. (New HOD Policy)**
6. **That our AMA ~~support~~ advocate for the expansion of governmental oversight of nonprofit hospitals and enforcement of federal and/or state guidelines and standards for community benefit requirements including the ability to enact penalties and/or loss of tax-exempt status. (New HOD Policy)**
7. **That our AMA reaffirm existing Policy H-155.958, which states that the AMA will encourage hospitals to adopt, implement, monitor, and publicize policies on patient discounts, charity care, and fair billing and collection practices and make access to those programs readily available to eligible patients. (Reaffirm HOD Policy)**

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the Recommendations in Council on Medical Service Report 1 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Recommendations in Council on Medical Service Report 1 adopted as amended and the remainder of the report be filed.

The Council on Medical Service recommends that the following recommendations be adopted in lieu of Resolution 802-I-23, and the remainder of the report be filed:

1) That our American Medical Association (AMA) support that all nonprofit hospitals be required to screen patients for charity care eligibility and other financial assistance program eligibility prior to billing. (New HOD Policy)

2) That our AMA support efforts to encourage debt collectors to ensure a patient has been screened for financial assistance eligibility before pursuing that patient for outstanding debt, provide an appeals process for those patients not screened previously or deemed ineligible, and require the hospital to reassume the debt account if an appeal is successful. (New HOD Policy)

3) That our AMA support development of minimum standards for nonprofit hospital financial assistance eligibility programs which are publicly accessible. (New HOD Policy)

4) That our AMA support a standardized definition of what is considered a "community benefit" when evaluating community health improvement activities. (New HOD Policy)

5) That our AMA support the development of a transparent, publicly available, standardized data set on community benefit including consideration of charity care-to-expense ratios. (New HOD Policy)

6) That our AMA support expansion of governmental oversight of nonprofit hospitals and enforcement of federal and/or state guidelines and standards for community benefit requirements including the ability to enact penalties and/or loss of tax-exempt status. (New HOD Policy)

7) That our AMA reaffirm existing Policy H-155.958, which states that the AMA will encourage hospitals to adopt, implement, monitor, and publicize policies on patient discounts, charity care, and fair billing and collection practices and make access to those programs readily available to eligible patients. (Reaffirm HOD Policy)

Online testimony on Council on Medical Service Report 1 was overwhelmingly supportive. An amendment was proffered to ensure that the language in the report recommendations were more proactive and actionable. This amendment received supportive testimony. The author provided in-person testimony in support of the Reference Committee recommendation. Your Reference Committee recommends that the recommendations in Council on Medical Service Report 1 be adopted as amended and the remainder of the report filed.

(14) CMS REPORT 4 – BIOSIMILAR COVERAGE STRUCTURES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Recommendation of Council on Medical Service Report 4 be amended by addition to read as follows:

That our American Medical Association (AMA):

(a) support the development and implementation of strategies to incentivize the use of lower cost biosimilars when safe, fiscally prudent for the patient and not financially disadvantageous to the clinical practice, clinically appropriate, and agreed upon as the best course of treatment by the patient and physician, and

(b) advocate to eliminate acquisition cost and reimbursement disparities for in-office biosimilar treatment across diverse treatment locations. (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the second Recommendation of Council on Medical Service Report 4 be amended by addition to read as follows:

That our AMA support patient education regarding biosimilars and their safety and efficacy. (New HOD Policy)

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the Recommendations in Council on Medical Service Report 4 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Recommendations in Council on Medical Service Report 4 be adopted as amended and the remainder of the report filed.

The Council on Medical Service recommends that the following recommendations be adopted and the remainder of the report be filed.

1. That our American Medical Association (AMA) support the development and implementation of strategies to incentivize the use of lower cost biosimilars when safe, fiscally prudent for the patient, clinically appropriate, and agreed upon as the best course of treatment by the patient and physician. (New HOD Policy)

2. That our AMA support patient education regarding biosimilars and their safety. (New HOD Policy)

3. That our AMA reaffirm Policy H-110.987, which works to ensure that prescription medications are affordable and accessible to patients. (Reaffirm HOD Policy)

4. That our AMA reaffirm Policy H-110.997 which supports the freedom of physicians in prescribing drugs for their patients and encourages physicians to supplement medical judgments with cost considerations in making these choices. (Reaffirm HOD Policy)

5. That our AMA reaffirm Policy D-125.989, which outlines efforts to ensure that physicians are able to transition patient to biosimilar medications with coverage from payers. (Reaffirm HOD Policy)

6. That our AMA reaffirm Policy H-125.972 which details efforts to encourage physician education related biosimilars. (Reaffirm HOD Policy)

Your Reference Committee heard testimony supportive of the Council on Medical Service Report 4. Testimony described the potential challenges around prescribing biosimilars, largely ensuring coverage from payers. Additionally, testimony outlined the need to ensure that patients have access to biosimilar medications when appropriate to limit cost-burdens on patients. Testimony proffered amendments to specify that physicians and physician offices would not face undue financial burdens as a result of biosimilar prescriptions. In-person testimony recommended minor amendments to the preliminary recommendation and adding efficacy education to patient education efforts mentioned in Recommendation 2. Due to the supportive testimony, both online and in-person, for the proffered amendments and report itself, your Reference Committee recommends that the recommendations in the Council on Medical Service Report 4 be adopted as amended and the remainder of the report filed.

(15) RESOLUTION 805 – COVERAGE FOR CARE FOR SEXUAL ASSAULT SURVIVORS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Resolve of Resolution 805 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association amend policy H-80.999 "Sexual Assault Survivors" by addition as follows:

1. Our AMA supports the preparation and dissemination of information and best practices intended to maintain and improve the skills needed by all practicing ~~physicians~~ clinicians involved in providing care to sexual assault survivors.

2. Our AMA advocates for the legal protection of sexual assault survivors' rights and work with state medical societies to ensure that each state implements these rights, which include but are not limited to, the right to: (a) receive a medical forensic examination free of charge, which includes but is not limited to HIV/STD testing and treatment, pregnancy testing ~~and prevention~~, drug testing for drug-facilitated assault, treatment of injuries, and collection of forensic evidence; (b) preservation of a sexual assault evidence collection kit for at least the maximum applicable statute of limitation; (c) notification of any intended disposal of a sexual assault evidence kit with the opportunity to be granted further preservation; (d) be informed of these rights and the policies governing the sexual assault evidence kit; and (e) access to emergency contraception information and treatment for pregnancy prevention free of charge.

3. Our AMA will collaborate with relevant stakeholders to develop recommendations for implementing best practices in the treatment of sexual assault survivors, including through engagement with the joint working group established for this purpose under the Survivor's Bill of Rights Act of 2016.

4. Our AMA will advocate for increased ~~post-pubertal~~ patient access to Sexual Assault Nurse Examiners, and other trained and qualified clinicians, in the emergency department for medical forensic examinations.

5. Our AMA will advocate at the state and federal level for (a) the timely processing of all sexual examination kits upon patient consent; (b) timely processing of "backlogged" sexual assault examination kits with patient consent; and (c) additional funding to facilitate the timely testing of sexual assault evidence kits.

6. Our AMA supports the implementation of a national database of Sexual Assault Nurse Examiner and Sexual Assault Forensic Examiner providers (Modify Current HOD Policy);

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the second Resolve of Resolution 805 be amended by addition to read as follows:

RESOLVED, that our AMA advocate for federal and state efforts to reduce financial barriers that limit sexual assault survivor's ability to seek physical and mental health care and social services after sexual assault, including funds to cover emergency, acute inpatient, and follow up services including testing, medications, and counseling without out-of-pocket costs for any patient.

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Resolution 805 be adopted as amended.

HOD ACTION: Resolution 805 adopted as amended.

RESOLVED, that our American Medical Association amend policy H-80.999 "Sexual Assault Survivors" by addition as follows:

1. Our AMA supports the preparation and dissemination of information and best practices intended to maintain and improve the skills needed by all practicing physicians involved in providing care to sexual assault survivors.

2. Our AMA advocates for the legal protection of sexual assault survivors' rights and work with state medical societies to ensure that each state implements these rights, which include but are not limited to, the right to: (a) receive a medical forensic examination free of charge, which includes but is not limited to HIV/STD testing and treatment, pregnancy testing and prevention, drug testing, treatment of injuries, and collection of forensic evidence; (b) preservation of a sexual assault evidence collection kit for at least the maximum applicable statute of limitation; (c) notification of any intended disposal of a sexual assault evidence kit with the opportunity to be granted further preservation; (d) be informed of these rights and the policies governing the sexual assault evidence kit; and (e) access to emergency contraception information and treatment for pregnancy prevention.

3. Our AMA will collaborate with relevant stakeholders to develop recommendations for implementing best practices in the treatment of sexual assault survivors, including through engagement with the joint working group established for this purpose under the Survivor's Bill of Rights Act of 2016.

4. Our AMA will advocate for increased post-pubertal patient access to Sexual Assault Nurse Examiners, and other trained and qualified clinicians, in the emergency department for medical forensic examinations.

5. Our AMA will advocate at the state and federal level for (a) the timely processing of all sexual examination kits upon patient consent; (b) timely processing of "backlogged" sexual assault examination kits with patient consent; and (c) additional funding to facilitate the timely testing of sexual assault evidence kits.

6. Our AMA supports the implementation of a national database of Sexual Assault Nurse Examiner and Sexual Assault Forensic Examiner providers (Modify Current HOD Policy); and be it further

RESOLVED, that our AMA advocate for federal and state efforts to reduce financial barriers that limit sexual assault survivors' ability to seek physical and mental health care and social services after sexual assault. (Directive to Take Action)

Your Reference Committee heard supportive online testimony on Resolution 805, which indicated the importance of making sure that adequate coverage is provided for post-assault exams. Amendments were proffered to specify the intent of the resolution and clarify the covered portions of the care offered. Both online and in-person testimony supported the online amendments as well as an additional amendment offered during the in-person hearing. Therefore, your Reference Committee recommends that Resolution 805 be adopted as amended.

(16) RESOLUTION 810 – IMMEDIATE DIGITAL ACCESS TO UPDATED MEDICATION FORMULARY FOR PATIENTS AND THEIR PHYSICIANS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 810 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association advocate for and support efforts for ~~the Centers for Medicare & Medicaid Services~~ payers to provide (or cause their associated carriers to provide) ~~hyperlink (such as a QR code) to~~ a digital, well-organized, and searchable formulary, including anticipated cost-sharing amounts and prior authorization requirements, that the patient or physician can easily access, with access instructions clearly included on the beneficiary's insurance card and/or online account webpage. ~~located on the insured's insurance card to all Medicare patients in such a manner that the patient can easily share and discuss covered medications with their prescribing physician during office appointments or other encounters.~~

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 810 be adopted as amended.

HOD ACTION: Resolution 810 adopted as amended.

RESOLVED, that our American Medical Association advocate for the Centers for Medicare & Medicaid Services to provide (or cause their associated carriers to provide) a hyperlink (such as a QR code) to a digital, well-organized, and searchable formulary located on the insured's insurance card to all Medicare patients in such a manner that the patient can easily share and discuss covered medications with their prescribing physician during office appointments or other encounters. (Directive To Take Action)

Your Reference Committee heard generally supportive testimony of Resolution 810; however, many testifiers suggested that the scope of the resolution be expanded beyond Medicare beneficiaries. A number of amendments to capture this expanded scope were proffered. Online testimony indicated the importance of ensuring that patients, along with their physicians, are able to view an accurate list of prescription medications included in their formulary. In-person testimony on Resolution 810 was largely supportive of the amended language, with some minor amendments to the proffered language. Additionally, a delegation proffered an amendment to ensure that the formulary included anticipated cost-sharing and prior authorization requirements. Testimony indicated concerns that the reference to specific types of technology (e.g., hyperlink and QR code) may be harmful should technology advance away from the referenced technology. Therefore, amendments were proffered to remove this portion of the resolution. Due to the overwhelming agreement in both online and in-person testimony to expand the scope of this resolution and specify the access and formulary information your Reference Committee recommends Resolution 810 be adopted as amended.

(17) RESOLUTION 811 – AMA PRACTICE EXPENSE SURVEY GEOGRAPHIC ANALYSIS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Resolve of Resolution 811 be <u>deleted</u>.

~~**RESOLVED, that our American Medical Association formally recognize that systemic bias in healthcare financing called "Structural Urbanism", has been a factor in leading to rural health disparities. (New HOD Policy)**~~

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the third Resolve of Resolution 811 be <u>amended by addition</u> to read as follows:

RESOLVED, that our AMA review the results from its 2023-2024 Physician Practice Information Survey to determine whether the data can be used to <u>generate statistically valid</u> estimate<u>s of</u> differences in physician practice expenses across practice geography (e.g., urban vs. rural, or region). (Directive to Take Action)

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the fourth Resolve of Resolution 811 be deleted.

~~**RESOLVED, that our AMA advocate for the Centers for Medicare and Medicaid Services use evidence rather than bias to determine if Geographic Practice Cost Indexes should continue to adjust physician payment regionally. (Directive to Take Action)**~~

RECOMMENDATION D:

Madam Speaker, your Reference Committee recommends that Resolution 811 be amended by addition of a new Resolve clause to read as follows:

RESOLVED, that our American Medical Association promote payment accuracy in the Medicare Geographic Practice Cost Index (GPCI). (New HOD Policy)

RECOMMENDATION E:

Madam Speaker, your Reference Committee recommends that Resolution 811 be amended by addition of a new Resolve clause to read as follows:

RESOLVED, that our AMA continue to strongly advocate for legislation to immediately improve physician shortages and access to care in rural areas, as long as the new funding is provided outside the budget neutrality limits in the Medicare Fee Schedule. (Directive to Take Action)

RECOMMENDATION F:

Madam Speaker, your Reference Committee recommends that Resolution 811 be adopted as amended.

HOD ACTION: Resolution 811 adopted as amended.

RESOLVED, that our American Medical Association formally recognize that systemic bias in healthcare financing called “Structural Urbanism”, has been a factor in leading to rural health disparities (New HOD Policy); and be it further

RESOLVED, that our AMA in advocating for health equity for all Americans, point out that Medicare payment policies have played a role in the shortage of rural physicians and the poorer health outcomes in rural America (Directive to Take Action); and be it further

RESOLVED, that our AMA review the results from its 2023-2024 Physician Practice Information Survey to determine whether the data can be used to estimate differences in physician practice

expenses across practice geography (e.g., urban vs. rural, or region) (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for the Centers for Medicare and Medicaid Services use evidence rather than bias to determine if Geographic Practice Cost Indexes should continue to adjust physician payment regionally. (Directive to Take Action)

Testimony on Resolution 811 was mixed, with speakers both supportive of, and opposed to, current Medicare Geographic Practice Cost Index (GPCI) adjustments established for every Medicare payment locality. One commenter highlighted the AMA's recent study on structural urbanism (Board of Trustees Report 13-I-22), which addressed efforts to cultivate the rural workforce and highlighted current challenges with federal payment policies specific to volume, coverage, and access. Comments strongly supportive of Resolution 811 emphasized that rural communities are systemically disadvantaged in part because the payment adjustments do not reflect practice costs. Additional supportive testimony cited high costs incurred by rural practices, and the fact that there are fewer patients to share in these costs.

Opponents noted that the resolves, as written, would reduce Medicare payments to urban and suburban physicians and that CMS already adjusts the work GPCI to benefit rural physicians. Opponents also testified that the best available data does not support major changes to the GPCIs. Amendments were proffered to delete Resolves 1, 2 and 4, edit Resolve 3, and add new resolve clauses that 1) promote payment accuracy in the Medicare GPCI, and 2) advocate for efforts aimed at improving physician shortages and access to care in rural areas, as long as the new funding is provided outside the budget neutrality limits in the Medicare Physician Payment Schedule.

Testimony also explained that the AMA's Physician Practice Information Survey was not intended to address geographic differences in practice costs. Commenters further asserted that the AMA's goal should be achieving Medicare payment increases that cover the practice costs of all physicians. Having heard both sides and in an attempt at compromise, your Reference Committee preliminarily recommended deleting the first and fourth resolves of Resolution 811; amending Resolve 3; and adding the two new resolves that were proffered in testimony. Because in-person testimony strongly supported our preliminary recommendation, your Reference Committee recommends that Resolution 811 be adopted as amended.

(18) RESOLUTION 815 – ADDRESSING THE CRISIS OF PEDIATRIC HOSPITAL CLOSURES AND IMPACT ON CARE

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Resolve clause in Resolution 815 be <u>amended by addition</u> to read as follows:

RESOLVED, that our American Medical Association recognize the closure of pediatric hospitals and units<u>, including pediatric inpatient psychiatry units and hospitals</u>, as a critical threat to children's health care access and quality (New HOD Policy); and be it further

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the second Resolve clause in Resolution 815 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA ~~advocate for~~ support federal and state policies to support the financial viability and access to pediatric care delivery organizations, particularly inpatient care units (Directive to Take Action); and be it further

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the third Resolve clause in Resolution 815 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA work with interested ~~relevant~~ organizations to improve access to care and reduce health disparities arising from pediatric hospital and unit closures~~, for example the American Academy of Pediatrics, American Hospital Association, Children's Hospital Association, and National Rural Health Association, to study the current and future projected impact of pediatric hospital and unit closures on health outcomes, access to care, and health disparities~~ (Directive to Take Action); and be it further

RECOMMENDATION D:

Madam Speaker, your Reference Committee recommends that the fourth Resolve clause in Resolution 815 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA work with interested organizations ~~build a national coalition with the American Hospital Association and other like-minded organizations~~ to increase awareness on the issue of pediatric hospital closures and to develop strategies to preserve access to high-quality pediatric emergency, inpatient, and critical care. (Directive to Take Action)

RECOMMENDATION E:

Madam Speaker, your Reference Committee recommends that Resolution 815 be adopted as amended.

HOD ACTION: Resolution 815 adopted as amended.

RESOLVED, that our American Medical Association recognize the closure of pediatric hospitals and units as a critical threat to children's health care access and quality (New HOD Policy); and be it further

RESOLVED, that our AMA advocate for federal and state policies to support the financial viability and access to pediatric care delivery organizations, particularly inpatient care units (Directive to Take Action); and be it further

RESOLVED, that our AMA work with relevant organizations, for example the American Academy of Pediatrics, American Hospital Association, Children's Hospital Association, and National Rural Health Association, to study the current and future projected impact of pediatric hospital and unit closures on health outcomes, access to care, and health disparities (Directive to Take Action); and be it further

RESOLVED, that our AMA build a national coalition with the American Hospital Association and other like-minded organizations to increase awareness on the issue of pediatric hospital closures and to develop strategies to preserve access to high-quality pediatric inpatient and critical care. (Directive to Take Action)

Your Reference Committee heard testimony supportive of Resolution 815. There were suggested amendments to the third and fourth resolves to broaden the language by changing to "all interested stakeholders" to encompass any organizations that may be interested in these efforts. In addition, there was an amendment proffered by the Council on Medical Service to the fourth resolve clause to remove the reference to building a national coalition, as it would be more appropriate for these efforts to be spearheaded by another organization and for the AMA to then support these efforts. Finally, there were amendments proposed to include emergency and psychiatric care in addition to pediatric inpatient units. Your Reference Committee recommends amendments to broaden the language in the third and fourth resolves, add references to psychiatric and emergency care, and change the fourth resolve to working with interested organizations on these efforts, as opposed to the AMA building a national coalition, which may be more appropriate for another organization. The author of the original resolution testified in favor of the amendments proffered. Your Reference Committee recommends that Resolution 815 be adopted as amended.

(19) RESOLUTION 818 – PAYMENT FOR PRE-CERTIFIED/PREAUTHORIZED PROCEDURES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Resolve of Resolution 818 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association support the position that the practice of retrospective denial of payment or payment recoupment for care which has been pre-certified by an insurer should be ~~banned~~ prohibited under federal statute, except when materially false or fraudulent information has knowingly been given to the insurer by the physician, hospital or ancillary service provider to obtain pre-certification (New HOD Policy); and be it further

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 818 be <u>amended by addition of a new Resolve clause</u> to read as follows:

<u>RESOLVED, that our AMA encourages legal action against health plans that engage in inappropriate post-service payment denials and payment recoupment. (Directive to Take Action)</u>

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Resolution 818 be <u>adopted as amended</u>.

HOD ACTION: Resolution 818 <u>adopted as amended</u>.

RESOLVED, that our American Medical Association support the position that the practice of retrospective denial of payment for care which has been pre-certified by an insurer should be banned, except when false or fraudulent information has knowingly been given to the insurer by the physician, hospital or ancillary service provider to obtain pre-certification (New HOD Policy); and be it further

RESOLVED, that our AMA continue to advocate for legislation, regulation, or other appropriate means to ensure that all health plans including those regulated by ERISA, pay for services that are pre-authorized, or pre-certified by such health plan, including services that are deemed pre-authorized or pre-certified because the physician participates in a "Gold Card" program operated by that health plan. (Directive to Take Action)

Your Reference Committee heard supportive testimony of Resolution 818. Testimony outlined the frustration and disruptions that can occur when payment for a procedure is retrospectively denied. Testimony proffered minor amendments to the first resolve clause in order to clarify the wording of the submitted resolution, these amendments received support in testimony. Additionally, testimony was offered to ensure that physicians are encouraged in taking legal action should they encounter post-service denials. In-person testimony was unanimously supportive of the amended language; therefore, your Reference Committee recommends that Resolution 818 be adopted as amended.

(20) RESOLUTION 820 – STATE MEDICAID COVERAGE OF HOME SLEEP TESTING

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 820 be <u>amended by addition</u> to read as follows:

RESOLVED, that our American Medical Association support efforts to expand access to and insurance coverage of <u>physician-ordered</u> home sleep testing, including for Medicaid beneficiaries, for the purpose of identifying sleep apnea and related sleep conditions. (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 820 be <u>adopted as amended</u>.

HOD ACTION: Resolution 820 <u>adopted</u>.

RESOLVED, that our American Medical Association support efforts to expand access to and insurance coverage of home sleep testing, including for Medicaid beneficiaries, for the purpose of identifying sleep apnea and related sleep conditions. (New HOD Policy)

Your Reference Committee heard supportive online testimony of Resolution 820, which expressed the need to ensure that all patients can access home sleep testing when needed. An online amendment was proffered to qualify that covered services are clinically appropriate; however, some testified that this may cause more hurdles to patient access. Therefore, your Reference Committee proffered the language "physician-ordered" to address concerns. Based on the supportive testimony for the revised amendment, your Reference Committee recommends that Resolution 820 be adopted as amended.

(21) RESOLUTION 821 – PATIENT ACCESS TO ASTHMA MEDICATIONS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 821 be <u>amended by addition</u> to read as follows:

RESOLVED, that our American Medical Association supports efforts to ensure access to and insurance coverage, including Medicaid coverage, <u>and reduce cost-sharing</u> for metered-dose inhaler formulations for children and others who require it for optimal medication administration. (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 821 be <u>adopted as amended</u>.

HOD ACTION: Resolution 821 <u>adopted as amended</u>.

RESOLVED, that our American Medical Association supports efforts to ensure access to and insurance coverage, including Medicaid coverage, for metered-dose inhaler formulations for children and others who require it for optimal medication administration. (New HOD Policy)

Online testimony on Resolution 821 was strongly supportive, with one proffered amendment to strengthen the resolution and ensure that patients are able to access affordable prescription medication. The author, as well as two additional delegations, supported the Reference Committee recommendation. Due to the overwhelmingly supportive testimony, your Reference Committee recommends that Resolution 821 be adopted as amended.

(22) RESOLUTION 823 – REINING IN MEDICARE ADVANTAGE - INSTITUTIONAL SPECIAL NEEDS PLANS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the third Resolve clause of Resolution 823 be deleted.

~~**RESOLVED, that our AMA advocate for an overall ban on facility-owned I-SNPs. (Directive to Take Action)**~~

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 823 be adopted as amended.

HOD ACTION: Resolution 823 adopted as amended.

RESOLVED, that our American Medical Association add I-SNPs to its advocacy efforts related to Medicare Advantage plans (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for increased policies, rules, and general oversight over I-SNPs (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for an overall ban on facility-owned I-SNPs. (Directive to Take Action)

Your Reference Committee heard mixed testimony on Resolution 823. The resolution was recommended for reaffirmation and testimony was provided opposing reaffirmation and in favor of adoption. During its review, the Reference Committee noted that the resolve clauses of Resolution 823 are contradictory. The Reference Committee believes that the resolution should not call for adding I-SNP plans to AMA advocacy efforts as well as calling for an outright ban on these plans. For this reason, your Reference Committee offers amendments to delete the third resolve in order to streamline and clarify the language of Resolution 823, while maintaining the spirit. The authors of this resolution testified in support of this amended language. Your Reference Committee recommends that Resolution 823 be adopted as amended.

RECOMMENDED FOR REFERRAL

(23) RESOLUTION 803 – HEALTHCARE SAVINGS ACCOUNT REFORM

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 803 be referred.

HOD ACTION: Resolution 803 referred.

RESOLVED, that our American Medical Association advocate for revision of Health Savings Accounts to:
1. Permit contributions from family members, employers, or other designated individuals, not limiting contributions to only those on high deductible health insurance plans;
2. Permit contributions to the accounts of dependents, including children and spouses;
3. Permit contributions from Medicare and Medicaid enrollees;
4. Permit the payment of health, dental, and vision insurance premiums from Health Savings Accounts;
5. Permit the money spent by an employer on health insurance to be directed, in part, into an employee HSA, at the employee's discretion;
6. Prioritize permitting the transfer of funds between HSAs, including between spouses and family members; and
7. Ensure that the expansion of the role and functions of Health Savings Accounts is complementary to, and does not replace, health insurance. (Modify Current HOD Policy)

Testimony on Resolution 803 was mixed, with supportive comments touting the potential tax advantages of health savings accounts (HSAs) and opponents raising concerns about the implications of expanding HSAs, including potential adverse effects on the risk pool, equity concerns, and problems with high deductible plans.

Your Reference Committee preliminarily recommended that Resolutions 803 and 807 be considered together and referred for study. A majority of in-person testimony supported this recommendation, with one AMA section requesting that the study consider whether the AMA could support allowing leftover ACA premium tax credits (i.e., when a selected plan's premium is lower than the premium tax credit) to be deposited into an account for patients to use on health expenses, including HSAs. Accordingly, your Reference Committee recommends that Resolution 803 be referred.

(24) RESOLUTION 807 - EXPANDED PLURALISM IN MEDICAID

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 807 be referred.

HOD ACTION: Resolution 807 not adopted.

Resolution 807

RESOLVED, that our American Medical Association suggest Medicaid reform that introduces more pluralism for Medicaid beneficiaries (New HOD Policy); and be it further

RESOLVED, that our AMA advocate for inclusion of choices of plan that allow Medicaid beneficiaries to directly benefit financially from using our healthcare system in a more cost-effective way (Directive to Take Action); and be it further

RESOLVED, that our AMA investigate whether the Health Savings Account (HSA) model could be adapted as one option in an expanded pluralistic system that would enable Medicaid beneficiaries to directly benefit from utilizing the healthcare system in a more cost-effective manner and, in doing so, offer Medicaid beneficiaries an opportunity to create generational wealth. (Directive to Take Action)

Testimony on Resolution 807 was mixed. A preponderance of the testimony opposed adoption of Resolve 3, with commenters noting that HSAs are not practical for many families covered by Medicaid. Testimony emphasized that tax-related recommendations for expanding HSAs should be reviewed by experts on that topic and that a study on the impact of HSAs on tax policy, health care financing, and patient outcomes would be very useful. Your Reference Committee preliminarily recommended that Resolutions 803 and 807 be considered together and referred for study. Accordingly, your Reference Committee recommends that Resolution 807 be referred.

(25) RESOLUTION 809 – MINIMUM REQUIREMENTS FOR MEDICATION FORMULARIES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 809 referred.

HOD ACTION: Resolution 809 referred.

RESOLVED, that our American Medical Association advocate that Medicare, Medicaid, and all other insurers create, maintain, and enforce a minimum formulary for all beneficiaries, regardless of their specific plan, that includes all commonly prescribed, inexpensive, generic medications unless there are reasonable safety or economic concerns regarding the medication. (Directive to Take Action)

Your Reference Committee heard limited but somewhat supportive testimony for the intent of Resolution 809. Testimony expressed the importance of ensuring that patients have access to the medications they are prescribed. The Council on Medical Service expressed concern regarding the practicality of the resolution as written. Specifically, the Council outlined concerns about the vagueness of the wording surrounding the medications that would be required to be listed in the resolution. Your Reference Committee heard the concerns expressed by the Council on Medical Service and feel that the resolution, as currently written, was non-specific. Specifically, concerns around the vagueness of what minimum formulary requirements were to be enforced and which medications should be included in that formulary. In-person testimony was also limited but expressed the intent of the resolution and outlined that, if appropriately fleshed out, it could make for policy that would support physician practice and patient access to prescriptions. Due to the concerns raised by the Council online and the in-person testimony outlining the potential helpfulness of the resolution's intent your Reference Committee recommends that Resolution 809 be referred.

(26) RESOLUTION 817 – ACA SUBSIDIES FOR UNDOCUMENTED IMMIGRANTS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 817 be referred.

HOD ACTION: Resolution 817 adopted.

RESOLVED, that our American Medical Association support federal and state efforts to provide subsidies for undocumented immigrants to purchase health insurance, including by extending eligibility for premium tax credits and cost-sharing reductions to purchase Affordable Care Act (ACA) plans. (New HOD Policy)

Testimony on Resolution 817 was mixed. Supportive comments spoke to the need to build on existing AMA policies (e.g., Policy H-165.823 and D-440.911) which already advocate that undocumented immigrants should be eligible for Affordable Care Act (ACA), Medicaid, and CHIP coverage. These commenters noted that the resolution would make subsidies available and ACA plans more affordable. Opposing testimony ranged from a suggestion that coverage gaps

experienced by U.S. citizens should be addressed before ACA subsidies are extended to undocumented people to more general opposition to subsidies being given to this population.

Online testimony both strongly supported and opposed Resolution 817. Your Reference Committee preliminarily recommended reaffirmation of Policy H-165.823[4], which supports extending eligibility to purchase ACA coverage to undocumented immigrants and recognizes the potential for state and local initiatives to provide coverage to immigrants without regard to immigration status, in lieu of Resolution 817. In-person testimony largely opposed reaffirmation and supported adoption of Resolution 817, although some speakers raised potential unintended consequences of both extending the subsidies to undocumented people, and not extending the subsidies to this population. Your Reference Committee believes that such unintended consequences should be explored before new policy is adopted and recommends that Resolution 817 be referred.

RECOMMENDED FOR REFERRAL FOR DECISION

(27) RESOLUTION 814 – LEGISLATION FOR PHYSICIAN PAYMENT FOR PRIOR AUTHORIZATION

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 814 be referred for decision.

HOD ACTION: Resolution 814 referred for decision.

RESOLVED, that our American Medical Association initiates prior authorization legislation aimed at Medicare Advantage plans, state Medicaid programs as well as commercial payers, via model legislation, that allows for fair reimbursement for physician's time and that of their office staff when dealing with prior authorization. (Directive to Take Action)

Your Reference Committee heard passionate and mixed testimony on Resolution 814. Testimony indicated the extreme frustration that prior authorization causes to physicians on a regular basis, and some suggested that payment for prior authorization could result in the diminishing of the practice itself. However, other testimony, including that from members, the Council on Legislation (COL), the Council on Medical Service (CMS), and the Board of Trustees (BOT), raised intense concern that payment for prior authorization would be viewed as legitimizing an invasive process that causes great harm to patients. Additionally, testimony provided by both CMS and COL indicated the extensive advocacy efforts that the AMA is undertaking to reform prior authorization (as noted in Board of Trustees Report 20-I-24) and expressed concern that the position of 814 could harm these efforts, especially the work of state medical associations with patient coalitions. Finally, CMS outlined findings from past reports that echoed the concerns that arose in testimony for Resolution 814. In reviewing testimony, your Reference Committee understood and sympathized with the legitimate concerns expressed regarding prior authorization and believes

that the intent of this resolution, to be paid for administrative work related to prior authorization, is covered by the ongoing efforts of AMA campaigns and work by the BOT.

In-person testimony primarily focused on debate between referral for decision and referral. One individual reemphasized the merits of the resolution and the burden that prior authorization places on physicians. Proponents of referring Resolution 814 testified to the hurdles faced when dealing with prior authorization. However, those testifying in favor of referral for decision emphasized the extensive work that has been, and continues to be, done by the AMA on this topic. Testimony conveyed a desire to have a decision made on this issue in an expeditious manner. Additional testimony expressed concern that allocating resources to study an issue that has been studied extensively is not only duplicative but could harm other AMA efforts by reducing their resources.

Based on the significant concern expressed in the mixed online testimony, the expansive efforts being made by the AMA, and the in-person testimony outlining the need for an expeditious and resource-efficient outcome for this item your Reference Committee recommends that Resolution 814 be referred for decision.

RECOMMENDED FOR REAFFIRMATION IN LIEU OF

(28) RESOLUTION 801 – REIMBURSEMENT FOR MANAGING PORTAL MESSAGES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Policies H-385.919, H-385.951, and H-270.962 be reaffirmed in lieu of Resolution 801.

HOD ACTION: Policies H-385.919, H-385.951, and H-270.962 reaffirmed in lieu of Resolution 801.

RESOLVED, that our American Medical Association immediately collaborate with payers to seek adequate reimbursement for professional time spent answering questions on the patient portal not related to a recent visit (Directive to Take Action); and be it further

RESOLVED, that our AMA continue to advocate for physicians to receive adequate compensation or seek relief from overreaching administrative tasks that take physicians' time away from direct patient care during our present climate of ever-increasing unpaid and unfunded mandates on their time. (Directive to Take Action)

Your Reference Committee heard testimony from four delegations supporting reaffirmation of existing policy in lieu of Resolution 801. Testimony from one delegation opposed Resolution 801 as written. In-person testimony did not oppose reaffirmation and therefore, your Reference Committee recommends that Policies H-385.919, H-385.951, and H-270.962 be reaffirmed in lieu of this resolution.

PAYMENT FOR ELECTRONIC COMMUNICATION, H-385.919

Our AMA will: (1) advocate that pilot projects of innovative payment models be structured to include incentive payments for the use of electronic communications such as Web portals, remote patient monitoring, real-time virtual office visits, and email and telephone communications; (2) continue to update its guidance on communication and information technology to help physicians meet the needs of their patients and practices; and (3) educate physicians on how to effectively and fairly bill for electronic communications between patients and their physicians.
(CMS Rep. 1, A-10; Reaffirmed in lieu of Res. 705, A-11; Reaffirmation: I-18)

REMUNERATION FOR PHYSICIAN SERVICES, H-385.951
1. Our American Medical Association actively supports payment to physicians by contractors and third party payers for physician time and efforts in providing case management and supervisory services, including but not limited to coordination of care and office staff time spent to comply with third party payer protocols.
2. It is our AMA policy that insurers pay physicians fair compensation for work associated with prior authorizations, including pre-certifications and prior notifications, that reflects the actual time expended by physicians to comply with insurer requirements and that compensates physicians fully for the legal risks inherent in such work.
3. Our AMA urges insurers to adhere to the AMA's Health Insurer Code of Conduct Principles including specifically that requirements imposed on physicians to obtain prior authorizations, including pre-certifications and prior notifications, must be minimized and streamlined and health insurers must maintain sufficient staff to respond promptly.
(Sub. Res. 814, A-96; Reaffirmation: A-02; Reaffirmation: I-08; Reaffirmation: I-09; Appended: Sub. Res. 126, A-10; Reaffirmed in lieu of Res. 719, A-11; Reaffirmed in lieu of Res. 721, A-11; Reaffirmation: A-11; Reaffirmed in lieu of Res. 822, I-11; Reaffirmed in lieu of Res. 711, A-14; Reaffirmed: Res. 811, I-19; Reaffirmation: A-22; Reaffirmed: BOT Rep. 30, A-24)

UNFUNDED MANDATES, H-270.962
Our AMA vigorously opposes any unfunded mandates on physicians.
(Res. 217, A-03; Reaffirmed: CMS Rep. 4, A-13; Reaffirmation: A-16; Reaffirmed: BOT Rep. 16, A-19)

(29) RESOLUTION 802 – ADDRESS PHYSICIAN BURNOUT WITH INBOX MANAGEMENT RESOURCES AND INCREASED PAYMENT

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Policies H-270.962, D-310.968, H-400.972, H-400.991, D-405.972, D-450.980, D-478.976, and D-478.995 be reaffirmed in lieu of Resolution 802.

HOD ACTION: Policies H-270.962, D-310.968, H-400.972, H-400.991, D-405.972, D-450.980, D-478.976, and D-478.995 reaffirmed in lieu of Resolution 802.

RESOLVED, that our American Medical Association develop additional inbox management resources (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for increasing the relative value unit for inbox management recognizing that it is asynchronous care that provides value and reduces overall health care costs (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for electronic health record tools that calculate physician time spent in the inbox. (Directive to Take Action)

Your Reference Committee heard mixed testimony on Resolution 802. There was testimony in favor of reaffirming AMA policy in lieu of the resolution, testimony amending the resolution, and testimony opposing the resolution. All those that testified agreed with the spirit of the resolution, both in person and online. Therefore, your Reference Committee believes that reaffirmation will achieve the goal of this resolution and thus recommends that Policies H-270.962, D-310.968, H-400.972, H-400.991, D405.972, D-450.980, D-478.976, and D-478.995 be reaffirmed in lieu of Resolution 802.

UNFUNDED MANDATES, H-270.962
Our AMA vigorously opposes any unfunded mandates on physicians. (Res. 217, A-03; Reaffirmed: CMS Rep. 4, A-13; Reaffirmation: A-16; Reaffirmed: BOT Rep. 16, A-19)

PHYSICIAN AND MEDICAL STUDENT BURNOUT, D-310.968

1. Our American Medical Association recognizes that burnout, defined as emotional exhaustion, depersonalization, and a reduced sense of personal accomplishment or effectiveness, is a problem among residents, fellows, and medical students.
2. Our AMA will work with other interested groups to regularly inform the appropriate designated institutional officials, program directors, resident physicians, and attending faculty about resident, fellow, and medical student burnout (including recognition, treatment, and prevention of burnout) through appropriate media outlets.
3. Our AMA will encourage partnerships and collaborations with accrediting bodies (e.g., the Accreditation Council for Graduate Medical Education and the Liaison Committee on Medical Education) and other major medical organizations to address the recognition, treatment, and prevention of burnout among residents, fellows, and medical students and faculty.

4. Our AMA will encourage further studies and disseminate the results of studies on physician and medical student burnout to the medical education and physician community.
5. Our AMA will continue to monitor this issue and track its progress, including publication of peer-reviewed research and changes in accreditation requirements.
6. Our AMA encourages the utilization of mindfulness education as an effective intervention to address the problem of medical student and physician burnout.
7. Our AMA will encourage medical staffs and/or organizational leadership to anonymously survey physicians to identify local factors that may lead to physician demoralization.
8. Our AMA will continue to offer burnout assessment resources and develop guidance to help organizations and medical staffs implement organizational strategies that will help reduce the sources of physician demoralization and promote overall medical staff well-being.
9. Our AMA will continue to:
    a. address the institutional causes of physician demoralization and burnout, such as the burden of documentation requirements, inefficient work flows and regulatory oversight.
    b. develop and promote mechanisms by which physicians in all practices settings can reduce the risk and effects of demoralization and burnout, including implementing targeted practice transformation interventions, validated assessment tools and promoting a culture of well-being.

(CME Rep. 8, A-07; Modified: Res. 919, I-11; Modified: BOT Rep. 15, A-19; Reaffirmation; A-22)

PHYSICIAN PAYMENT REFORM, H-400.972

1. It is the policy of our American Medical Association to take all necessary legal, legislative, and other action to redress the inequities in the implementation of the RBRVS, including, but not limited to:
    a. Reduction of allowances for new physicians.
    b. The non-payment of EKG interpretations.
    c. Defects in the Geographic Practice Cost Indices and area designations.
    d. Inappropriate Resource-Based Relative Value Units.
    e. The deteriorating economic condition of physicians' practices disproportionately affected by the Medicare payment system.
    f. The need for restoration of the RBRVS conversion factor to levels consistent with the statutory requirement for budget neutrality.
    g. The inadequacy of payment for services of assistant surgeons.
    h. The loss of surgical-tray benefit for many outpatient procedures (Reaffirmed by Rules & Credentials Cmt., A-96);
2. Seek an evaluation of:
    a. Stress factors (i.e., intensity values) as they affect the calculation of the Medicare Payment Schedule, seeking appropriate, reasonable, and equitable adjustments.
    b. Descriptors (i.e., vignettes) and other examples of services used to determine RBRVS values and payment levels and to

seek adjustments so that the resulting values and payment levels appropriately pertain to the elderly and often infirm patients.

3. Evaluate the use of the RBRVS on the calculation of the work component of the Medicare Payment Schedule and to ascertain that the concept for the work component continues to be an appropriate part of a resource-based relative value system.
4. Seek to assure that all modifiers, including global descriptors, are well publicized and include adequate descriptors.
5. Seek the establishment of a reasonable and consistent interpretation of global fees, dealing specifically with preoperative office visits, concomitant office procedures, and/or future procedures.
6. Seek from CMS and/or Congress an additional comment period beginning in the Fall of 1992.
7. Seek the elimination of regulations directing patients to points of service.
8. Support further study of refinements in the practice cost component of the RBRVS to ensure better reflection of both absolute and relative costs associated with individual services, physician practices, and medical specialties, considering such issues as data adequacy, equity, and the degree of disruption likely to be associated with any policy change.
9. Take steps to assure that relative value units in the Medicare payment schedule, such as nursing home visits, are adjusted to account for increased resources needed to deliver care and comply with federal and state regulatory programs that disproportionately affect these services and that the Medicare conversion factor be adjusted and updated to reflect these increased overall costs.
10. Support the concepts of HR 4393 (the Medicare Geographic Data Accuracy Act of 1992), S 2680 (the Medicare Geographic Data Accuracy Act of 1992), and S 2683 (Medicare Geographic Data Accuracy Act) for improving the accuracy of the Medicare geographic practice costs indices (GPCIs) and work with CMS and the Congress to assure that GPCIs are updated in as timely a manner as feasible and reflect actual physician costs, including gross receipt taxes.
11. Request that CMS refine relative values for particular services on the basis of valid and reliable data and that CMS rely upon the work of the AMA/Specialty Society RVS Updating Committee (RUC) for assignment of relative work values to new or revised CPT codes and any other tasks for which the RUC can provide credible recommendations.
12. Pursue aggressively recognition and CMS adoption for Medicare payment schedule conversion factor updates of an index providing the best assurance of increases in the monetary conversion factor reflective of changes in physician practice costs, and to this end, to consider seriously the development of a "shadow" Medicare Economic Index.
13. Continue to implement and refine the Payment Reform Education Project to provide member physicians with accurate and timely information on developments in Medicare physician payment reform.

14. Take steps to assure all relative value units contained in the Medicare Fee Schedule are adjusted as needed to comply with ever-increasing federal and state regulatory requirements.
(Sub. Res. 109, A-92; Reaffirmed: I-92; Reaffirmed by CMS Rep. 8, A-95 and Sub. Res. 124, A-95; Reaffirmation A-99 and Reaffirmed; Res. 127, A-99; Reaffirmation: A-02; Reaffirmation: A-06; Reaffirmation: I-07; Reaffirmed: BOT Rep. 14, A-08; Reaffirmation: A-09; Reaffirmed: CMS Rep. 01, A-19; Reaffirmed: Res. 212, I-21)

GUIDELINES FOR THE RESOURCE-BASED RELATIVE VALUE SCALE, H-400.991

1. Our American Medical Association reaffirms its current policy in support of adoption of a fair and equitable Medicare indemnity payment schedule under which physicians would determine their own fees and Medicare would establish its payments for physician services using:
    a. An appropriate RVS based on the resource costs of providing physician services.
    b. An appropriate monetary conversion factor.
    c. An appropriate set of conversion factor multipliers.
2. Our AMA supports the position that the current Harvard RBRVS study and data, when sufficiently expanded, corrected and refined, would provide an acceptable basis for a Medicare indemnity payment system.
3. Our AMA reaffirms its strong support for physicians' right to decide on a claim-by-claim basis whether or not to accept Medicare assignment and its opposition to elimination of balance billing. (Reaffirmed: Sub. Res. 132, A-94)
4. Our AMA reaffirms its opposition to the continuation of the Medicare maximum allowable actual charge (MAAC) limits.
5. Our AMA promotes enhanced physician discussion of fees with patients as an explicit objective of a Medicare indemnity payment system.
6. Our AMA supports expanding its activities in support of state and county medical society-initiated voluntary assignment programs for low-income Medicare beneficiaries.
7. Our AMA reaffirms its current policy that payments under a Medicare indemnity payment system should reflect valid and demonstrable geographic differences in practice costs, including professional liability insurance premiums. In addition, as warranted and feasible, the costs of such premiums should be reflected in the payment system in a manner distinct from the treatment of other practice costs.
8. Our AMA believes that payment localities should be determined based on principles of reasonableness, flexibility and common sense (e.g., localities could consist of a combination of regions, states, and metropolitan and nonmetropolitan areas within states) based on the availability of high quality data.
9. Our AMA believes that, in addition to adjusting indemnity payments based on geographic practice cost differentials, a method of adjusting payments to effectively remedy demonstrable access problems in specific geographic areas should be developed and implemented.
10. Where specialty differentials exist, criteria for specialty designation should avoid sole dependence on rigid criteria, such as board

certification or completion of residency training. Instead, a variety of general national criteria should be utilized, with carriers having sufficient flexibility to respond to local conditions. In addition to board certification or completion of a residency, such criteria could include, but not be limited to:

a. Partial completion of a residency plus time in practice.
b. Local peer recognition
c. Carrier analysis of practice patterns. A provision should also be implemented to protect the patients of physicians who have practiced as specialists for a number of years.

11. Our AMA strongly opposes any attempt to use the initial implementation or subsequent use of any new Medicare payment system to freeze or cut Medicare expenditures for physician services in order to produce federal budget savings.
12. Our AMA believes that whatever process is selected to update the RVS and conversion factor, only the AMA has the resources, experience and umbrella structure necessary to represent the collective interests of medicine, and that it seek to do so with appropriate mechanisms for full participation from all of organized medicine, especially taking advantage of the unique contributions of national medical specialty societies.

BOT Rep. AA, I-88; Reaffirmed: I-92; Reaffirmed and Modified: CMS Rep. 10, A-03; Reaffirmation: A-06; Reaffirmed: CMS Rep. 01, A-16; Reaffirmed: Res. 212, I-21)

PHYSICIAN BURNOUT, D-405.972

1. Our American Medical Association will work with Centers for Medicare and Medicaid Services (CMS), The Joint Commission, and other accrediting bodies and interested stakeholders to add an institutional focus on physician wellbeing as an accreditation standard for hospitals, focusing on system-wide interventions that do not add additional burden to physicians.
2. Our AMA will work with hospitals and other stakeholders to determine areas of focus on physician wellbeing, to include the removal of intrusive questions regarding physician physical or mental health or related treatments on initial or renewal hospital credentialing applications.

(Res. 723, A-22; Reaffirmation: I-22)

PHYSICIAN TIME SPENT WITH PATIENTS AND WITH HOSPITAL DOCUMENTATION, D-450.980

Our AMA will:

(1) advocate for continued research into quality determinants--including time spent with patients--and lead the effort to develop and appropriately implement quality indicators, i.e., clinical performance measures;

(2) continue to work with accrediting bodies and government agencies to substantially reduce hospital paperwork; and

(3) continue to work with electronic health record (EHR) system developers to ensure that the perspectives of practicing physicians are adequately incorporated, to ensure the standardization and integration

of clinical performance measures developed by physicians for physicians, and to ensure a seamless integration of the EHR into the day-to-day practice of medicine.
(BOT Action in response to referred for decision Res. 511, A-03; Reaffirmation: I-10; Reaffirmed: BOT Rep. 04, A-20)

INNOVATION TO IMPROVE USABILITY AND DECREASE COSTS OF ELECTRONIC HEALTH RECORD SYSTEMS FOR PHYSICIANS, D-478.976
1) Our AMA will: (A) advocate for CMS and the Office of the National Coordinator (ONC) to support collaboration between and among proprietary and open-source EHR developers to help drive innovation in the marketplace; (B) continue to advocate for research and physician education on EHR adoption and design best practices specifically concerning key features that can improve the quality, safety, and efficiency of health care regardless of proprietary or open-source status; and (C) through its partnership with AmericanEHR Partners, continue to survey physician use and issues with various EHRs-open source and proprietary-to create more transparency and support more informed decision making in the selection of EHRs.
2) Our AMA will, through partnership with AmericanEHR Partners, continue to survey physician use and issues with various EHRs--open source and proprietary--to create more transparency and formulate more formal decision making in the selection of EHRs.
3) Our AMA will work with AmericanEHR Partners to modify the current survey to better address the economics of EHR use by physicians including the impact of scribes.
4) Our AMA will make available the findings of the AmericanEHR Partners' survey and report back to the House of Delegates.
(BOT Rep. 23, A-13; BOT Rep. 24, A-13; Reaffirmed: BOT Rep. 17, A-15; Appended: Res. 603, I-16; Modified: BOT Rep. 20, A-17)

NATIONAL HEALTH INFORMATION TECHNOLOGY, D-478.995
1. Our American Medical Association will closely coordinate with the newly formed Office of the National Health Information Technology Coordinator all efforts necessary to expedite the implementation of an interoperable health information technology infrastructure, while minimizing the financial burden to the physician and maintaining the art of medicine without compromising patient care.
2. Our AMA:
    a. Advocates for standardization of key elements of electronic health record (EHR) and computerized physician order entry (CPOE) user interface design during the ongoing development of this technology.
    b. Advocates that medical facilities and health systems work toward standardized login procedures and parameters to reduce user login fatigue.
    c. Advocates for continued research and physician education on EHR and CPOE user interface design specifically concerning key design principles and features that can improve the quality, safety, and efficiency of health care.

d. Advocates for continued research on EHR, CPOE and clinical decision support systems and vendor accountability for the efficacy, effectiveness, and safety of these systems.

3. Our AMA will request that the Centers for Medicare & Medicaid Services:
   a. Support an external, independent evaluation of the effect of Electronic Medical Record (EMR) implementation on patient safety and on the productivity and financial solvency of hospitals and physicians' practices.
   b. Develop, with physician input, minimum standards to be applied to outcome-based initiatives measured during this rapid implementation phase of EMRs.
4. Our AMA will
   a. seek legislation or regulation to require all EHR vendors to utilize standard and interoperable software technology components to enable cost efficient use of electronic health records across all health care delivery systems including institutional and community based settings of care delivery.
   b. work with CMS to incentivize hospitals and health systems to achieve interconnectivity and interoperability of electronic health records systems with independent physician practices to enable the efficient and cost effective use and sharing of electronic health records across all settings of care delivery.
5. Our AMA will seek to incorporate incremental steps to achieve electronic health record (EHR) data portability as part of the Office of the National Coordinator for Health Information Technology's (ONC) certification process.
6. Our AMA will collaborate with EHR vendors and other stakeholders to enhance transparency and establish processes to achieve data portability.
7. Our AMA will directly engage the EHR vendor community to promote improvements in EHR usability.
8. Our AMA will advocate for appropriate, effective, and less burdensome documentation requirements in the use of electronic health records.
9. Our AMA will urge EHR vendors to adopt social determinants of health templates, created with input from our AMA, medical specialty societies, and other stakeholders with expertise in social determinants of health metrics and development, without adding further cost or documentation burden for physicians.

(Res. 730, I-04; Reaffirmed in lieu of Res. 818, I-07; Reaffirmed in lieu of Res. 726, A-08; Reaffirmation: A-10; Reaffirmed: BOT Rep. 16, A-11; Modified: BOT Rep. 16, A-11; Modified: BOT Rep. 17, A-12; Reaffirmed in lieu of Res. 714, A-12; Reaffirmed in lieu of Res. 715, A-12; Reaffirmed: BOT Rep. 24, A-13; Reaffirmed in lieu of Res. 724, A-13; Appended: Res. 720, A-13; Appended: Sub. Res. 721, A-13; Reaffirmed: CMS Rep. 4, I-13; Reaffirmation I-13; Appended: BOT Rep. 18, A-14; Appended: BOT Rep. 20, A-14; Reaffirmation A-14; Reaffirmed: BOT Rep. 17, A-15; Reaffirmed in lieu of Res. 208, A-15; Reaffirmed in lieu of Res. 223, A-15; Reaffirmation I-15; Reaffirmed: CMS Rep. 07, I-16; Reaffirmed: BOT Rep. 05, I-16; Appended: Res. 227, A-17; Reaffirmed in lieu of: Res. 243, A-17; Modified: BOT Rep.

39, A-18; Reaffirmed: BOT Rep. 45, A-18; Reaffirmed: BOT Rep. 19, A-18; Reaffirmation: A-19; Reaffirmed: CMS Rep. 3, I-19; Reaffirmed: CMS Rep. 2, A-22; Reaffirmation: Res. 715, A-24)

(30) RESOLUTION 819 – ESTABLISHING A NEW OFFICE-BASED FACILITY SETTING TO PAY SEPARATELY FROM THE MEDICARE PHYSICIAN FEE SCHEDULE FOR THE TECHNICAL REIMBURSEMENT OF PHYSICIAN SERVICES USING HIGH-COST SUPPLIES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Policy H-400.957 be reaffirmed in lieu of Resolution 819.

HOD Action: Policy H-400.957 reaffirmed in lieu of Resolution 819.

RESOLVED, that our American Medical Association study options to reform the Medicare Physician Fee Schedule by (1) removing high-cost supplies from the Medicare Physician Fee Schedule by establishing a new office-based facility setting to pay separately for the technical reimbursement of physician services using high-cost supplies (2) removing high-cost radiation therapy equipment from the Medicare Physician Fee Schedule by establishing a new case rate model for radiation oncology. (Directive to Take Action)

Your Reference Committee heard mixed testimony on Resolution 819. Testimony indicated support that the issues in the resolution are indeed important but are already being addressed at length by both the AMA and the RVS Update Committee (RUC). Testimony from RUC representatives outlined their own efforts to ensure that all physicians are paid for high-cost supplies in a fair and efficient manner. This resolution was suggested for reaffirmation, a position supported by RUC representatives. In-person testimony expressed support for the resolution as written and explained that reimbursement for high-cost supplies can be a challenge for many physicians. However, RUC members and leadership, along with the Council on Medical Service, expressed that efforts are ongoing to ensure that these needs are met. Your Reference Committee was compelled by this testimony and therefore recommends that Policy H-400.957 be reaffirmed in lieu of Resolution 819.

MEDICARE REIMBURSEMENT OF OFFICE-BASED PROCEDURES H-400.957

1. Our American Medical Association will encourage CMS to expand the extent and amount of reimbursement for procedures performed in the physician's office, to shift more procedures from the hospital to the office setting, which is more cost effective.
2. Our AMA will seek to have the RBRVS practice expense RVUs reflect the true cost of performing office procedures.
3. Our AMA will work with CMS to develop consistent regulations to be followed by carriers that include reimbursement for the costs of disposable supplies and surgical tray fees incurred with office-based procedures and surgery. (Sub. Res. 103, I-93; Reaffirmed by Rules & Credentials Cmt., A-96; Reaffirmation A-04Reaffirmation I-04; Reaffirmed: CMS Rep. 1, A-14; Reaffirmed: CMS Rep. 3, A-14;

Reaffirmed in lieu of Res. 216, I-14; Reaffirmed: CMS Rep. 04, I-18; Reaffirmed: BOT Action in response to referred for decision Res. 111, A-19; Reaffirmed: BOT Action in response to referred for decision Res. 132, A-19; Reaffirmation: A-22)

(31) RESOLUTION 826 – RENEWING THE EXPANSION OF PREMIUM TAX CREDITS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Policies H-165.824, H-185.948, and H-165.904 be reaffirmed in lieu of the first resolved clause of Resolution 826.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Policies H-165.828 and H-165.838 reaffirmed in lieu of the second resolved clause of Resolution 826.

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the third resolved clause of Resolution 826 be adopted.

HOD Action: Policy H-165.824, H-185.948, and H-165.904 reaffirmed in lieu of Resolved 1 of Resolution 826; Policies H-165.828 and H-165.838 reaffirmed in lieu of Resolved 2 of Resolution 826; and Resolved 3 of Resolution 826 adopted as amended.

RESOLVED, that our AMA ~~will immediately initiate or substantially invest in a focused grassroots campaign to~~ support extending Affordable Care Act tax credit enhancement from the American Rescue Plan Act and the Inflation Reduction Act.

RESOLVED, that our American Medical Association (AMA) reaffirm that expanding coverage and protecting access to care is a top AMA priority; and be it further

RESOLVED, that our AMA will monitor and oppose efforts to rollback affordable and quality health insurance coverage at the federal level; and be it further

RESOLVED, that our AMA will immediately initiate or substantially invest in a focused grassroots campaign to support extending Affordable Care Act tax credit enhancement from the American Rescue Plan Act and the Inflation Reduction Act.

Your Reference Committee heard passionate testimony regarding Resolution 826. Testimony outlined that many individuals who utilize tax credit enhancements from the Affordable Care Act (ACA) for health insurance will lose coverage if the enhanced tax credits are not extended. While all testimony supported the importance of ensuring that individuals have access to

affordable health insurance, some testimony indicated concern with the wording, not the intent, of first two resolved clauses. Your Reference Committee feels that the first and second Resolved clauses are adequately addressed in policies that express the AMA's strong intent to ensure that health insurance coverage is available in a manner that keeps health care access affordable to Americans and to protect against any rollback in the quality or affordability of care.

Additional testimony indicated that the AMA is participating in a coalition (Keep Americans Covered - https://americanscovered.org/) that aims to ensure that these tax credits are extended and to keep health care affordable. Since the AMA is already involved in a coalition of patients, consumers, physicians, hospitals, health insurers, and employers working together to extend the tax credits, your Reference committee believes that the adoption of the third Resolved clause of this resolution would enshrine current efforts in policy.

Therefore, your Reference Committee recommends that Policies H-165.824, H-185.948, and H-165.904 be reaffirmed in lieu of the first Resolved clause of Resolution 826, Policies H-165.828 and H-165.838 be reaffirmed in lieu of the second Resolved clause of Resolution 826, and the third Resolved clause of Resolution 826 be adopted.

IMPROVING AFFORDABILITY IN THE HEALTH INSURANCE EXCHANGES H-165.824

1. Our American Medical Association will:
   a. support adequate funding for and expansion of outreach efforts to increase public awareness of advance premium tax credits.
   b. support expanding eligibility for premium tax credits up to 500 percent of the federal poverty level.
   c. support providing young adults with enhanced premium tax credits while maintaining the current premium tax credit structure which is inversely related to income.
   d. encourage state innovation, including considering state-level individual mandates, auto-enrollment and/or reinsurance, to maximize the number of individuals covered and stabilize health insurance premiums without undercutting any existing patient protections.
2. Our AMA supports:
   a. eliminating the subsidy "cliff", thereby expanding eligibility for premium tax credits beyond 400 percent of the federal poverty level (FPL).
   b. increasing the generosity of premium tax credits.
   c. expanding eligibility for cost-sharing reductions.
   d. increasing the size of cost-sharing reductions. (CMS Rep. 02, A-18; Appended: CMS Rep. 02, A-19; Reaffirmed: CMS Rep. 3, I-21)

HEALTH INSURANCE FOR CHILDREN H-185.948

Our AMA supports requiring all children to have adequate health insurance as a strategic priority. (Res. 610, I-08; Reaffirmed: CMS Rep. 01, A-18)

UNIVERSAL HEALTH COVERAGE H-165.904

1. Our American Medical Association seeks to ensure that federal health system reform include payment for the urgent and emergent treatment of illnesses and injuries of indigent, non-U.S. citizens in the U.S. or its territories.
2. Our AMA seeks federal legislation that would require the federal government to provide financial support to any individuals, organizations, and institutions providing legally-mandated health care services to foreign nationals and other persons not covered under health system reform.
3. Our AMA continues to assign a high priority to the problem of the medically uninsured and underinsured and continues to work toward national consensus on providing access to adequate health care coverage for all Americans (Sub. Res. 138, A-94; Appended: Sub. Res. 109, I-98; Reaffirmation A-02; Reaffirmation A-07; Reaffirmation I-07; Reaffirmed: Res. 239, A-12; Reaffirmed: CMS Rep. 1, A-22)

HEALTH INSURANCE AFFORDABILITY H-165.828

1. Our American Medical Association supports modifying the eligibility criteria for premium credits and cost-sharing subsidies for those offered employer-sponsored coverage by lowering the threshold that determines whether an employee's premium contribution is affordable to the level at which premiums are capped for individuals with the highest incomes eligible for subsidized coverage in Affordable Care Act (ACA) marketplaces.
2. Our AMA supports legislation or regulation, whichever is relevant, to fix the ACA's "family glitch," thus determining the eligibility of family members of workers for premium tax credits and cost-sharing reductions based on the affordability of family employer-sponsored coverage and household income.
3. Our AMA encourages the development of demonstration projects to allow individuals eligible for cost-sharing subsidies, who forego these subsidies by enrolling in a bronze plan, to have access to a health savings account (HSA) partially funded by an amount determined to be equivalent to the cost-sharing subsidy.
4. Our AMA supports capping the tax exclusion for employment-based health insurance as a funding stream to improve health insurance affordability, including for individuals impacted by the inconsistency in affordability definitions, individuals impacted by the "family glitch," and individuals who forego cost-sharing subsidies despite being eligible.
5. Our AMA supports additional education regarding deductibles and cost-sharing at the time of health plan enrollment, including through the use of online prompts and the provision of examples of patient cost-sharing responsibilities for common procedures and services.

6. Our AMA supports efforts to ensure clear and meaningful differences between plans offered on health insurance exchanges.
7. Our AMA supports clear labeling of exchange plans that are eligible to be paired with a Health Savings Account (HSA) with information on how to set up an HSA.
8. Our AMA supports the inclusion of pregnancy as a qualifying life event for special enrollment in the health insurance marketplace. (CMS Rep. 8, I-15; Reaffirmed in lieu of: Res. 121, A-16; Reaffirmation: A-17; Reaffirmed: CMS Rep. 09, A-19; Reaffirmed: CMS Rep. 02, A-19; Reaffirmed in lieu of: Res. 101, A-19; Reaffirmed: CMS Rep. 01, I-20; Reaffirmed: CMS Rep. 2, I-20Modified: CMS Rep. 3, I-21Appended: Res. 701, I-21)

HEALTH SYSTEM REFORM H-165.838

1. Our American Medical Association is committed to working with Congress, the Administration, and other stakeholders to achieve enactment of health system reforms that include the following seven critical components of AMA policy:
    a. Health insurance coverage for all Americans.
    b. Insurance market reforms that expand choice of affordable coverage and eliminate denials for pre-existing conditions or due to arbitrary caps.
    c. Assurance that health care decisions will remain in the hands of patients and their physicians, not insurance companies or government officials.
    d. Investments and incentives for quality improvement and prevention and wellness initiatives.
    e. Repeal of the Medicare physician payment formula that triggers steep cuts and threaten seniors' access to care.
    f. Implementation of medical liability reforms to reduce the cost of defensive medicine.
    g. Streamline and standardize insurance claims processing requirements to eliminate unnecessary costs and administrative burdens.
2. Our AMA advocates that elimination of denials due to pre-existing conditions is understood to include rescission of insurance coverage for reasons not related to fraudulent representation.
3. Our AMA House of Delegates supports AMA leadership in their unwavering and bold efforts to promote AMA policies for health system reform in the United States.
4. Our AMA supports health system reform alternatives that are consistent with AMA policies concerning pluralism, freedom of choice, freedom of practice, and universal access for patients.
5. AMA policy is that insurance coverage options offered in a health insurance exchange be self-supporting, have uniform solvency requirements; not receive special advantages from government subsidies; include payment rates established through meaningful negotiations and contracts; not require

provider participation; and not restrict enrollees' access to out-of-network physicians.

6. Our AMA will actively and publicly support the inclusion in health system reform legislation the right of patients and physicians to privately contract, without penalty to patient or physician.
7. Our AMA will actively and publicly oppose the Independent Medicare Commission (or other similar construct), which would take Medicare payment policy out of the hands of Congress and place it under the control of a group of unelected individuals.
8. Our AMA will actively and publicly oppose, in accordance with AMA policy, inclusion of the following provisions in health system reform legislation:
    a. Reduced payments to physicians for failing to report quality data when there is evidence that widespread operational problems still have not been corrected by the Centers for Medicare and Medicaid Services.
    b. Medicare payment rate cuts mandated by a commission that would create a double-jeopardy situation for physicians who are already subject to an expenditure target and potential payment reductions under the Medicare physician payment system.
    c. Medicare payments cuts for higher utilization with no operational mechanism to assure that the Centers for Medicare and Medicaid Services can report accurate information that is properly attributed and risk-adjusted.
    d. Redistributed Medicare payments among providers based on outcomes, quality, and risk-adjustment measurements that are not scientifically valid, verifiable and accurate.
    e. Medicare payment cuts for all physician services to partially offset bonuses from one specialty to another.
    f. Arbitrary restrictions on physicians who refer Medicare patients to high quality facilities in which they have an ownership interest.
9. Our AMA will continue to actively engage grassroots physicians and physicians in training in collaboration with the state medical and national specialty societies to contact their Members of Congress, and that the grassroots message communicate our AMA's position based on AMA policy.
10. Our AMA will use the most effective media event or campaign to outline what physicians and patients need from health system reform.
11. AMA policy is that national health system reform must include replacing the sustainable growth rate (SGR) with a Medicare physician payment system that automatically keeps pace with the cost of running a practice and is backed by a fair, stable funding formula, and that the AMA initiate a "call to action" with the Federation to advance this goal.
12. AMA policy is that creation of a new single payer, government-run health care system is not in the best interest of the country and must not be part of national health system reform.

13. AMA policy is that effective medical liability reform that will significantly lower health care costs by reducing defensive medicine and eliminating unnecessary litigation from the system should be part of any national health system reform.(Sub. Res. 203, I-09; Reaffirmation A-10; Reaffirmed in lieu of Res. 102, A-10; Reaffirmed in lieu of Res. 228, A-10; Reaffirmed: CMS Rep. 2, I-10; Reaffirmed: Sub. Res. 222, I-10; Reaffirmed: CMS Rep. 9, A-11; Reaffirmation A-11; Reaffirmed: CMS Rep. 6, I-11; Reaffirmed in lieu of Res. 817, I-11; Reaffirmation I-11; Reaffirmation A-12; Reaffirmed in lieu of Res. 108, A-12; Reaffirmed: Res. 239, A-12; Reaffirmed: Sub. Res. 813, I-13; Reaffirmed: CMS Rep. 9, A-14; Reaffirmation A-15; Reaffirmed in lieu of Res. 215, A-15; Reaffirmation: A-17; Reaffirmed in lieu of: Res. 712, A-17; Reaffirmed in lieu of: Res. 805, I-17; Reaffirmed: CMS Rep. 03, A-18; Reaffirmed: CMS Rep. 09, A-19; Reaffirmed: CMS Rep. 3, I-21Reaffirmation: A-22; Reaffirmed: CMS Rep. 02, I-23\

Madam Speaker, this concludes the report of Reference Committee J. I would like to thank Barbara Arnold, MD, FACS; Clarence Chou MD, DLFAPA, DLFAACAP; Michael Cromer, MD, FAAFP; Mary Krebs, MD, FAAFP; Samantha Thomas, BS, Roxanne Tyroch, MD, FACP, and all those who testified before the Committee.

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DISCLAIMER

The following is a preliminary report of actions taken by the House of Delegates at its 2024 Interim Meeting and should not be considered final. Only the Official Proceedings of the House of Delegates reflect official policy of the Association.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (I-24)

Report of Reference Committee K

Cynthia Romero, MD, Chair

Your reference committee recommends the following consent calendar for acceptance:

RECOMMENDED FOR ADOPTION

1. BOT 07 - Reevaluation of Scoring Criteria for Rural Communities in the National Health Service Corps Loan Repayment Program
2. BOT 11 - Carbon Pricing to Address Climate Change
3. CSAPH 03 - HPV-Associated Cancer Prevention
4. Resolution 903 - Improving the Identification of Intimate Partner Violence (IPV) in People with Disabilities
5. Resolution 909 - Support of Universal School Meals for School Age Children
6. Resolution 910 - Food Insecurity Among Patients with Celiac Disease, Food Allergies, and Food Intolerance
7. Resolution 915 - Reducing Barriers in Sports Participation for LGBTQIA+ People
8. Resolution 916 - Access to Healthcare for Transgender and Gender Diverse People in the Carceral System
9. Resolution 929 - Safety Concerns Regarding Inadequate Labeling of Food Products Upon Ingredient Changes with Known Major Food Allergens

RECOMMENDED FOR ADOPTION AS AMENDED

10. CSAPH 01 - Cannabis Therapeutic Claims in Marketing and Advertising
11. CSAPH 04 - Reducing Sodium Intake to Improve Public Health
12. CSAPH 05 - Teens and Social Media
13. Resolution 901 - Heat Alerts and Response Plans
14. Resolution 902 - Advancing Menopause Research and Care
15. Resolution 904 - Regulation of Ionized Radiation Exposure for Healthcare Workers
16. Resolution 905 - Regulation and Transparency of Contaminants in Menstrual Hygiene Products
17. Resolution 912 - Assuring Representation of Older Age Adults in Clinical Trials
18. Resolution 913 - Sexually Transmitted Infections are on the Rise in the Senior Population
19. Resolution 914 - Protecting the Healthcare Supply Chain from the Impacts of Climate Change
20. Resolution 917 - Mpox Global Health Emergency Recognition and Response

21. Resolution 918 - Healthcare in Tribal Jails
22. Resolution 919 - Improving Rural Access to Comprehensive Cancer Care Service
23. Resolution 922 - Advocating for the Regulation of Pink Peppercorn as a Tree Nut
24. Resolution 931 – Mass Deportation as a Public Health Issue
25. Resolution 932 – National Preparedness for IV Fluid Shortages

RECOMMENDED FOR ADOPTION IN LIEU OF

26. CSAPH 02 - Drug Shortages: 2024 Update
    Resolution 930 - Economic Factors to Promote Reliability of Pharmaceutical Supply
27. Resolution 907 - Call for Study: The Need for Hospital Interior Temperatures to be Thermally Neutral to Humans within Those Hospitals
28. Resolution 911 - Adequate Masking and HPV Education for Health Care Workers (including those over age 45)
29. Resolution 923 - Updated Recommendations for Child Safety Seats

RECOMMENDED FOR REFFERAL

30. Resolution 908 - Support for Doula Care Programs

RECOMMENDED FOR NOT ADOPTION

31. Resolution 928 - Public Safety Agencies Data Collection Enhancement

RECOMMENDED FOR REAFFIRMATION IN LIEU OF

32. Resolution 920 - Revise FAA Regulations to Include Naloxone (Narcan) in the On-Board Medical Kit for Commercial Airlines flying within the Continental United States

Amendments

If you wish to propose an amendment to an item of business, click here:
Submit New Amendment

RECOMMENDED FOR ADOPTION

(1) BOARD OF TRUSTEES REPORT 07 - REEVALUATION OF SCORING CRITERIA FOR RURAL COMMUNITIES IN THE NATIONAL HEALTH SERVICE CORPS LOAN REPAYMENT PROGRAM

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Board of Trustees Report 07 be adopted and the remainder of the report be filed.

HOD ACTION: Board of Trustees Report 07 be adopted and the remainder of the report be filed.

Therefore, the Board of Trustees recommends that the following recommendations be adopted and the remainder of the report be filed:

1) Our AMA supports the efforts of the Health Resources and Services Administration (HRSA) to conduct a comprehensive reevaluation and assessment of the effectiveness and equity of the Health Professional Shortage Area scoring criteria in order to meet the physician workforce needs of rural communities and underserved areas. (New HOD Policy)
2) Our AMA urges increased federal and state resources to improve the accuracy of the Shortage Designation Management System (SDMS) data used to determine Health Professional Shortage Area (HPSA) scoring.
3) AMA policies D-200.980, H-305.925, H-465.988, and H-200.991, which support funding for NHSC and loan repayment programs, be reaffirmed.
4) AMA policy H-465.997, which supports efforts to place NHSC physicians in underserved areas, be reaffirmed.
5) AMA policy H-200.972, which supports efforts to increase recruitment and retention of physicians to practice in HPSAs, be reaffirmed.

Your Reference Committee heard unanimously supportive testimony for this report, highlighting the importance of aligning scoring criteria with the populations that rural clinics serve. Therefore, your Reference Committee recommends that the Board of Trustees Report 07 be adopted.

(2) BOARD OF TRUSTEES REPORT 11 – CARBON PRICING TO ADDRESS CLIMATE CHANGE

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Board of Trustees Report 11 be adopted and the remainder of the report be filed.

HOD ACTION: Board of Trustees Report 11 be adopted and the remainder of the report be filed.

The Board of Trustees recommends that the following be adopted and the remainder of the report be filed.

1. Amend current HOD policy, D-135.966: Declaring Climate Change a Public Health Crisis, by addition to read as follows:

1. Our AMA declares climate change a public health crisis that threatens the health and well-being of all individuals.
2. Our AMA will protect patients by advocating for policies that: (a) limit global warming to no more than 1.5 degrees Celsius, (b) reduce US greenhouse gas emissions aimed at a 50 percent reduction in emissions by 2030 and carbon neutrality by 2050, and (c) support rapid implementation and incentivization of clean energy solutions and significant investments in climate resilience through a climate justice lens.
3. Our AMA will consider signing on to the Department of Health and Human Services Health Care Pledge and ~~or~~ making a ~~similar~~ commitment to lower its own greenhouse gas emissions.
4. Our AMA encourages the health sector to lead by example in committing to carbon neutrality by 2050.
5. Our AMA will develop a strategic plan for how we will enact our climate change policies including advocacy priorities and strategies to decarbonize physician practices and the health sector with report back to the House of Delegates at the 2023 Annual Meeting.
6. Our AMA supports the use of international, federal, regional, and state carbon pricing systems as an important tool to reduce global greenhouse gas emissions and achieve net-zero targets. Our AMA recommends that carbon dividends or energy subsidies for low-income households be a key component of any established carbon pricing system, to reduce the potential economic burden on households with lower incomes.

Your Reference Committee heard unanimously supportive testimony for this report, including from authors, who had submitted the original resolution that was referred for study and served as the motivation for this report. Therefore, your Reference Committee recommends that the Board of Trustees Report 11 be adopted.

(3) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT 3 – HPV-ASSOCIATED CANCER PREVENTION

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the Recommendations in CSAPH Report 3 be adopted and the remainder of the report be filed.

HOD ACTION: Recommendations in Council on Science and Public Health 3 be adopted and the remainder of the report filed.

The Council on Science and Public Health recommends that the following be adopted, and the remainder of the report be filed.

A. That our AMA amend policy H-440.872, "HPV-Associated Cancer Prevention" by addition and deletion to read as follows:

HPV-Associated Cancer Prevention, H-440.872

1. Our AMA (a) strongly urges physicians and other health care professionals to educate themselves, appropriate patients, and patients' parents or caregivers when applicable, about HPV and associated diseases, the importance of initiating and completing HPV vaccination, as well as routine HPV related cancer screening; and (b) encourages the development and funding of programs targeted at HPV vaccine introduction and HPV related cancer screening in countries without organized HPV related cancer screening programs.

2. Our AMA will work with interested parties to intensify efforts to improve awareness and understanding about HPV and associated diseases in all individuals, regardless of sex, such as, but not limited to, cervical cancer, head and neck cancer, anal cancer, and genital cancer, the availability and efficacy of HPV vaccinations, and the need for routine HPV related cancer screening in the general public.

3. Our AMA supports legislation and funding for research aimed towards discovering screening methodology and early detection methods for other non-cervical HPV associated cancers.

4. Our AMA:

(a) encourages the integration of HPV vaccination and ~~routine cervical~~ appropriate HPV-related cancer screening into all appropriate health care settings and visits,

(b) supports the availability of the HPV vaccine and routine cervical cancer screening to appropriate patient groups ~~that benefit most from preventive measures~~, including but not limited to low-income and pre-sexually active populations,

(c) recommends HPV vaccination for all groups for whom the federal Advisory Committee on Immunization Practices recommends HPV vaccination.

5. Our AMA supports ~~will encourage~~ efforts by states ~~appropriate stakeholders to investigate means~~ to increase HPV vaccine availability and accessibility, and HPV vaccination rates through a combination of policies such as ~~by~~ facilitating administration of HPV vaccinations in community-based settings ~~including school settings~~ including local health departments and schools, reminder-based interventions, school-entry requirements, and requirements for comprehensive and evidence-based sexual education.

~~6. Our AMA will study requiring HPV vaccination for school attendance~~.

6~~7~~. Our AMA encourages collaboration with interested parties to make available human papillomavirus vaccination, according to ACIP recommendations, to people who are incarcerated for the prevention of HPV-associated cancers.

7. Our AMA advocate that racial, ethnic, socioeconomic, and geographic differences in high-risk HPV subtype prevalence be taken into account during the development, clinical testing, and strategic distribution of next-generation HPV vaccines

8. Our AMA will encourage continued research into (a) interventions that equitably increase initiation of HPV vaccination and completion of the HPV vaccine series; (b) the impact of broad opt-out provisions on HPV vaccine uptake; and (c) the impact of the COVID-19 pandemic and vaccine misinformation on HPV vaccine uptake. (Modify Current HOD Policy)

B. That our AMA adopt the following new HOD policy.

Immunization Requirements

Our AMA recognizes that immunization requirements, including those for school attendance, serve as a strong motivator for parents and families to immunize their children according to the schedule recommended by the Centers for Disease Control and Prevention. (New HOD Policy)

C. That our AMA reaffirm Policy H-440.970, "Nonmedical Exemptions from Immunizations. (Reaffirm HOD Policy)

Your Reference Committee heard mostly supportive testimony for this report noting that the recommendations support efforts to increase HPV vaccine availability and accessibility, and HPV vaccination rates through a combination of policies. There was testimony supporting re-referral of CSAPH 3 calling for the report to include recommendations concerning the risk of HPV exposure to health care personnel during surgical procedures. However, it was noted that this is out of the scope of the report which called for a study about HPV vaccination requirements for school entry. It was also noted that the Council on Science and Public Health is working on a report on surgical smoke which will include risk of HPV exposure to health care professionals and appropriate PPE to use. An amendment was proffered to strikeout "school-entry requirements" because of the lack of positive data on HPV vaccination as a school entry requirement. There was no testimony in support of this amendment and therefore, your Reference Committee recommends that the recommendations in Council on Science and Public Health Report 3 be adopted.

(4) RESOLUTION 903 - IMPROVING THE IDENTIFICATION OF INTIMATE PARTNER VIOLENCE (IPV) IN PEOPLE WITH DISABILITIES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 903 be adopted.

HOD ACTION: Resolution 903 be adopted.

RESOLVED, that our American Medical Association advocate for increased research on the prevalence of intimate partner violence (IPV) in people with disabilities and the unique IPV-related issues faced by people with disabilities (Directive to Take Action); and be it further

RESOLVED, that our AMA advocated for increased research on the efficacy of population-specific intimate partner violence (IPV) screening tools that address the specific manifestations of abuse faced by people with disabilities. (Directive to Take Action)

Your Reference Committee heard limited, but supportive testimony on this resolution. Testimony noted that intimate partner violence is experienced by up to 80 percent of people with disabilities. Those with physical and developmental disabilities may be more reliant on their partners or caregivers, thereby setting up a dangerous dynamic where abusers may be able to physically abuse their victims. Therefore, your Reference Committee recommends that Resolution 903 be adopted.

(5) RESOLUTION 909 - SUPPORT OF UNIVERSAL SCHOOL MEALS FOR SCHOOL AGE CHILDREN

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 909 be adopted.

HOD ACTION: Resolution 909 be adopted.

RESOLVED, that our American Medical Association advocate for federal and state efforts to adopt, fund, and implement universal school meal programs that include the provision of breakfast and lunch to all school-aged children, free of charge to families, regardless of income. (Directive to Take Action)

Your Reference Committee heard testimony that was supportive of this resolution. It was noted that food insecurity and poor nutrition are a massive and pervasive problem. Universal free school meals can address these problems and are associated with increased meal participation and potentially increased school attendance, decreased rates of obesity, and decreased suspensions. Making free meals available to everyone reduces the stigma associated with free meals. An amendment proposed by an individual sought to limit the resolution to publicly funded schools, but the majority of the testimony was in support of the resolution as written. Therefore, your Reference Committee recommends that Resolution 909 be adopted.

(6) RESOLUTION 910 - FOOD INSECURITY AMONG PATIENTS WITH CELIAC DISEASE, FOOD ALLERGIES, AND FOOD INTOLERANCE

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 910 be adopted.

HOD ACTION: Resolution 910 be adopted.

RESOLVED, that our American Medical Association support federal and state efforts to increase the affordability and quality of food alternatives for people with celiac disease, food allergies, and food intolerance (New HOD Policy); and be it further

RESOLVED, that our AMA support federal and state efforts to extend requirements for mandatory nutrient fortification to food alternatives for people with celiac disease, food allergies, and food intolerance (New HOD Policy); and be it further

RESOLVED, that our AMA support efforts to expand nutrition assistance eligibility and benefits to equitably meet the needs of households affected by celiac disease, food allergies, and food intolerance and increase access to food alternatives for people with celiac disease, food allergies, and food intolerance, including, but not limited to, efforts by food banks and pantries, food delivery systems, and prescription produce programs. (New HOD Policy)

Your Reference Committee heard mostly supportive testimony on this item. It was noted that food insecurity is extremely prevalent among patients with celiac disease, food allergies, and food intolerance and it is important to support measures to address food insecurity in this patient population. An individual in opposition noted that there could be potential for misuse of nutrition assistance benefits by individuals who receive a celiac disease diagnosis through methods that are not evidence-based. However, your Reference Committee wants to note that diagnosis of celiac disease is out of the scope of this resolution which does not directly address diagnosis of celiac disease. Therefore, Madam Speaker, your Reference Committee recommends that Resolution 910 be adopted.

(7) RESOLUTION 915 - REDUCING BARRIERS IN SPORTS PARTICIPATION FOR LGBTQIA+ PEOPLE

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 915 be adopted.

HOD ACTION: Resolution 915 be adopted.

RESOLVED, that our American Medical Association will educate physicians on benefits and barriers to sports participation affecting LGBTQIA+ communities (Directive to Take Action); and be it further

RESOLVED, that our AMA will support legislative and regulatory protections to ensure access to participation in sports inclusive of LGBTQIA+ persons. (New HOD Policy)

Your Reference Committee heard mostly supportive testimony on this item. It was noted that prohibiting LGBTQIA+ students from participating in sports is a form of discrimination on the basis of gender and the social, mental, and physical benefits of sports participation should be accessible to all. One delegation sought referral of the second resolve due to vagueness, noting support for the rights of the LGBTQIA+ population to participate in competitive athletics, but noting concerns about the safety or fairness to biological females at birth when biological males at birth are permitted to participate in female sports. Since the majority of testimony presented was supportive, your Reference Committee recommends that Resolution 915 be adopted.

(8) RESOLUTION 916 - ACCESS TO HEALTHCARE FOR TRANSGENDER AND GENDER DIVERSE PEOPLE IN THE CARCERAL SYSTEM

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 916 be adopted.

HOD ACTION: Resolution 916 be adopted.

RESOLVED, that our American Medical Association advocate for readily accessible gender-affirming care to meet the distinct healthcare needs of transgender and gender diverse people in the carceral system, including but not limited to gender-affirming surgical procedures and the continuation or initiation of hormone therapy without disruption or delay. (Directive to Take Action)

Your Reference Committee heard mostly supportive testimony on this item. Testimony noted that transgender and gender diverse individuals in the carceral system deserve equitable access to gender-affirming care, such as gender-affirming surgical procedures and hormone therapy, because these interventions are evidence-based and medically necessary. An individual in opposition noted that while they support continuation of care, they have concerns with the initiation of care in carceral settings because many physicians who treat justice-involved individuals might not have the appropriate skills to provide the needed care for transgender and gender diverse individuals. Testimony further noted that most physicians who provide care to justice-involved individuals are primary care physicians and therefore are appropriately trained to initiate care for transgender and gender diverse individuals. Your Reference Committee agrees and therefore, Madam Speaker, your Reference Committee recommends that Resolution 916 be adopted.

(9) RESOLUTION 929 – SAFETY CONCERNS REGARDING INADEQUATE LABELING OF FOOD PRODUCTS UPON INGREDIENT CHANGES WITH KNOWN MAJOR FOOD ALLERGENS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 929 be adopted.

HOD ACTION: Resolution 929 be adopted.

RESOLVED, that our American Medical Association support legislation or regulation that any repackaging entity verify with the food manufacturer/distributor as an ordinary and routine transaction of commerce that no major food allergen ingredient changes have occurred (New HOD Policy); and be it further

RESOLVED, that our AMA support legislation or regulation requiring major food allergen ingredient changes be labeled and packaged with accentuated, obvious warning labeling identifying such change. (New HOD Policy)

Your Reference Committee received limited testimony on Resolution 929. Testimony was supportive of the spirit of this resolution but noted that there were questions about what kinds of entities routinely repackage food products and the burden this additional labeling may place on retailers. One amendment was proffered to expand the Resolution regarding aggregate food categories, however your Reference Committee found that amendment to be outside the scope of the original Resolution and encourages the authors to resubmit at a future meeting so a worthwhile issue can be fully considered on its merits. Given the limited, yet supportive testimony, your Reference Committee recommends that Resolution 929 be adopted.

RECOMMENDED FOR ADOPTION AS AMENDED

(10) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT 1 – CANNABIS THERAPEUTIC CLAIMS IN MARKETING AND ADVERTISING

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the Recommendation of CSAPH 1 be amended by addition to read as follows:

1. That our AMA:
a) Oppose cannabis and cannabis-based product advertising that includes claims or statements that are not supported by peer-reviewed scientific evidence.
b) Will continue to monitor regulatory approaches to cannabis marketing. (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the Recommendations in CSAPH Report 1 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Recommendations in Council on Science and Public Health Report 1 be adopted as amended and the remainder of the report be filed.

The Council on Science and Public Health recommends that the following be adopted, and the remainder of the report be filed.
That our AMA:
a) Oppose cannabis and cannabis-based product advertising that includes claims or statements that are not supported by scientific evidence.
b) Will continue to monitor regulatory approaches to cannabis marketing. (New HOD Policy)

Your Reference Committee heard supportive testimony for this report. Testimony noted that the increasing prevalence of cannabis legalization has brought a growing concern regarding the accuracy and transparency of therapeutic claims made in cannabis advertising and marketing. An amendment was proffered to specify the level of scientific evidence. Your Reference Committee agrees and therefore, your Reference Committee recommends that Council on Science and Public Health Report 1 be adopted as amended.

(11) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT 4 – REDUCING SODIUM INTAKE TO IMPROVE PUBLIC HEALTH

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the Recommendation of CSAPH 4 be amended by addition to read as follows:

1) That Policy H-150.929, "Promotion of Healthy Lifestyles I: Reducing the Population Burden of Cardiovascular Disease by Reducing Sodium Intake" be amended by addition and deletion to read as follows:

Our AMA ~~will~~:
(1) Calls for a step-wise, minimum 50% reduction in sodium in processed foods, fast food products, and restaurant meals to be achieved over the next decade.
(2) Urges the FDA to publish future editions of their voluntary targets expeditiously to make further progress on sodium reduction.
(3) Supports federal, state, and local efforts to set robust targets for reducing sodium levels in school meals, meals in health care facilities, and other meals provided by daily meal providers.
(~~24~~) Will advocate for federal, state, and local efforts to reduce sodium levels in products from ~~F~~food manufacturers and restaurants ~~should review their product lines and reduce sodium levels~~ to the greatest extent possible,(without increasing levels of other unhealthy ingredients, such as added sugars or artificial ingredients). ~~Gradual but steady reductions over several years may be the most effective way to minimize sodium levels.~~
(5) Supports federal, state, and local efforts to require front-of-package warning labels for foods that are high in sodium based on the established recommended daily value.
(~~26~~) ~~To~~ Will assist in achieving the Healthy People 2030~~2010~~ goal for sodium consumption, by ~~will~~ working with the FDA, the National Heart Lung Blood Institute, the Centers for Disease Control and Prevention, the American Heart Association, Academy of Nutrition and Dietetics, and other interested partners to educate consumers about the benefits of ~~long-term, moderate~~ reductions in sodium intake and other dietary approaches to reduce hypertension.

(7) Supports the continuing education of physicians and other members of the health care team on counseling patients on lifestyle modification strategies to manage blood pressure, advocating for culturally relevant dietary models that reduce sodium intake.
(~~3~~8) Recommends that the FDA consider all options to promote reductions in the sodium content of processed foods.
(9) Supports further study and evaluation of national salt reduction programs to determine the viability, industry engagement, and health and economic benefits of such programs.
(10) Supports federal, state, and local efforts to regulate advertising of foods and products high in sodium, especially advertising targeted to children. (Modify Current HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the Recommendations in CSAPH Report 4 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Recommendations in Council on Science and Public Health Report 4 be adopted as amended and the remainder of the report be filed.

The Council on Science and Public Health recommends that the following be adopted, and the remainder of the report be filed.

1) That Policy H-150.929, "Promotion of Healthy Lifestyles I: Reducing the Population Burden of Cardiovascular Disease by Reducing Sodium Intake" be amended by addition and deletion to read as follows:

Our AMA ~~will~~:
(1) Calls for a step-wise, minimum 50% reduction in sodium in processed foods, fast food products, and restaurant meals to be achieved over the next decade.
(2) Urges the FDA to publish future editions of their voluntary targets expeditiously to make further progress on sodium reduction.
(3) Supports federal, state, and local efforts to set robust targets for reducing sodium levels in school meals, meals in health care facilities, and other meals provided by daily meal providers.
(~~2~~4) Will advocate for federal, state, and local efforts to reduce sodium levels in products from ~~F~~ food manufacturers and restaurants ~~should review their product lines and reduce sodium levels~~ to the greatest extent possible.~~(~~ without increasing levels of other unhealthy ingredients, such as added sugars or artificial ingredients~~)~~. ~~Gradual but steady reductions over several years may be the most effective way to minimize sodium levels.~~
(5) Supports federal, state, and local efforts to require front-of-package warning labels for foods that are high in sodium based on the established recommended daily value.

(~~26~~) ~~To~~ Will assist in achieving the Healthy People 2030~~2010~~ goal for sodium consumption, by ~~will~~ working with the FDA, the National Heart Lung Blood Institute, the Centers for Disease Control and Prevention, the American Heart Association, and other interested partners to educate consumers about the benefits of ~~long-term, moderate~~ reductions in sodium intake and other dietary approaches to reduce hypertension.
(7) Supports the continuing education of physicians and other members of the health care team on counseling patients on lifestyle modification strategies to manage blood pressure, advocating for culturally relevant dietary models that reduce sodium intake.
(~~3~~8) Recommends that the FDA consider all options to promote reductions in the sodium content of processed foods.
(9) Supports further study and evaluation of national salt reduction programs to determine the viability, industry engagement, and health and economic benefits of such programs. (Modify Current HOD Policy)

Your Reference Committee heard largely supportive testimony for this report with one comment proposing the addition of two clauses: one on the regulation of advertising foods high in sodium to specific populations and the other asking AMA to work with other interested parties in developing recommendations on salt substitutes. The Council on Science and Public Health was supportive of adding the first proposed clause, with a specific focus on regulating advertising to children, but not of the second, citing limited evidence to make such recommendations. Another minor amendment was proffered to include the Academy of Nutrition and Dietetics in the list of potential partners to work with on meeting the Healthy People 2030 goal to reduce sodium, which was considered a helpful organization to include. Therefore, your Reference Committee recommends that the recommendations in Council on Science and Public Health Report 4 be adopted as amended.

(12) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT 5 – TEENS AND SOCIAL MEDIA

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the second Recommendation in CSAPH Report 5 be amended by addition to read as follows:

Our AMA: (1) will collaborate with relevant professional organizations to: (a) support the development of continuing education programs to enhance physicians' knowledge of the health impacts of social media and social networking usage; and (b) support the development of effective clinical tools and protocols for the identification, treatment, and referral of children, adolescents, and adults at risk for and experiencing health sequelae of social media and social networking usage; (2) advocates for schools to provide safe and effective, evidence-based educational programs ~~by which~~ so that (a) all students can learn to

identify and mitigate the onset of mental health sequelae of social media and social networking usage, and (b) all students develop skills in digital literacy to serve as an individual protective foundation for interaction with various types of digital media (including social media); (3) affirms that use of social media and social networking has the potential to positively or negatively impact the physical and mental health of individuals, especially adolescents and those with preexisting psychosocial conditions; (4) advocates for and support media and social networking services addressing and developing safeguards tailored to youth users, including ensuring robust protections for youth online privacy, providing effective tools to manage screentime content and access, considering special circumstances for certain youth populations (such as LGBTQ+ youth and youth with disabilities), and promoting the development and dissemination of age-appropriate digital literacy training; and (5) advocates for the study of the positive and negative biological, psychological, and social effects of social media and social networking services use. (Modify Current HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the Recommendations in CSAPH Report 5 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Recommendations in Council on Science and Public Health Report 5 be adopted as amended and the remainder of the report be filed.

The Council on Science and Public Health recommends that the following be adopted, and the remainder of the report be filed:

1)That our AMA:
(1) urges physicians to: (a) educate themselves about social media; (b) be prepared to counsel patients and/or their guardians about the potential risks and harms of social media; and (c) consider expanding clinical interviews to inquire about social media use;
(2) encourages further clinical, epidemiological, and interdisciplinary research on the impact of social media on health;
(3) supports education of clinicians, educators, and the public on digital media literacy and the health effects of social media;
(4) recognizes that the relative risks and benefits of social media may depend on individual differences (e.g., social media engagement, pre-existing traits, and environment);

(5) supports legislative, regulatory, and associated initiatives that, at a minimum, provide youth with strong data privacy protections, require platforms to be designed to align with child development, and provide transparency into the potential harms posed by platforms to young people and any steps taken to mitigate those harms; and
(6) will collaborate with professional societies, industry, and other stakeholders to improve social media platform privacy protections, transparency (e.g., algorithmic, data, and process), data sharing processes, and systems for accountability and redress in response to online harassment. (New HOD Policy)

2) That current AMA policy D-478.965, "Addressing Social Media and Social Networking Usage and its Impacts on Mental Health" be amended by addition and deletion to read as follows:

Our AMA: (1) will collaborate with relevant professional organizations to: (a) support the development of continuing education programs to enhance physicians' knowledge of the health impacts of social media and social networking usage; and (b) support the development of effective clinical tools and protocols for the identification, treatment, and referral of children, adolescents, and adults at risk for and experiencing health sequelae of social media and social networking usage; (2) advocates for schools to provide safe and effective educational programs ~~by which~~ so that (a) all students can learn to identify and mitigate the onset of mental health sequelae of social media and social networking usage, and (b) all students develop skills in digital literacy to serve as an individual protective foundation for interaction with various types of digital media (including social media); (3) affirms that use of social media and social networking has the potential to positively or negatively impact the physical and mental health of individuals, especially adolescents and those with preexisting psychosocial conditions; (4) advocates for and support media and social networking services addressing and developing safeguards tailored to youth users, including ensuring robust protections for youth online privacy, providing effective tools to manage screentime content and access, and promoting the development and dissemination of age-appropriate digital literacy training; and (5) advocates for the study of the positive and negative biological, psychological, and social effects of social media and social networking services use. (Modify Current HOD Policy)

Your Reference Committee heard testimony in support of this Council on Science and Public Health report, which reviews the evidence on the impact of social media on adolescent health and outlines the positive and negative trends. An amendment was proposed asking that consideration be given to special circumstances such as for LGBTQ+ and youth with disabilities. This amendment received support, and the Council indicated they are not opposed to the amendment as it aligns with discussion in their report. Additional amendments were proposed to specify the call for further research on the impact of social media, your Reference Committee does not believe this additional specificity is necessary. Therefore, your Reference Committee recommends that the recommendations in Council on Science and Public Health Report 5 be adopted as amended.

(13) RESOLUTION 901 – HEAT ALERTS AND RESPONSE PLANS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends the second Resolve clause of Resolution 901 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA supports efforts to implement and fund comprehensive heat response plans and ~~allow Federal Emergency Management Agency funds and resources to be used for heat response~~ encourages all relevant government agencies to develop greater capacity to better respond to the consequences of heat emergencies, especially when high temperatures are combined with other emergencies or utility disruptions.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 901 be adopted as amended.

HOD ACTION: Resolution 901 be adopted as amended.

RESOLVED, that our American Medical Association supports federal, state, and local efforts to use the most updated and evidence-based heat index formulas and other relevant factors to accurately estimate heat-related morbidity and mortality, proactively issue heat alerts, and improve implementation of response plans (New HOD Policy); and be it further

RESOLVED, that our AMA supports efforts to implement and fund comprehensive heat response plans and allow Federal Emergency Management Agency funds and resources to be used for heat response. (New HOD Policy)

Your Reference Committee heard largely supportive testimony on this item. However, one comment noted that the Federal Emergency Management Agency (FEMA) can currently respond to extreme heat events, provided the tenets of the Stafford Act are met. This comment suggested amending the proposed resolution by broadening the language to include multiple federal agencies, as greater emergency preparedness efforts for extreme heat emergencies, along with concurrent climate change threats, should be improved throughout the federal government. In-person testimony supported the amended resolution proposed in the preliminary report based on the Online Reference Committee testimony. Therefore, Madam Speaker, your Reference Committee recommends that Resolution 901 be adopted as amended.

(14) RESOLUTION 902 - ADVANCING MENOPAUSE RESEARCH AND CARE

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Resolve of Resolution 902 be amended by addition to read as follows:

RESOLVED, that our American Medical Association advocate for increased funding for biomedical, behavioral, and public health research on perimenopause, menopause, and related chronic conditions (Directive to Take Action); and be it further

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the third Resolve of Resolution 902 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA support efforts to increase awareness and education to the public, health care professionals, patients, and other relevant communities related to menopause, mid-life women's health and related conditions, treatment, and preventive ~~preventative~~ services.

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Resolution 902 be adopted as amended.

HOD ACTION: Resolution 902 be adopted as amended.

RESOLVED, that our American Medical Association advocate for increased funding for biomedical and public health research on perimenopause, menopause, and related chronic conditions (Directive to Take Action); and be it further

RESOLVED, that our AMA support expanded training opportunities for medical students, residents, and other health professions trainees to improve care, treatment, and management services for perimenopause, menopause, and related chronic conditions (New HOD Policy); and be it further

RESOLVED, that our AMA support efforts to increase awareness and education related to menopause, mid-life women's health and related conditions, treatment, and preventative services. (New HOD Policy)

Your Reference Committee heard generally supportive testimony on this resolution. Minor amendments were proposed to align language with that used by certifying boards and to specify education actions, which your Reference Committee thought strengthened the policy. Additional questions were raised around potential vagueness of the term "support" and that it could result in significant cost to our AMA. However, your Reference Committee notes that the attached fiscal note to Resolution 902 is "modest" (between $1,000 and $5,000). Therefore, Madam Speaker, your Reference Committee recommends that Resolution 902 be adopted as amended.

(15) RESOLUTION 904 - REGULATION OF IONIZED RADIATION EXPOSURE FOR HEALTHCARE WORKERS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 904 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association encourage public and private healthcare institutions to ensure ~~more~~ comprehensive coverage of different body types by providing readily available PPE that reduces exposure to as low as reasonably achievable for ~~more completely protects~~ employees of all genders and pregnancy statuses~~, such as lead and lead-free aprons with, capped sleeves, axillary supplements, and maternity aprons~~.

RESOLVED, that our AMA work with the appropriate and interested parties to study how best to accomplish comprehensive protection from ionizing radiation for employees, taking into account variation in body types, pregnancy status, specifics of procedures being performed, as well as how exposure can be limited beyond PPE (personal protected equipment), with report back at I-25.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Policy H-440.810, "Availability of Personal Protective Equipment (PPE)", be reaffirmed.

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Resolution 904 be adopted as amended.

RECOMMENDATION D:

Madam Speaker, your Reference Committee recommends that the title be changed of Resolution 904 to read as follows:

REGULATION OF IONIZING RADIATION EXPOSURE FOR HEALTH CARE WORKERS

HOD ACTION: Resolution 904 be adopted as amended with a title change.

RESOLVED, that our American Medical Association encourage public and private healthcare institutions to ensure more comprehensive coverage of different body types by providing PPE that more completely protects employees of all genders and pregnancy statuses, such as lead and lead-free aprons with capped sleeves, axillary supplements, and maternity aprons. (New HOD Policy)

Your Reference Committee heard testimony generally supportive of the intent of the resolution, however there were some concerns with the language as written, resulting in recommendations for referral. Your Reference Committee, recognizing the complexity of this issue, proposes amendments to remove prescriptive equipment asks and instead assert general support for the underlying principles, thus allowing each institution to devise an exposure limiting strategy that fits their workforce. While there were additional amendments submitted requesting the issue be studied further, your Reference Committee recognizes that our AMA historically has deferred to specialty societies as the subject matter experts for developing specific recommendations about the practice of their own specialty. Additionally, clause 7 of Policy H-440.810 broadly supports access to appropriate PPE for various body types, and is also recommended for reaffirmation. Therefore, Madam Speaker, your Reference Committee recommends that Resolution 904 be adopted as amended.

H-440.810, "Availability of Personal Protective Equipment (PPE)"

Our American Medical Association affirms that the medical staff of each health care institution should be integrally involved in disaster planning, strategy and tactical management of ongoing crises.

Our AMA supports evidence-based standards and national guidelines for PPE use, reuse, and appropriate cleaning/decontamination during surge conditions.

Our AMA will advocate that it is the responsibility of health care facilities to provide sufficient personal protective equipment (PPE) for all employees and staff, as well as trainees and contractors working in such facilities, in the event of a pandemic, natural disaster, or other surge in patient volume or PPE need.

Our AMA supports physicians and health care professionals and other workers in health care facilities in being permitted to use their professional judgement and augment institution-provided PPE with additional, appropriately decontaminated, personally-provided personal protective equipment (PPE) without penalty.

Our AMA supports the rights of physicians and trainees to participate in public commentary addressing the adequacy of clinical resources and/or health and environmental safety conditions necessary to provide appropriate and safe care of patients and physicians during a pandemic or natural disaster.

Our AMA will work with the HHS Office of the Assistant Secretary for Preparedness and Response to gain an understanding of the PPE supply chain and ensure the adequacy of the Strategic National Stockpile for public health emergencies.

Our AMA encourages the diversification of personal protective equipment design to better fit all body types, cultural expressions and practices among health care personnel.

(16) RESOLUTION 905 - REGULATION AND TRANSPARENCY OF CONTAMINANTS IN MENSTRUAL HYGIENE PRODUCTS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Resolve of Resolution 905 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association support more comprehensive research on ~~contaminants~~ ingredients in menstrual hygiene products (MHP), including but not limited to tampons, other MHPs, and vaginal wipes, and the absorption of toxins into systemic circulation in an effort to better understand their effects on health (New HOD Policy); and be it further

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the second Resolve of Resolution 905 be deleted:

~~**RESOLVED, that our AMA support regulations and legislation that mandate transparency, disclosure, and accurate labeling of contaminants in menstrual hygiene products. (New HOD Policy)**~~

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Resolution 905 be adopted as amended.

RECOMMENDATION D:

Madam Speaker, your Reference Committee recommends that the title be changed of Resolution 905 to read as follows:

RESEARCH AND TRANSPARENCY OF INGREDIENTS IN MENSTRUAL HYGIENE PRODUCTS

HOD ACTION: Resolution 905 be adopted as amended with a title change.

RESOLVED, that our American Medical Association support more comprehensive research on contaminants in menstrual hygiene products (MHP), including but not limited to tampons, other MHPs, and vaginal wipes, and the absorption of toxins into systemic circulation in an effort to better understand their effects on health (New HOD Policy); and be it further

RESOLVED, that our AMA support regulations and legislation that mandate transparency, disclosure, and accurate labeling of contaminants in menstrual hygiene products. (New HOD Policy)

Your Reference Committee heard testimony that it is important to more fully understand menstrual hygiene product ingredients and their risks. However, there was some concern about preemptively supporting regulation and legislation without peer-reviewed scientific evidence of harms of ingredients to support this work. Therefore, Madam Speaker, your Reference Committee recommends that Resolution 905 be adopted as amended and the title be changed to reflect the policy therein.

(17) RESOLUTION 912 - ASSURING REPRESENTATION OF OLDER AGE ADULTS IN CLINICAL TRIALS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Resolve of Resolution 912 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association specifically advocate for inclusion of older patients (both men and women) by amending H-460.911 as follows:

H-460.911 Increasing ~~Minority, Female, and other Underrepresented Group~~ Participation in Clinical Research of People Identifying with Minoritized and Marginalized Groups

1. Our American Medical Association advocates that:

a. The Food and Drug Administration (FDA) and National Institutes of Health (NIH) conduct annual surveillance of clinical trials by gender, race, age ~~and~~ ethnicity, ~~including consideration of pediatric and elderly populations,~~ and disability status to determine if proportionate representation of people identifying with minoritized and marginalized groups, including by sex, gender, race, ethnicity, ~~and~~ age, ~~women and minorities including older adults and children if appropriate~~ and disability status is maintained in terms of enrollment and retention. This surveillance effort should be modeled after National Institute of Health guidelines on the inclusion of women and minority populations.

b. The FDA have a page on its web site that details the prevalence of people identifying with minoritized and marginalized groups, including sex, gender, race, ethnicity, ~~and~~ age, ~~minorities and women and older adults including those over age 75~~ and disability status in its clinical trials and its efforts to increase their enrollment and participation in this research.

c. Resources be provided to community level agencies that work with people identifying with minoritized and marginalized groups, including by sex, gender, race, ethnicity, ~~and~~ age, ~~those minorities, females, older adults including those over age 75~~ and disability status and other underrepresented groups who are not proportionately represented in clinical trials to address issues of lack of access, distrust, and lack of patient awareness of the benefits of trials in healthcare. These ethnic groups may ~~minorities~~ include Black Individuals/African Americans, Hispanic~~s~~ or Latino, Asians~~/~~, Pacific Islanders/Native Hawaiians, Middle Eastern or Northern African, and American Indian or Alaskan Natives ~~Native Americans~~.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the second Resolve of Resolution 912 be deleted:

~~RESOLVED, that our AMA monitor the effectiveness of H-460.911 on an annual basis (Directive to Take Action); and be it further~~

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the third Resolve of Resolution 912 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA collaborate with AHRQ, FDA, NIH and other ~~relevant stakeholders~~ interested parties to increase public and physician awareness and education on the topic of inclusivity in clinical trial participation (Directive to Take Action).

RECOMMENDATION D:

Madam Speaker, your Reference Committee recommends that the fourth Resolve of Resolution 912 be deleted:

~~RESOLVED, that our AMA specifically submit comments to the FDA on current proposed industry guidelines for inclusion of underrepresented populations in clinical trials[1] by September 2025.~~

RECOMMENDATION E:

Madam Speaker, your Reference Committee recommends that Resolution 912 be adopted as amended.

HOD ACTION: Resolution 912 be adopted as amended.

RESOLVED, that our American Medical Association specifically advocate for inclusion of older patients (both men and women) by amending H-460.911 as follows:

1. Our American Medical Association advocates that:
a. The Food and Drug Administration (FDA) and National Institutes of Health (NIH) conduct annual surveillance of clinical trials by gender, race, age and ethnicity, ~~including consideration of pediatric and elderly populations~~, to determine if proportionate representation of women and minorities including older adults and children if appropriate is maintained in terms of enrollment and retention. This surveillance effort should be modeled after National Institute of Health guidelines on the inclusion of women and minority populations.
b. The FDA have a page on its web site that details the prevalence of minorities and women and older adults including those over age 75 in its clinical trials and its efforts to increase their enrollment and participation in this research.
c. Resources be provided to community level agencies that work with those minorities, females, older adults including those over age 75 and other underrepresented groups who are not proportionately represented in clinical trials to address issues of lack of

access, distrust, and lack of patient awareness of the benefits of trials in healthcare. These minorities include Black Individuals/African Americans, Hispanics, Asians/Pacific Islanders/Native Hawaiians, and Native Americans (Directive to Take Action); and be it further

RESOLVED, that our AMA monitor the effectiveness of H-460.911 on an annual basis (Directive to Take Action); and be it further

RESOLVED, that our AMA collaborate with AHRQ, FDA, NIH and other relevant stakeholders to increase public awareness and education on the topic of inclusivity in clinical trial participation (Directive to Take Action); and be it further

RESOLVED, that our AMA specifically submit comments to the FDA on current proposed industry guidelines for inclusion of underrepresented populations in clinical trials[1] by September 2025. (Directive to Take Action)

Your Reference Committee heard supportive testimony on this item, with some discussion on amendments to refine implementation. Per AMA policies, your Reference Committee however proposes amendments to update policy towards person-first language, and to make ethnicity categories consistent with recommendations from the Office of Management and Budget. One amendment was proposed to strike an annual report on this issue, as enrollment by age group is disclosed by the National Institutes of Health (here, hyperlink available in online report). Additionally, an amendment was proposed to strike reference to submitting comment on an FDA rule, as that docket has already been closed as of October 2024, however our AMA did submit comment that can be found online (hyperlink available in online report). Therefore, Madam Speaker, your Reference Committee recommends that Resolution 912 be adopted as amended.

(18) RESOLUTION 913 - SEXUALLY TRANSMITTED INFECTIONS ARE ON THE RISE IN THE SENIOR POPULATION

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Resolve of Resolution 913 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association advocate and promote the U.S. Preventive Services Task Force (USPSTF) recommendations for STI screening through interested ~~senior~~ older adult advocates ~~such as AARP~~, specifically targeting chlamydia, gonorrhea, human immunodeficiency virus (HIV), HPV and syphilis, for the ~~senior~~ older adult population who are not regularly screened (Directive to Take Action); and be it further

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the second Resolve of Resolution 913 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA continue to promote discussion, collaboration, and consensus among expert groups and medical specialty societies involved in the development of practice guidelines for sexually transmitted diseases in the ~~senior~~ older adult population (Directive to Take Action); and be it further

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the third Resolve of Resolution 913 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA offer CME education regarding best practices for reducing sexually transmitted disease (including oral cancer risks) in the ~~senior~~ older adult population through the AMA's Ed Hub as a resource to guide the delivery of clinical preventative services. (Directive to Take Action)

RECOMMENDATION D:

Madam Speaker, your Reference Committee recommends that Resolution 913 be adopted as amended.

RECOMMENDATION E:

Madam Speaker, your Reference Committee recommends that the title be changed of Resolution 913 to read as follows:

SEXUALLY TRANSMITTED INFECTIONS ARE ON THE RISE IN THE OLDER ADULT POPULATION

HOD ACTION: Resolution 913 be adopted as amended with a title change.

RESOLVED, that our American Medical Association advocate and promote the U.S. Preventive Services Task Force (USPSTF) recommendations for STI screening through interested senior advocates such as AARP, specifically targeting chlamydia, gonorrhea,

human immunodeficiency virus (HIV), HPV and syphilis, for the senior population who are not regularly screened (Directive to Take Action); and be it further

RESOLVED, that our AMA continue to promote discussion, collaboration, and consensus among expert groups and medical specialty societies involved in the development of practice guidelines for sexually transmitted diseases in the senior population (Directive to Take Action); and be it further

RESOLVED, that our AMA offer CME education regarding best practices for reducing sexually transmitted disease (including oral cancer risks) in the senior population through the AMA's Ed Hub as a resource to guide the delivery of clinical preventative services. (Directive to Take Action)

Your Reference Committee heard supportive testimony on this item. It was noted that there has been a rise in STIs in older patients. Health care workers can wrongfully assume that their older patients are no longer sexually active and are no longer at risk for STIs, thus decreasing screening and treatment, making this resolution important. An individual raised concern whether USPSTF screening recommendations applied to older adults due to the potential for a lack of evidence, yet this resource is the standard for educating physicians on screening recommendations. Testimony noted that AARP should be deleted because there is no need to reference a private organization in AMA policy. Further, the term "senior" was amended to "older adult" to remain consistent with current AMA policy. Therefore, Madam Speaker, your Reference Committee recommends that Resolution 913 be adopted as amended.

(19) RESOLUTION 914 - PROTECTING THE HEALTHCARE SUPPLY CHAIN FROM THE IMPACTS OF CLIMATE CHANGE

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 914 be amended by addition to read as follows:

RESOLVED, that our American Medical Association support the development of strategies and technologies to strengthen supply chain networks, including economic incentives for building climate and disaster resiliency and redundancy into new or updated facilities, increasing emergency stockpiles of key products, and incentivizing the innovation and adoption of reusable medical products to resist the impact of supply chain disturbances. (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 914 be adopted as amended.

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the title be changed of Resolution 914 to read as follows:

PROTECTING THE HEALTH CARE SUPPLY CHAIN FROM THE IMPACTS OF DISASTER

HOD ACTION: Resolution 914 be adopted as amended with a title change.

RESOLVED, that our American Medical Association support the development of strategies and technologies to strengthen supply chain networks, including building climate resiliency into new or updated facilities, increasing emergency stockpiles of key products, and incentivizing the innovation and adoption of reusable medical products to resist the impact of supply chain disturbances. (New HOD Policy)

Your Reference Committee heard unanimous testimony calling for our AMA to advocate for a more resilient supply chain, echoing the discussions heard on CSAPH Report 02, and Resolutions 930 and 932. Much of the testimony was focused on the ongoing difficulties caused by Hurricanes Helene and Milton, but past disasters were also cited as having deleterious impacts on patient care. One amendment was proffered to expand the scope of the resolution to encompass other disasters, such as earthquakes or war, which similarly could benefit from increased resiliency and redundancy. Your Reference Committee therefore recommends that Resolution 914 be adopted as amended.

(20) RESOLUTION 917 - MPOX GLOBAL HEALTH EMERGENCY RECOGNITION AND RESPONSE

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Resolve of Resolution 917 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association promotes the recognition of mpox as a public health ~~emergency~~ threat and the need for ongoing surveillance, preparedness, and resource allocation to prevent future outbreaks (New HOD Policy); and be it further

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the fourth Resolve of Resolution 917 be amended by addition to read as follows:

RESOLVED, that our AMA encourages coordinated national and international efforts to address mpox, including global surveillance, resource sharing, research, and outreach programs that enhance public knowledge of mpox transmission, prevention, and vaccine effectiveness, particularly in resource-constrained settings (New HOD Policy); and be it further

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Resolution 917 be adopted as amended.

HOD ACTION: Resolution 917 be adopted as amended.

RESOLVED, that our American Medical Association promotes the recognition of mpox as a public health emergency and the need for ongoing surveillance, preparedness, and resource allocation to prevent future outbreaks (New HOD Policy); and be it further

RESOLVED, that our AMA strongly urges federal, state, and local agencies, in collaboration with public health organizations and medical associations, to develop and implement effective strategies for the prevention, control, and management of mpox, with particular focus on marginalized populations such as LGBTQ+ communities and those living with HIV (New HOD Policy); and be it further

RESOLVED, that our AMA supports increased public and private funding for mpox research, education, vaccination distribution, and long-term patient care, ensuring equitable access and addressing barriers to healthcare for at-risk populations (New HOD Policy); and be it further

RESOLVED, that our AMA encourages coordinated national and international efforts to address mpox, including global surveillance, resource sharing, and outreach programs that enhance public knowledge of mpox transmission, prevention, and vaccine effectiveness, particularly in resource-constrained settings (New HOD Policy); and be it further

RESOLVED, that our AMA calls for improved response by the Department of Health and Human Services (HHS) to mpox outbreaks, addressing the failures identified in the Government Accountability Office (GAO) report, including enhanced communication, distribution of vaccines and testing, and collaboration with local leaders (New HOD Policy); and be it further

RESOLVED, that our AMA advocates for the inclusion of community-driven, culturally competent prevention efforts and educational campaigns to reduce stigma, improve quality of life, and promote health equity for those disproportionately affected by mpox. (Directive to Take Action)

Your Reference Committee heard unanimously supportive testimony on this item. Testimony noted that mpox was recently declared an international public health emergency by the WHO and not a domestic public health emergency and thus, the language was adjusted to better align with recognition of mpox as an infectious disease threat. It was also noted that this item includes language identifying particular populations to prioritize outreach, research and prevention efforts towards because they are disproportionately impacted by mpox. Therefore, Madam Speaker, your Reference Committee recommends that Resolution 917 be adopted as amended.

(21) RESOLUTION 918 – HEALTHCARE IN TRIBAL JAILS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends the first Resolve of Resolution 918 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association strongly supports carceral facilities and youth detention centers managed by the Bureau of Indian Affairs Division of Corrections ~~being~~ be eligible for designation ~~designated~~ as Health Professional Shortage Areas and the assignment of U.S. Public Health Service Commissioned Corps officers to these facilities (New HOD Policy);

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 918 be adopted as amended.

HOD ACTION: Resolution 918 be adopted as amended.

RESOLVED, that our American Medical Association strongly supports carceral facilities and youth detention centers managed by the Bureau of Indian Affairs Division of Corrections being designated as Health Professional Shortage Areas and the assignment of U.S. Public Health Service Commissioned Corps officers to these facilities (New HOD Policy); and be it further

RESOLVED, that our AMA will advocate for the development, staffing, and operation of sustainable, on-site medical and behavioral health services, including evidence-based and culturally-appropriate addiction treatment, for incarcerated American Indian and Alaska Native persons (Directive to Take Action); and be it further

RESOLVED, that our AMA strongly supports routine audits and inspection of facilities managed by the Bureau of Indian Affairs Division of Correction, ensuring that these facilities abide by all standards and guidelines outlined by the National Commission on Correctional Health Care. (New HOD Policy)

Your Reference Committee heard unanimously supportive testimony on this item with one minor suggested amendment to improve clarity. Testimony noted that American Indian and Alaskan Native (AI/AN) communities are deserving of better care and that tribal jails are severely underfunded and inadequately staffed, often lacking sufficient health care services, which further exacerbates the health disparities faced by AI/AN populations. Therefore, Madam Speaker, your Reference Committee recommends that Resolution 918 be adopted as amended.

(22) RESOLUTION 919 – IMPROVING RURAL ACCESS TO COMPREHENSIVE CANCER CARE SERVICE

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the second Resolve Resolution 919 be amended by addition to read as follows:

RESOLVED, that our AMA call for increased federal and state funding to support research on rural cancer disparities and equity in care, access, and outcomes and development of interventions to address those disparities (Directive to Take Action);

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the third Resolve of Resolution 919 be amended by addition to read as follows:

RESOLVED, that our AMA advocate for evidence-based collaborative models for innovative telementoring/ teleconsultation between health care systems, academic medical centers, and community physicians to improve access to cancer screening, diagnosis, treatment, rehabilitation, and patient services in rural areas. (Directive to Take Action)

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Resolution 919 be adopted as amended.

RECOMMENDATION D:

Madam Speaker, your Reference Committee recommends that the title be changed for Resolution 919 to read as follows:

IMPROVING RURAL ACCESS TO COMPREHENSIVE CANCER CARE SERVICES

HOD ACTION: Resolution 919 be adopted as amended with a title change.

RESOLVED, that our American Medical Association work with relevant stakeholders to develop a national strategy to eliminate rural cancer disparities in screening, treatment, and outcomes and achieve health equity in cancer outcomes across all geographic regions (Directive to Take Action); and be it further

RESOLVED, that our AMA call for increased federal and state funding to support research on rural cancer disparities in care, access, and outcomes and development of interventions to address those disparities (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for evidence-based collaborative models for innovative telementoring/teleconsultation between health care systems, academic medical centers, and community physicians to improve access to cancer screening, treatment, and patient services in rural areas. (Directive to Take Action)

Your Reference Committee heard supportive testimony on this item. Testimony noted that rural communities continue to face significant disparities in cancer screening, diagnosis, treatment, and outcomes, and this resolution helps promote equitable access to cancer care across geographic regions. It was also noted that this resolution recognizes the role that innovative telemedicine and teleconsultation services can play in expanding access to care for rural populations. Amendments were proffered to include “diagnosis” and “rehabilitation” in the third Resolve noting that this addition would help recognize the importance of cancer diagnosis and rehabilitation and the need for improved access to these services. Therefore, your Reference Committee recommends that Resolution 919 be adopted as amended.

(23) RESOLUTION 922 – ADVOCATING FOR THE REGULATION OF PINK PEPPERCORN AS A TREE NUT

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Resolve of Resolution 922

be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association ask ~~the Food and Drug Administration (FDA), National Institute of Allergy and Infectious Diseases (NIAID), and other relevant stakeholders~~ interested parties to develop skin antigen testing for pink peppercorn to further develop research and clinical application (Directive to Take Action); and be it further

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the second Resolve of Resolution 922 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA ask ~~the FDA, NIAID, and other relevant stakeholders~~ interested parties to conduct ~~appropriate~~ adequate and well-controlled studies to determine the cross-reactivity of pink peppercorn as a tree nut and the prevalence of this allergy, with subsequent regulation, reporting, and public education as appropriate.

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Resolution 922 be adopted as amended.

RECOMMENDATION D:

Madam Speaker, your Reference Committee recommends that the title be changed of Resolution 922 to read as follows:

ADVOCATING FOR FURTHER RESEARCH OF PINK PEPPERCORN ALLERGY

HOD ACTION: Resolution 922 be adopted as amended with a title change.

RESOLVED, that our American Medical Association ask the Food and Drug Administration (FDA), National Institute of Allergy and Infectious Diseases (NIAID), and other relevant stakeholders to develop skin antigen testing for pink peppercorn to further develop research and clinical application (Directive to Take Action); and be it further

RESOLVED, that our AMA ask the FDA, NIAID, and other relevant stakeholders to conduct appropriate studies to determine the cross-reactivity of pink peppercorn as a tree nut, with subsequent regulation, reporting, and public education as appropriate. (Directive to Take Action)

Your Reference Committee heard generally supportive testimony for the intent of Resolution 922, with some discussion as to the best implementation of the goal. Amendments were proffered to simplify the Resolution and to focus our AMA's efforts on the appropriate public agencies, rather than tasks which are primarily handled by private entities, with the expectation that private companies would be downstream participants. Given this testimony, your Reference Committee broadened the language to encompass all appropriate interested parties. "Relevant stakeholder" was amended to "interested parties" to remain consistent with AMA language, and other amendments were proffered to clarify the research required to best accomplish the goal. As such, your Reference Committee recommends that Resolution 922 be adopted as amended.

(24) RESOLUTION 931 - MASS DEPORTATION AS A PUBLIC HEALTH ISSUE

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Resolve of Resolution 931 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association (AMA) recognizes mass deportation of immigrants, asylum seekers, ~~and~~ refugees, and others with or seeking an immigration benefit as a public health issue, and recognizes the long-term mental and physical health implications of deportation on individuals, families, and communities; and be it further

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the second Resolve of Resolution 931 be amended by addition to read as follows:

RESOLVED, that our AMA oppose deportation of health care workers and medically vulnerable patients solely based on their documentation status; and be it further

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Resolution 931 be adopted as amended.

HOD ACTION: Resolution 931 be adopted as amended.

RESOLVED, that our American Medical Association (AMA) recognizes mass deportation of immigrants, asylum seekers, and refugees as a public health issue, and recognizes the long-term mental and physical health implications of deportation on individuals, families, and communities; and be it further

RESOLVED, that our AMA oppose deportation of health care workers solely based on their documentation status; and be it further

RESOLVED, that our AMA oppose the large-scale internment of individuals targeted for deportation efforts.

Your Reference Committee heard overwhelmingly supportive testimony on this resolution, with many personal testimonials regarding colleagues and patients who are at risk of being deported. There was one call to refer for decision, but the stated purpose was only to make the language of the resolution more inclusive to a larger population at risk of deportation. Calls for referral were largely opposed, and your Reference Committee believes the amended language with the term "immigration benefit" is the best estimation of an encompassing term that covers the populations of concern that were previously missing. These populations include those with T visas, U visas, Deferred Action for Childhood Arrivals (DACA) recipients and non-citizens here under the Violence Against Women Act (VAWA). Another amendment was proffered to include medically vulnerable patients in the second Resolve, which was supported by others in the hearing. As such, your Reference Committee recommends that Resolution 931 be adopted as amended.

(25) RESOLUTION 932 - NATIONAL PREPAREDNESS FOR IV FLUID SHORTAGES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Resolve of Resolution 932 be deleted:

~~**RESOLVED, that our American Medical Association advocates that the Secretary of Health and Human Services declare a public health emergency during critical medication and supply shortages, including IV fluids, to enable regulatory flexibility and resource allocation when such shortages significantly impact patient care delivery (Directive to Take Action); and be it further**~~

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the second Resolve of Resolution 932 be amended by addition to read as follows:

RESOLVED, that our AMA urges the Centers for Medicare & Medicaid Services to implement policies to temporarily halt financial and other penalties for affected quality metrics during periods of documented medication and IV fluid shortages as well as in other emergencies in order to prevent physicians and hospitals from being penalized for circumstances beyond their control (Directive to Take Action); and be it further

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the third Resolve of Resolution 932 be deleted:

~~**RESOLVED, that our AMA works with relevant stakeholders to prevent and mitigate all critical medications and medical supplies, including designating production facilities as critical infrastructure, supporting health system contingency planning, and developing a national strategic reserve (Directive to Take Action).**~~

RECOMMENDATION D:

Madam Speaker, your Reference Committee recommends that Resolution 932 be adopted as amended.

RECOMMENDATION E:

Madam Speaker, your Reference Committee recommends that the title be changed of Resolution 932 to read as follows:

WAIVING QUALITY METRICS IN TIMES OF EMERGENCY

HOD ACTION: Resolution 932 be adopted as amended with a title change.

RESOLVED, that our American Medical Association advocates that the Secretary of Health and Human Services declare a public health emergency during critical medication

and supply shortages, including IV fluids, to enable regulatory flexibility and resource allocation when such shortages significantly impact patient care delivery (Directive to Take Action); and be it further

RESOLVED, that our AMA urges the Centers for Medicare & Medicaid Services to implement policies to temporarily halt financial and other penalties for affected quality metrics during periods of documented medication and IV fluid shortages in order to prevent physicians and hospitals from being penalized for circumstances beyond their control (Directive to Take Action); and be it further

RESOLVED, that our AMA works with relevant stakeholders to prevent and mitigate all critical medications and medical supplies, including designating production facilities as critical infrastructure, supporting health system contingency planning, and developing a national strategic reserve (Directive to Take Action).

Your Reference Committee heard significant supportive testimony as to the intent of Resolution 932, furthering the discussion on supply chain disruptions in CSAPH Report 2, Resolution 914, and Resolution 930. Several testifying described the hardships that patients have faced due to the national shortage of IV fluids, and how it could have been prevented by having a more robust and redundant supply chain. While several important points were raised in this Resolution, your Reference Committee recommends that Resolves 1 and 3 be incorporated into CSAPH Report 2 and Resolution 914, respectively. The second Resolve, which is now recommended to stand alone, represents a gap in AMA policy where physicians may be forced to choose between preserving their quality metrics or appropriately rationing critical medical supplies in an emergency situation. While there was testimony noting that the Center for Medicare and Medicaid Services has waived some quality metrics during the ongoing IV fluid shortages, there is no guarantee that a similar waiver will be made during future disasters. Therefore, your Reference Committee recommends that Resolution 932 be adopted as amended.

RECOMMENDED FOR ADOPTION IN LIEU OF

(26) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT 2 – DRUG SHORTAGES: 2024 UPDATE
RESOLUTION 930 - ECONOMIC FACTORS TO PROMOTE RELIABILITY OF PHARMACEUTICAL SUPPLY

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Recommendation in CSAPH Report 2 be amended by addition to read as follows:

26. Our AMA encourages the FDA, the FTC, or other relevant oversight entities, to examine the practice of compounding pharmacies and the entities that utilize them advertising drugs actively in shortage, particularly when targeted to new patients.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the Recommendations in CSAPH Report 2 be adopted as amended in lieu of Resolution 930 and the remainder of the report be filed.

HOD ACTION: Recommendations in CSAPH Report 2 be adopted as amended in lieu of Resolution 930 and the remainder of the report be filed.

The Council on Science and Public Health recommends that the following be adopted in lieu of Resolution 922-I-23, and that the remainder of the report be filed:

1. That Policy H-100.956, "National Drug Shortages," be amended by addition and deletion to read as follows:

1. Our American Medical Association considers drug shortages to be an urgent public health crisis, and recent shortages have had a dramatic and negative impact on the delivery and safety of appropriate health care to patients.
2. Our AMA supports recommendations that have been developed by multiple stakeholders to improve manufacturing quality systems, identify efficiencies in regulatory review that can mitigate drug shortages, and explore measures designed to drive greater investment in production capacity for products that are in short supply, and will work in a collaborative fashion with these and other stakeholders to implement these recommendations in an urgent fashion.
3. Our AMA supports authorizing the Secretary of the U.S. Department of Health and Human Services (DHHS) to expedite facility inspections and the review of manufacturing changes, drug applications and supplements that would help mitigate or prevent a drug shortage.

4. Our AMA will advocate that the U.S. Food and Drug Administration (FDA) and/or Congress require drug manufacturers to establish a plan for continuity of supply of vital and life-sustaining medications and vaccines to avoid production shortages whenever possible. This plan should include establishing the necessary resiliency and redundancy in manufacturing capability to minimize disruptions of supplies in foreseeable circumstances including the possibility of a disaster affecting a plant.
5. The Council on Science and Public Health shall continue to evaluate the drug shortage issue, including the impact of group purchasing organizations and pharmacy benefit managers on drug shortages, and report back at least annually to the House of Delegates on progress made in addressing drug shortages.
6. Our AMA urges continued analysis of the root causes of drug shortages that includes consideration of federal actions, evaluation of manufacturer, Group Purchasing Organization (GPO), pharmacy benefit managers, and distributor practices, contracting practices by market participants on competition, access to drugs, pricing, and analysis of economic drivers, and supports efforts by the Federal Trade Commission (FTC) to oversee and regulate such forces.
7. Our AMA urges regulatory relief designed to improve the availability of prescription drugs by ensuring that such products are not removed from the market or caused to stop production due to compliance issues unless such removal is clearly required for significant and obvious safety reasons.
8. Our AMA supports the view that wholesalers should routinely institute an allocation system that attempts to fairly distribute drugs in short supply based on remaining inventory and considering the customer's purchase history.
9. Our AMA will collaborate with medical specialty society partners and other stakeholders in identifying and supporting legislative remedies to allow for more reasonable and sustainable payment rates for prescription drugs.
10. Our AMA urges that during the evaluation of potential mergers and acquisitions involving pharmaceutical manufacturers, the FTC consult with the FDA to determine whether such an activity has the potential to worsen drug shortages.
11. Our AMA urges the FDA to require manufacturers and distributors to provide greater transparency regarding the pharmaceutical product supply chain, including production locations of drugs, any unpredicted changes in product demand, and provide more detailed information regarding the causes and anticipated duration of drug shortages.
12. Our AMA supports the collection and standardization of pharmaceutical supply chain data in order to determine the data indicators to identify potential supply chain issues, such as drug shortages.
13. Our AMA encourages global implementation of guidelines related to pharmaceutical product supply chains, quality systems, and management of product lifecycles, as well as expansion of global reporting requirements for indicators of drug shortages.
14. Our AMA urges drug manufacturers to accelerate the adoption of advanced manufacturing technologies such as continuous pharmaceutical manufacturing~~.~~, and supports the use of incentives such as prioritized regulatory review, reduction of user fees, and direct grant opportunities for manufacturers seeking to invest in manufacturing processes.
15. Our AMA supports the concept of creating a rating system to provide information about the quality management maturity, resiliency and redundancy, and shortage mitigation plans, of pharmaceutical manufacturing facilities to increase visibility and transparency and provide incentive to manufacturers. Additionally, our AMA

encourages GPOs and purchasers to contractually require manufacturers to disclose their quality rating, when available, on product labeling.

16. Our AMA encourages electronic health records vendors to make changes to their systems to ease the burden of making drug product changes.
17. Our AMA urges the FDA to evaluate and provide current information regarding the quality of outsourcer compounding facilities.
18. Our AMA urges DHHS and the U.S. Department of Homeland Security to examine and consider drug shortages as a national security initiative and include vital drug production sites in the critical infrastructure plan.
19. Our AMA urges the Drug Enforcement Agency and other federal agencies to regularly communicate and consult with the FDA regarding regulatory actions which may impact the manufacturing, sourcing, and distribution of drugs and their ingredients.
20. Our AMA supports innovative approaches for diversifying the generic drug manufacturing base to move away from single-site manufacturing, increasing redundancy, and maintaining a minimum number of manufacturers for essential medicines.
21. Our AMA supports the public availability of FDA facility inspection reports to allow purchasers to better assess supply chain risk.
22. Our AMA opposes the practice of preferring drugs experiencing a shortage on approved pharmacy formularies when other, similarly effective drugs are available in adequate supply but otherwise excluded from formularies or coverage plans.
23. Our AMA shall continue to monitor proposed methodologies for and the implications of a buffer supply model for the purposes of reducing drug shortages and will report its findings as necessary.
24. Our AMA opposes increasing drug prices or waiving fee exemptions in a manner that incentivizes a drug manufacturer to have its drug be declared in shortage.
25. Our AMA opposes the use of punitive fees on physician practices that do not maintain buffer supplies of drugs.
26. Our AMA encourages the FDA, the FTC, or other relevant oversight entities, to examine the practice of compounding pharmacies advertising drugs actively in shortage, particularly when targeted to new patients. (Modify Current Policy)

2. That the following new HOD policy be adopted:

Artificial Drug Shortages Limiting Access to Medications

Our AMA will:
1. Oppose laws, regulations, or business practices which create artificial scarcity of drugs, such as limitations on pharmacy procurement or restrictions on which pharmacies a patient can use, which prevent the filling of an otherwise valid prescription from their physician;
2. Advocate for pharmacies and distributors subject to the national opioid litigation settlement to make public the specific metrics, formulas, data sources, algorithms, thresholds and other policies and analyses that are used to delay or deny orders to pharmacies, restrict physicians' prescribing privileges and other actions that impede patients' access to medication; and
3. Advocate for pharmacies and distributors to provide physicians with all due process rights and opportunities to contest any decision to restrict a physician's prescribing

privileges based on a pharmacy or distributor metric, formula, algorithm or other policy before such restriction is put into effect. (New HOD Policy)

3. That policies H-120.923, "Legalization of Interpharmacy Transfer of Electronic Controlled Substance Prescriptions", H-120.920, "Access to Medications", and D-110.987, "The Impact of Pharmacy Benefit Managers on Patients and Physicians" be reaffirmed. (Reaffirm HOD Policy)

RESOLVED, that our American Medical Association amend H-100.956 "National Drug Shortages" by addition of a new Resolve:

Our AMA support federal drug shortage prevention and mitigation programs that create payer incentives to enable practitioners and participating entities to voluntarily enter contracts directly with manufacturers that will pay more than prevailing market price for generic sterile injectable drugs at high risk of shortage to promote stable manufacturing and reliability of these products. (Modify Current HOD Policy)

Testimony on CSAPH 2 was uniformly supportive, with one minor clarifying amendment to expand the scope of recommendation 26 to include other commercial entities that may not be registered compounding pharmacies themselves, but otherwise contribute to the underlying issue discussed in the report. Additionally, Resolution 930 is concerned with drug shortages and proposes a potential solution, by increasing the direct payments made for drugs at risk. However, several testifying noted that the recommendation of 930 may be incompatible with recommendation 24 of CSAPH 2, and did not favor adoption. As such, your Reference Committee recommends that CSAPH 2 as amended be adopted in lieu of Resolution 930. It is additionally noted that Resolutions 914 and 932, which deal with other aspects of supply chain resilience and emergency response, are discussed previously in this report and may address some of the testimony heard on this item.

(27) RESOLUTION 907 - CALL FOR STUDY: THE NEED FOR HOSPITAL INTERIOR TEMPERATURES TO BE THERMALLY NEUTRAL TO HUMANS WITHIN THOSE HOSPITALS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Alternate Resolution 907 be adopted in lieu of Resolution 907.

SUPPORTING SUSTAINABLE HEALTHCARE CERTIFICATION

RESOLVED, that our AMA supports the Joint Commission's Sustainable Healthcare Certification, which supports health systems in pursuing decarbonization by establishing greenhouse gas (GHG) baseline emissions as well as measuring and documenting GHG reductions.

HOD ACTION: Alternate Resolution 907 be adopted in lieu of Resolution 907.

RESOLVED, that our American Medical Association study the potential feasibility of the creation of a hospital accreditation standard for implementation by the Centers for Medicare and Medicaid Services, through accreditation visits provided by The Joint Commission, Det Norske Veritas, and other accrediting agencies, such that hospital internal temperatures will require ongoing monitoring for compliance with a new standard for hospital internal temperatures (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate that hospital "common areas" must be maintained within a temperature range across which most humans would be comfortable when dressed for the weather of the season (for example, between 21 degrees C - 25 degrees C), toward decreasing health care's greenhouse gas impact, with a report back at the 2025 Interim Meeting of the AMA House of Delegates (Directive to Take Action); and be it further

RESOLVED, that our AMA will forward the results of this study regarding the maintaining of hospital internal temperatures within a suitably narrow range to health care journalists, hospital regulators, hospital executives, and other relevant parties, toward the eventual implementation of the findings and recommendations that are anticipated to be reached. (Directive to Take Action)

Your Reference Committee heard mixed testimony on this item, with several commenters opposing the resolution as written and proffering alternate resolutions. Comments in opposition to this resolution noted numerous challenges in the feasibility of studying this issue and/or felt that it was overly prescriptive. Your Council on Science and Public Health proffered an alternate resolution in support of the existing Joint Commission voluntary Sustainable Healthcare Certification, which your Reference Committee believes achieves the original intent of the resolution. Therefore, Madam Speaker, your Reference Committee recommends that Alternate Resolution 907 be adopted in lieu of Resolution 907.

(28) RESOLUTION 911 - ADEQUATE MASKING AND HPV EDUCATION FOR HEALTH CARE WORKERS (INCLUDING THOSE OVER AGE 45)

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Alternate Resolution 911 be adopted in lieu of Resolution 911.

PREVENTING HEALTH CARE RELATED TRANSMISSION OF HPV

RESOLVED, that our American Medical Association advocate for improved protection for all health care workers and patients who have potential exposure to HPV (Directive to Take Action).

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Policy D-405.967, "HPV Vaccination to Protect Healthcare Workers over Age 45" be reaffirmed.

HOD ACTION: Alternate Resolution 911 be adopted in lieu of Resolution 911.

RESOLVED, that our American Medical Association advocate for the provision of N-95 masks or equivalent be required for all HCWs (health care workers) and patients who have potential exposure to HPV (Directive to Take Action); and be it further

RESOLVED, that our AMA promote education for medical professionals on the importance of HPV education and professional responsibilities in these procedures (Directive to Take Action); and be it further

RESOLVED, that our AMA work with the Centers for Disease Control and Prevention (CDC), the Advisory Committee on Immunization Practices (ACIP) and the Occupational Safety and Health Administration (OSHA) along with other relevant stakeholders to address airborne transmission risks of HPV during surgical procedures and to prevent health care-related transmission.(Directive to Take Action); and be it further

RESOLVED, that our AMA Media Relations Team publicize with a press release to make physicians aware of these new policies, including those outlined in H-440.872, HPV Associated Cancer Prevention. (Directive to Take Action)

Your Reference Committee heard mixed testimony on this item. Testimony against reaffirmation of this item noted that existing policy is missing the call for universal masking (preferably N95 or equivalent) of all people in the room including the patient who may have potential exposure to HPV. Testimony highlighted that data hasn't clearly established that exposure to aerosolized HPV is the cause of increased head and neck cancers, and there is also no clear data showing that using N-95 would be protective. Testimony in opposition of the first Resolve clause also highlighted this lack of data as well and noted that the other Resolve clauses were reaffirmation. It was also noted that the Council on Science and Public Health is working on a report on surgical smoke which will include risk of HPV exposure to health care professionals and appropriate PPE to use. Therefore, Madam Speaker, your Reference Committee recommends that alternate resolution 911 be adopted in lieu of Resolution 911 and existing policy be reaffirmed.

D-405.967 HPV Vaccination to Protect Healthcare Workers over Age 45

1. Our American Medical Association encourages the CDC to review the available evidence for recommending the HPV vaccine for health care professionals to prevent health care related infection of HPV.
2. Our AMA supports the need for additional ongoing research regarding minimization of occupational exposure to HPV, including through use of personal protective equipment.

(29) RESOLUTION 923 – UPDATED RECOMMENDATIONS FOR CHILD SAFETY SEATS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Alternate Resolution 923 be adopted in lieu of Resolution 923.

RESOLVED, that our American Medical Association supports the following evidence-based principles on proper child safety seat use:

1. **All infants and toddlers should ride in a rear-facing car safety seat as long as possible, until they reach the highest weight or height allowed by the seat's manufacturer.**
2. **All children who have outgrown the rear-facing weight or height limit for their car safety seat should use a forward-facing car safety seat with a harness for as long as possible, up to the highest weight or height allowed by the seat's manufacturer.**
3. **All children whose weight or height is above the forward-facing limit for their car safety seat should use a belt-positioning booster seat until the vehicle lap and shoulder seat belt fits properly, typically when they have reached 4 feet 9 inches in height and are between 8 and 12 years of age.**
4. **When children are old enough and large enough to use the vehicle seat belt alone, they should always use lap and shoulder seat belts for optimal protection.**
5. **All children younger than 13 years should be restrained in the rear seats of vehicles for optimal protection.**

RESOLVED, that our AMA rescind policy 15.950, "Child Safety Seats – Public Education and Awareness." (Rescind HOD Policy)

HOD ACTION: Alternate Resolution 923 be adopted in lieu of Resolution 923.

RESOLVED, that our American Medical Association supports the following evidence-based principles in education and advocacy efforts around proper child safety seat use:
(1) The use of rear-facing car safety seats with a harness from birth for as long as possible, until children reach the maximum height or weight specifications of their rear-facing car seat;

(2) The use of forward-facing car safety seats from the time children outgrow rear-facing seats until they reach the maximum height or weight specifications of their forward-facing car seat;
(3) The use of belt-positioning booster seats from the time children they outgrow forward-facing car seats until a seat belt fits properly with the lap belt across the upper thighs and the shoulder belt across the center of the shoulder and chest;
(4) The use of lap and shoulder seat belts for all who have outgrown booster seats; and
(5) That all children under age 13 are seated only in the back row (New HOD Policy); and be it further

RESOLVED, that our AMA rescind policy 15.950, “Child Safety Seats – Public Education and Awareness.” (Rescind HOD Policy)

Your Reference Committee heard strong support for the intent of this resolution, which seeks to update AMA policy to ensure alignment with the latest evidence-based recommendations on child safety seats. Several different amendments were proffered, some to make the policy more specific and aligned to current recommendations and others aiming to make the language less specific noting that the recommendations may change over time. Your Reference Committee believes the best course of action is aligning the language to current evidence-based recommendations and including reference to the highest weight or height allowed by the seat's manufacturer. Therefore, your Reference Committee recommends the adoption of Alternate Resolution 923.

RECOMMENDED FOR REFFERAL

(30) RESOLUTION 908 - SUPPORT FOR DOULA CARE PROGRAMS

RECOMMENDATION:

Resolution 908 be referred.

HOD ACTION: Resolution 908 be referred.

RESOLVED, that our American Medical Association support access to continuous one-to-one emotional support provided by nonmedical support personnel, such as doulas, including for patients who are incarcerated or detained. (New HOD Policy)

Your Reference Committee heard mixed testimony on this resolution. Testimony highlighted many personal stories of the importance of doulas for emotional support in maternity care, integration of doulas within their practice and positive patient experiences. However, other testimony noted concerns for scope of practice for doulas, as well as ensuring their level of training and credentialing for this role. There were several calls for referral for study of this item to better detail the role of the doula within physician-led, team-based maternity care to support recommendations. Therefore, your Reference Committee recommends that Resolution 908 be referred.

RECOMMENDED FOR NOT ADOPTION

(31) RESOLUTION 928 – PUBLIC SAFETY AGENCIES DATA COLLECTION ENHANCEMENT

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 928 be not adopted.

HOD ACTION: Resolution 928 be not adopted.

RESOLVED, that our American Medical Association shall actively collaborate with the National Emerency Medical Services Information System (NEMSIS) to promote a listing of necessary data points and variables to be added to the currently available information collection systems, in a mandatory and searchable fashion, to facilitate the required research (Directive to Take Action); and be it further

RESOLVED, that our AMA shall actively collaborate with the American College of Surgeons to promote addition of these variable fields to data collection systems of the National Trauma Data Bank (NTDB) and the Trauma Quality Improvement Program (TQIP), in a mandatory and searchable fashion, to facilitate the required research (Directive to Take Action); and be it further

RESOLVED, that our AMA shall advocate to the US Congress to mandate the collection of these data and fund the transition to and the ongoing collection of these data. (Directive to Take Action)

Your Reference Committee heard testimony in opposition to this resolution. While it was noted that research using large databases is important, surgeons who use this system testified that data entry is currently time consuming and burdensome. Further, it was noted that additional variables to develop and then collect would create added expense and may limit participation in this useful quality assurance work. Therefore, your Reference Committee recommends Resolution 928 be not adopted.

RECOMMENDED FOR REAFFIRMATION IN LIEU OF

(32) RESOLUTION 920 – REVISE FAA REGULATIONS TO INCLUDE NALOXONE (NARCAN) IN THE ON-BOARD MEDICAL KIT FOR COMMERCIAL AIRLINES FLYING WITHIN THE CONTINENTAL UNITED STATES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Policy H-45.981 be reaffirmed in lieu of Resolution 920.

HOD ACTION: Policy H-45.981 be reaffirmed in lieu of Resolution 920.

RESOLVED, that our American Medical Association work with the FAA and any other appropriate Federal Agency to require Naloxone (Narcan) or any other FDA approved opioid antagonist to be a component of the medical kit of any commercial airline that flies within the Continental United States (Directive to Take Action); and be it further

RESOLVED, that existing house policy "US Airlines Aircraft Emergency Kits" H-45.981 be modified as follows:

2. Our AMA will:
a. support the addition of ~~naloxone,~~ epinephrine auto injector and glucagon to the airline medical kit.
b. encourage airlines to voluntarily include ~~naloxone,~~ epinephrine auto injector and glucagon in their airline medical kits.
c. encourage the addition of ~~naloxone,~~ epinephrine auto injector and glucagon to the emergency medical kits of all US airlines (14CFR Appendix A to Part 121 - First Aid Kits and Emergency Medical Kits); and
d. Work with the FAA and any other appropriate Federal Agency to require Naloxone (Narcan) or any other FDA approved opioid antagonist to be a component of the medical kit of any commercial airline that flies within the Continental United States. (Modify Current Policy)

Your Reference Committee heard limited but supportive testimony on reaffirmation of this item. Therefore, Madam Speaker, your Reference Committee that policy H-45.981 be reaffirmed in lieu of Resolution 920.

H-45.981 Improvement in US Airlines Aircraft Emergency Kits
1. Our American Medical Association urges federal action to require all US air carriers to report data on in-flight medical emergencies, specific uses of in-flight medical kits and emergency lifesaving devices, and unscheduled diversions due to in-flight medical emergencies; this action should further require the Federal Aviation Administration to work with the airline industry and appropriate medical specialty societies to periodically

review data on the incidence and outcomes of in-flight medical emergencies and issue recommendations regarding the contents of in-flight medical kits and the use of emergency lifesaving devices aboard commercial aircraft.

2. Our AMA will:
    a. support the addition of naloxone, epinephrine auto injector and glucagon to the airline medical kit.
    b. encourage airlines to voluntarily include naloxone, epinephrine auto injector and glucagon in their airline medical kits.
    c. encourage the addition of naloxone, epinephrine auto injector and glucagon to the emergency medical kits of all US airlines (14CFR Appendix A to Part 121 - First Aid Kits and Emergency Medical Kits).

3. That our American Medical Association advocate for U.S. passenger airlines to carry standard pulse oximeters, automated blood pressure cuffs and blood glucose monitoring devices in their emergency medical kits.

Madam Speaker, this concludes the report of Reference Committee K . I would like to thank Maria Basile, MD, Kenneth M. Certa, MD, Breyen Coffin, MD, Nancy Ellerbroek, MD, Amit Ghose, MD, Sudeep Kukreja, MD, and all those who testified before the Committee.

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