

## APPENDIX - REPORTS OF REFERENCE COMMITTEES

## November 2021 Special 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 at a given meeting and have precedence. Discrepancies between the reference committee reports and the Proceedings may exist, 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 light-colored background as in the example below:

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 or different from changes proposed by the original item of business, those changes are shown with double underscore or double ~~striketrough~~, and in some cases are highlighted in yellow.

## REPORT OF REFERENCE COMMITTEE ON AMENDMENTS TO CONSTITUTION AND BYLAWS

## RECOMMENDED FOR ADOPTION

- (1) BOARD OF TRUSTEES REPORT 5 – TERMS AND LANGUAGE IN POLICIES ADOPTED TO PROTECT POPULATIONS FROM DISCRIMINATION AND HARASSMENT

## RECOMMENDATION:

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 Policy G-600.067, “Terms and Language in Policies Adopted to Protect Populations from Discrimination and Harassment,” be rescinded, the following be adopted, and the remainder of this report be filed:

1. That our AMA recommend preferred terminology for protected personal characteristics to be used in AMA policies and position statements. (Directive to Take Action)

Testimony was heard in general support of Board of Trustees Report 5. Testimony noted that the report aims to recommend consistency by optimizing language to protect vulnerable populations. Speakers noted that it is essential that the House of Medicine have a common definition of terms to prevent misunderstandings and facilitate collaboration to move medicine forward. One amendment suggested that the report be amended to replace “his/her” to “an individual’s” in policy H-140.837, however, this amendment was offered on existing policy cited in the body of the report and not within the recommendations themselves. Your Reference Committee recommends that the recommendations in Board of Trustees Report 5 be adopted and the remainder of the report be filed.

Policy G-600.067, “Terms and Language in Policies Adopted to Protect Populations from Discrimination and Harassment”

Our AMA will: (1) undertake a study to identify all discrimination and harassment references in AMA policies and the code of ethics, noting when the language is consistent and when it is not; (2) research language and terms used by other national organizations and the federal government in their policies on discrimination and harassment; (3) present the preliminary study results to the Minority Affairs Section, the Women’s Physician Section, and the Advisory Committee on LGBTQ Issues to reach consensus on optimal language to protect vulnerable populations including racial and ethnic minorities, sexual and gender minorities, and women, from discrimination and harassment; and (4) produce a report within 18 months with study results and recommendations.

- (2) BOARD OF TRUSTEES REPORT 11 – NATIONAL GUIDELINES FOR GUARDIANSHIP

## RECOMMENDATION:

Recommendations in Board of Trustees Report 11 be adopted and the remainder of the Report be filed.

**HOD ACTION:** Recommendations in Board of Trustees Report 11 adopted and the remainder of the Report filed.

The Board of Trustees recommends that the following be adopted in lieu of Resolution 17-A-19, and the remainder of this report be filed:

1. That Opinion 8.10, “Preventing, Identifying and Treating Violence and Abuse;” H-515.961, “Elder Mistreatment;” and H-515-984, “Health Care Costs of Violence and Abuse Across the Lifespan,” be reaffirmed. (Reaffirm HOD Policy)

2. That our AMA support initiatives by the American Bar Association Commission on Law and Aging and other associations and agencies of the federal government to address elder abuse and to ensure consistent protection of elders’ rights in all states. (Directive to Take Action)

The report was introduced by the Board of Trustees, and no further testimony was heard. Your Reference Committee recommends that the recommendations in Board of Trustees Report 11 be adopted and the remainder of the report be filed.

Ethical Opinion E-8.10, “Preventing, Identifying and Treating Violence and Abuse”

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

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

- (a) Become familiar with:
  - i. how to detect violence or abuse, including cultural variations in response to abuse;
  - ii. community and health resources available to abused or vulnerable persons;
  - iii. public health measures that are effective in preventing violence and abuse;
  - iv. legal requirements for reporting violence or abuse.
- (b) Consider abuse as a possible factor in the presentation of medical complaints.
- (c) Routinely inquire about physical, sexual, and psychological abuse as part of the medical history.
- (d) Not allow diagnosis or treatment to be influenced by misconceptions about abuse, including beliefs that abuse is rare, does not occur in “normal” families, is a private matter best resolved without outside interference, or is caused by victims’ own actions.
- (e) Treat the immediate symptoms and sequelae of violence and abuse and provide ongoing care for patients to address long-term consequences that may arise from being exposed to violence and abuse.
- (f) Discuss any suspicion of abuse sensitively with the patient, whether or not reporting is legally mandated, and direct the patient to appropriate community resources.
- (g) Report suspected violence and abuse in keeping with applicable requirements. Before doing so, physicians should:
  - i. inform patients about requirements to report;
  - ii. obtain the patient’s informed consent when reporting is not required by law. Exceptions can be made if a physician reasonably believes that a patient’s refusal to authorize reporting is coerced and therefore does not constitute a valid informed treatment decision.
- (h) Protect patient privacy when reporting by disclosing only the minimum necessary information.

Collectively, physicians should:

- (i) Advocate for comprehensive training in matters pertaining to violence and abuse across the continuum of professional education.
- (j) Provide leadership in raising awareness about the need to assess and identify signs of abuse, including advocating for guidelines and policies to reduce the volume of unidentified cases and help ensure that all patients are appropriately assessed.
- (k) Advocate for mechanisms to direct physicians to community or private resources that might be available to aid their patients.
- (l) Support research in the prevention of violence and abuse and collaborate with public health and community organizations to reduce violence and abuse.
- (m) Advocate for change in mandatory reporting laws if evidence indicates that such reporting is not in the best interests of patients.

Policy H-515.961, “Elder Mistreatment”

Our AMA recognizes: (1) elder mistreatment as a serious and pervasive public health problem that requires an organized effort from physicians and all medical professionals to improve the timely recognition and provision of clinical care in vulnerable elders who experience mistreatment; and (2) the importance of an interdisciplinary and collaborative approach to this issue, and encourage states to bring together teams with representatives from medicine, nursing, social work, adult protective services (APS), criminal and civil law, and law enforcement to develop appropriate interventions and evaluate their effectiveness.

Policy D-515.984, “Health Care Costs of Violence and Abuse Across the Lifespan”

1. Our AMA urges the National Academies of Sciences, Engineering, and Medicine to continue to study the impact and health care costs of violence and abuse across the lifespan.

2. Our AMA encourages the National Institutes of Health, the Agency for Healthcare Research and Quality, and the Centers for Disease Control and Prevention to conduct research on the cost savings resulting from health interventions on violence and abuse.

3. Our AMA encourages the appropriate federal agencies to increase funding for research on the impact and health care costs of elder mistreatment.

(3) BOARD OF TRUSTEES REPORT 13 – STUDY OF FORCED ORGAN HARVESTING BY CHINA

RECOMMENDATION:

Recommendations in Board of Trustees Report 13 be adopted and the remainder of the Report be filed.

**HOD ACTION:** Recommendations in Board of Trustees Report 13 adopted and the remainder of the Report filed.

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

1. That our American Medical Association continue to engage the Chinese Medical Association and the transplant community in the People’s Republic of China (PRC) through promotion and support of relevant activities and policies of the World Medical Association that relate to organ transplantation. (Directive to Take Action)

2. That our AMA, through its membership in the World Medical Association, continue to call for the PRC’s compliance with internationally recognized organ transplantation standards, such as those of the World Health Organization, and for the PRC to make available externally verifiable data on organ transplantation. (Directive to Take Action)

3. That our AMA condemn the retrieval of organs for transplantation without the informed consent of the donor. (New HOD Policy)

4. That Policy D-370.981, “Study of Forced Organ Harvesting by China,” be rescinded, having been accomplished by this report. (Rescind HOD Policy)

Testimony was heard in unanimous support of Board of Trustees Report 13. Your Reference Committee recommends that the recommendations in Board of Trustees Report 13 be adopted and the remainder of the report be filed.

## Policy D-370.981, “Study of Forced Organ Harvesting by China”

Our AMA will gather and study all information available and possible on the issue of forced organ harvesting by China and issue a report to our House of Delegates at the 2020 Annual Meeting.

(4) BOARD OF TRUSTEES REPORT 15 – OPPOSING ATTORNEY PRESENCE  
AT AND/OR RECORDING OF INDEPENDENT MEDICAL  
EXAMINATIONS

RECOMMENDATION:

Recommendations in Board of Trustees Report 15 be adopted and the remainder of the report be filed.

**HOD ACTION:** Recommendations in Board of Trustees Report 15 adopted and the remainder of the report filed.

The Board of Trustees recommends that the following recommendation be adopted in lieu of Resolution 1-A-19 and that the remainder of the report be filed:

That, upon request of state medical associations and national medical specialty societies, our AMA will provide assistance and consultation in opposing the ability of courts to compel recording and videotaping of, or allow a court reporter or an attorney to be present during the independent medical examination, as a condition precedent to allowing the physician’s medical opinion in court. (Directive to Take Action)

Testimony was heard in general support of this report. Supporting testimony noted that the presence of recording devices or third parties may inhibit physicians’ ability to receive the information they need from patients. Additional supporting testimony noted that given the variation in state laws regarding independent medical examinations and workers’ compensation, a blanket policy opposing this in all instances is not practical, and it thus makes sense for the AMA to provide assistance and consultation on this matter at the request of state medical associations and national specialty societies. Opposing testimony noted that independent medical examinations are not truly independent, and recording should be encouraged for the protection of those making claims of injury or disability. Your Reference Committee believes that the recommendations given in this report are supported by the preponderance of testimony, and therefore recommends that the recommendations in Board of Trustees Report 15 be adopted and the remainder of the report be filed.

(5) BOARD OF TRUSTEES REPORT 16 – RESEARCH HANDLING OF DE-  
IDENTIFIED PATIENT INFORMATION

RECOMMENDATION:

Recommendations in Board of Trustees Report 16 be adopted and the remainder of the report be filed.

**HOD ACTION:** Recommendations in Board of Trustees Report 16 adopted and the remainder of the report filed.

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

1. That our American Medical Association (AMA) reaffirm Policies H-315.975, “Police, Payer, and Government Access to Patient Health Information,” H-315.978, “Privacy and Confidentiality,” and H-315.987, “Limiting Access to Medical Records.” (Reaffirm HOD Policy)

2. That our AMA adopt a technical change to Policy H-315.974, “Guiding Principles, Collection and Warehousing of Electronic Medical Record Information,” by addition as follows: (Modify Current HOD Policy)

Policy H-315.974, “Guiding Principles, Collection and Warehousing of Electronic Medical Record Information”

Our AMA expressly advocates for physician ownership of all claims data, transactional data and de-identified and/or aggregate data created, established and maintained by a physician practice, regardless of how and where such data is stored but specifically including any such data derived from a physician’s medical records, electronic health records, or practice management system, while preserving the principle that physicians act as trusted stewards of Protected Health Information.

3. That our AMA support efforts to promote transparency in the use of de-identified patient data and to protect patient privacy by developing methods of, and technologies for, de-identification of patient information that reduce the risk of re-identification of such information. (New HOD Policy)

4. That our Council on Ethical and Judicial Affairs consider re-examining existing guidance relevant to the confidentiality of patient information, striving to preserve the benefits of widespread use of de-identified patient data for purposes of promoting quality improvement, research, and public health while mitigating the risks of re-identification of such data. (Directive to Take Action)

5. That Policy D-315.975, “Research Handling of De-Identified Patient Information,” be rescinded, as having been fulfilled by this report. (Rescind HOD Policy)

This report was introduced by the Board of Trustees and further testimony was minimal. An amendment was offered suggesting that additional language be added to specifically state that use and disclosure of patient information be consistent with federal, state, local, or tribal law, regulation, or policy, but your Reference Committee believes that these laws, regulations and policies will be considered regardless. Your Reference Committee recommends that the recommendations in Board of Trustees Report 16 be adopted and the remainder of the report be filed.

Policy H-315.974, “Guiding Principles, Collection and Warehousing of Electronic Medical Record Information”

Our AMA expressly advocates for physician ownership of all claims data, transactional data and de-identified aggregate data created, established and maintained by a physician practice, regardless of how and where such data is stored but specifically including any such data derived from a physician’s medical records, electronic health records, or practice management system, while preserving the principle that physicians act as trusted stewards of Protected Health Information.

Policy H-315.975, “Police, Payer, and Government Access to Patient Health Information”

(1) Our AMA advocates vigorously, with respect to the final privacy rule or other privacy legislation, to define “health care operations” narrowly to include only those activities and functions that are routine and critical for general business operations and that cannot reasonably be undertaken with de-identified information.

(2) Our AMA advocates vigorously, with respect to the final privacy rule or other privacy legislation, that the Centers for Medicare & Medicaid Services (CMMS) and other payers shall have access to medical records and individually identifiable health information solely for billing and payment purposes, and routine and critical health care operations that cannot reasonably be undertaken with de-identified health information.

(3) Our AMA advocates vigorously, with respect to the final privacy rule or other privacy legislation, that CMMS and other payers may access and use medical records and individually identifiable health information for non-billing, non-payment purposes and non-routine, non-critical health care operations that cannot reasonably be undertaken with de-identified health information, only with the express written consent of the patient or the patient’s authorized representative, each and every time, separate and apart from blanket consent at time of enrollment.

(4) Our AMA advocates vigorously, with respect to the final privacy rule or other privacy legislation that no government agency, including law enforcement agencies, be permitted access to medical records or individually identifiable health information (except for any discretionary or mandatory disclosures made by physicians and other health care providers pursuant to ethical guidelines or to comply with applicable state or federal reporting laws) without the express written consent of the patient, or a court order or warrant permitting such access.

(5) Our AMA continues to strongly support and advocate a minimum necessary standard of disclosure of individually identifiable health information requested by payers, so that the information necessary to accomplish the intended purpose of the request be determined by physicians and other health care providers, as permitted under the final privacy rule.

Policy H-315.978, “Privacy and Confidentiality”

Our AMA policy is that where possible, informed consent should be obtained before personally identifiable health information is used for any purpose. However, in those situations where specific informed consent is not practical or possible, either (1) the information should have identifying information stripped from it or (2) an objective, publicly accountable entity must determine that patient consent is not required after weighing the risks and benefits of the proposed use. Re-identification of personal health information should only occur with patient consent or with the approval of an objective, publicly accountable entity.

Policy H-315.987, “Limiting Access to Medical Records”

Our AMA: (1) will pursue the adoption of federal legislation and regulations that will: limit third party payers’ random access to patient records unrelated to required quality assurance activities; limit third party payers’ access to medical records to only that portion of the record (or only an abstract of the patient’s records) necessary to evaluate for reimbursement purposes; require that requests for information and completion of forms be delineated and case specific; allow a summary of pertinent information relative to any inquiry into a patient’s medical record be provided in lieu of a full copy of the records (except in instances of litigation where the records would be discoverable); and provide proper compensation for the time and skill spent by physicians and others in preparing and completing forms or summaries pertaining to patient records; and (2) supports the policy that copies of medical records of service no longer be required to be sent to insurance companies, Medicaid or Medicare with medical bills.

Policy D-315.975, “Research Handling of De-Identified Patient Information”

Our AMA will study the handling of de-identified patient information and report findings and recommendations back to the AMA House of Delegates.

(6) BOARD OF TRUSTEES REPORT 20 - SPECIALTY SOCIETY  
REPRESENTATION IN THE HOUSE OF DELEGATES FIVE-YEAR  
REVIEW

RECOMMENDATION:

Recommendations in Board of Trustees Report 20 be adopted and the remainder of the report be filed.

**HOD ACTION:** Recommendations in Board of Trustees Report 20 adopted and the remainder of the report filed.

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

1. That the American Academy of Insurance Medicine, American Academy of Sleep Medicine, American Society of Gastrointestinal Endoscopy, American Urological Association, American Society of Plastic Surgeons,

AMSUS The Society of Federal Health Professionals and North American Spine Society retain representation in the American Medical Association House of Delegates. (Directive to Take Action)

2. Having failed to meet the requirements for continued representation in the AMA House of Delegates as set forth in AMA Bylaw B-8.5, American Society of Radiation Oncology, American Society for Surgery of the Hand, Society for Vascular Surgery, and the Society of American Gastrointestinal and Endoscopic Surgeons be placed on probation and be given one year to work with AMA membership staff to increase their AMA membership. (Directive to Take Action)
3. Having failed to meet the requirements for continued representation in the AMA House of Delegates as set forth in AMA Bylaw B-8.5 after a year's grace period to increase membership, the American Society of Abdominal Surgeons and the International Association of Independent Medical Evaluators not retain representation in the House of Delegates. (Directive to Take Action)

This report was introduced by the Board of Trustees and limited supporting testimony was heard. Your Reference Committee recommends that the recommendations in Board of Trustees Report 20 be adopted and the remainder of the report be filed.

(7) COUNCIL ON CONSTITUTION AND BYLAWS REPORT 1 – FURTHER ACTION ON BYLAW 7.5.2

RECOMMENDATION:

Recommendations in Council on Constitution and Bylaws Report 1 be adopted and the remainder of the report be filed.

**HOD ACTION:** Recommendations in Council on Constitution and Bylaws Report 1 adopted and the remainder of the report filed.

The Council on Constitution and Bylaws recommends that the following amendments to the AMA Bylaws 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.

7.5 Young Physicians Section. The Young Physicians Section is a fixed Section.

7.5.1 Membership. All active physician members of the AMA who are not resident/fellow physicians, but who are under 40 years of age or are within the first 8 years of professional practice after residency and fellowship training programs, shall be members of the Young Physicians Section until December 31 of the year of their 40th birthday or December 31 of the eighth year following completion of their graduate medical education, whichever comes last.

7.5.2 Cessation of Eligibility of Governing Council Members. If any Governing Council member ceases to meet the membership requirements of Bylaw 7.5.1 prior to the expiration of the term for which elected, the term of such member shall terminate and the position shall be declared vacant. If any member's term would terminate prior to the conclusion of an Annual Meeting, such member shall be permitted to serve in office until the conclusion of the Annual Meeting ~~in the calendar year~~ following that when such member ceases to meet the membership requirements of Bylaw 7.5.1, as long as the member remains an active physician member of the AMA.

7.5.2.1 The chair position is a three-year commitment and divided into the roles of chair-elect, chair, and immediate past chair. The young physician must meet the requirements of Bylaws 7.5.1 and 7.5.2 when elected as chair-elect. The chair-elect, chair and immediate past chair shall be granted membership in the Section and be permitted to complete the term of office even if unable to continue to meet all of the requirements of Bylaw 7.5.1, as long as the physician remains an active physician member of the AMA.  
(Modify Bylaws)



The report was introduced by the author, and limited supporting testimony was heard. Your Reference Committee recommends that the recommendations in Council on Constitution and Bylaws Report 1 be adopted and the remainder of the report be filed.

(8) COUNCIL ON CONSTITUTION AND BYLAWS REPORT 2 – RESCISSION  
OF BYLAWS RELATED TO RUN-OFF ELECTIONS

RECOMMENDATION:

Recommendations in Council on Constitution and Bylaws Report 2 be adopted  
and the remainder of the report be filed.

**HOD ACTION:** Recommendations in Council on Constitution and Bylaws Report 2  
adopted and the remainder of the report filed.

The Council on Constitution and Bylaws recommends that the following amendments to the AMA Bylaws 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.

3.4.2 Method of Election. Where there is no contest, a majority vote without ballot shall elect. All other elections shall be by ballot.

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~~3.4.2.2 At Large Trustees to be Elected to Fill Vacancies after a Prior Ballot. The nomination and election of Trustees to fill a vacancy that did not exist at the time of the prior ballot shall be held after election of other Trustees and shall follow the same procedure. Individuals so elected shall be elected to a complete 4 year term of office. Unsuccessful candidates in any election for Trustee, other than the young physician trustee and the resident/fellow physician trustee, shall automatically be nominated for subsequent elections until all Trustees have been elected. In addition, nominations from the floor shall be accepted.~~

[Subsequent bylaw provisions will be renumbered accordingly.]

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6.8 Election - Council on Constitution and Bylaws, Council on Medical Education, Council on Medical Service, and Council on Science and Public Health.

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~~6.8.1.5 Council Members to be Elected to Fill Vacancies after a Prior Ballot. The nomination and election of members of the Council to fill a vacancy that did not exist at the time of the prior ballot shall be held after election of other members of the Council, and shall follow the same procedure. Individuals elected to such vacancy shall be elected to a complete 4 year term. Unsuccessful candidates in the election for members of the Council shall automatically be nominated for subsequent elections to fill any such vacancy until all members of the Council have been elected. In addition, nominations from the floor shall be accepted.~~

(Modify Bylaws)

The report was introduced by the author and no further testimony was heard. Your Reference Committee recommends that the recommendations in Council on Constitution and Bylaws Report 2 be adopted and the remainder of the report be filed.

(9) COUNCIL ON CONSTITUTION AND BYLAWS REPORT 3 – AMA  
WOMEN PHYSICIANS SECTION: CLARIFICATION OF BYLAW  
LANGUAGE

RECOMMENDATION:

Recommendations in Council on Constitution and Bylaws Report 3 be adopted  
and the remainder of the report be filed.

**HOD ACTION:** Recommendations in Council on Constitution and Bylaws Report 3  
adopted and the remainder of the report filed.

The Council on Constitution and Bylaws recommends: 1) that the following amendments to the AMA Bylaws be adopted; and 2) 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.

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

7.10.1 Membership. All female physicians and female medical students who are active members of the AMA shall be eligible to be members of the Women Physicians Section. ~~7.10.1.1 Other active members of the AMA who express an interest in women's issues may also shall be eligible to join the section.~~ (Modify Bylaws)

The report was introduced by the author, and limited supporting testimony was heard. Your Reference Committee recommends that the recommendations in Council on Constitution and Bylaws Report 3 be adopted and the remainder of the report be filed.

(10) COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS REPORT 1 - SHORT-  
TERM MEDICAL SERVICE TRIPS

RECOMMENDATION:

Recommendations in Council on Ethical and Judicial Affairs Report 1 be  
adopted and the remainder of the report be filed.

**HOD ACTION:** Recommendations in Council on Ethical and Judicial Affairs Report  
1 referred.

In light of these deliberations, the Council on Ethical and Judicial Affairs recommends that the following be adopted and the remainder of this report be filed:

Short-term medical service trips, which send physicians and physicians in training from wealthier countries to provide care in resource-limited settings for a period of days or weeks, have emerged as a prominent response for addressing global health inequities. They also provide training and educational opportunities, thus offering benefit both to the communities that host them and the medical professionals and trainees who volunteer their time and clinical skills.

By definition, short-term medical service trips take place in contexts of scarce resources and in the shadow of colonial histories. These realities define fundamental ethical responsibilities to enable good health outcomes, promote justice and sustainability, minimize burdens on host communities, and respect persons and local cultures. Responsibly carrying out short-term medical service trips requires diligent preparation on the part of sponsors and participants in collaboration with host communities.

Physicians and trainees who are involved with short-term medical service trips should ensure that the trips with which they are associated:

- (a) Focus prominently on promoting justice and sustainability by collaborating with the host community to define mission parameters, including identifying community needs, mission goals, and how the volunteer medical

team will integrate with local health care professionals and the local health care system. In collaboration with the host community, short-term medical service trips should identify opportunities for and priority of efforts to support the community in building health care capacity. Trips that also serve secondary goals, such as providing educational opportunities for trainees, should prioritize benefits as defined by the host community over benefits to members of the volunteer medical team.

(b) Seek to proactively identify and minimize burdens the trip may place on the host community, including not only direct, material costs of hosting volunteers, but on possible disruptive effects the presence of volunteers could have for local practice and practitioners as well. Sponsors and participants should ensure that team members practice only within their skill sets and experience, and that resources are available to support the success of the trip, including arranging for local mentors, translation services, and volunteers' personal health needs as appropriate.

(c) Seek to become broadly knowledgeable about the communities in which they will work and take advantage of resources to begin to cultivate the "cultural sensitivity" they will need to provide safe, respectful, patient-centered care in the context of the specific host community. Members of the volunteer medical team are expected to uphold the ethics standards of their profession and volunteers should insist that strategies are in place to address ethical dilemmas as they arise. In cases of irreducible conflict with local norms, volunteers may withdraw from care of an individual patient or from the mission after careful consideration of the effect that will have on the patient, the medical team, and the mission overall, in keeping with ethics guidance on the exercise of conscience.

Sponsors of short-term medical service trips should:

(d) Ensure that resources needed to meet the defined goals of the trip will be in place, particularly resources that cannot be assured locally.

(e) Proactively define appropriate roles and permissible range of practice for members of the volunteer team, including the training, experience, and oversight of team members required to provide acceptable safe, high-quality care in the host setting. Team members should practice only within the limits of their training and skills in keeping with the professional standards of the sponsor's country.

(f) Put in place a mechanism to collect data on success in meeting collaboratively defined goals for the trip in keeping with recognized standards for the conduct of health services research and quality improvement activities in the sponsor's country.

Limited, mixed testimony was heard on this report. Testimony in favor of referral expressed concern that issues regarding scope of practice on medical service trips not exceeding the scope of the licensee in the practitioner's home state, working with local communities, supervising trainees, and potential harm caused by these trips were not adequately addressed in the recommendations. Another speaker expressed concern that sections (d) and (f) of the recommendations may be unrealistic. Testimony in favor of adoption lauded the improved recommendations in this report over the previous version, including support from those who organize medical service trips. Your Reference Committee believes that the issues of concern are adequately addressed in the recommendations, particularly in the first three points of guidance. Therefore, your Reference Committee recommends that Council on Ethical and Judicial Affairs Report 1 be adopted and the remainder of the report be filed.

- (11) COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS REPORT 2 - AMENDMENTS TO OPINIONS 1.2.11, "ETHICAL INNOVATION IN MEDICAL PRACTICE"; 11.1.2, "PHYSICIAN STEWARDSHIP OF HEALTH CARE RESOURCES"; 11.2.1, "PROFESSIONALISM IN HEALTH CARE SYSTEMS"; AND 1.1.6, "QUALITY"

#### RECOMMENDATION:

Recommendations in Council on Ethical and Judicial Affairs Report 2 be adopted and the remainder of the report be filed.

**HOD ACTION:** Recommendations in Council on Ethical and Judicial Affairs Report  
2 adopted and the remainder of the report filed.

In light of the foregoing, the Council on Ethical and Judicial Affairs recommend that Opinion 1.2.11, “Ethically Sound Innovation in Medical Practice”; Opinion 11.2.1, “Professionalism in Health Care Systems”; Opinion 11.1.2, “Physician Stewardship of Health Care Resources”; and Opinion 1.1.6, “Quality,” be amended as follows and the remainder of this report be filed:

1. Opinion 1.2.11, Ethically Sound Innovation in Clinical Practice

Innovation in medicine can ~~span a wide range of activities. From~~ It encompasses not only improving an existing intervention, ~~to introducing an innovation in one’s own clinical practice for the first time, to~~ using an existing intervention in a novel way, or translating knowledge from one clinical context into another but also developing or implementing new technologies to enhance diagnosis, treatment, and health care operations. Innovation shares features with both research and patient care, but it is distinct from both.

When physicians participate in developing and disseminating innovative practices, they act in accord with professional responsibilities to advance medical knowledge, improve quality of care, and promote the well-being of individual patients and the larger community. Similarly, these responsibilities are honored when physicians enhance their own practices by expanding the range of tools, techniques, and or interventions they ~~offer to patients~~ employ in providing care.

Individually, physicians who are involved in designing, developing, disseminating, or adopting innovative modalities should:

- (a) Innovate on the basis of sound scientific evidence and appropriate clinical expertise.
- (b) Seek input from colleagues or other medical professionals in advance or as early as possible in the course of innovation.
- (c) Design innovations so as to minimize risks to individual patients and maximize the likelihood of application and benefit for populations of patients.
- (d) Be sensitive to the cost implications of innovation.
- (e) Be aware of influences that may drive the creation and adoption of innovative practices for reasons other than patient or public benefit.

When they offer existing innovative diagnostic or therapeutic services to individual patients, physicians must:

- (f) Base recommendations on patients’ medical needs.
- (g) Refrain from offering such services until they have acquired appropriate knowledge and skills.
- (h) Recognize that in this context informed decision making requires the physician to disclose:
  - (i) how a recommended diagnostic or therapeutic service differs from the standard therapeutic approach if one exists;
  - (ii) why the physician is recommending the innovative modality;
  - (iii) what the known or anticipated risks, benefits, and burdens of the recommended therapy and alternatives are;
  - (iv) what experience the professional community in general and the physician individually has had to date with the innovative therapy;

- (v) what conflicts of interest the physician may have with respect to the recommended therapy.
- (i) Discontinue any innovative therapies that are not benefiting the patient.
- (j) Be transparent and share findings from their use of innovative therapies with peers in some manner. To promote patient safety and quality, physicians should share both immediate or delayed positive and negative outcomes.

To promote responsible innovation, health care institutions and the medical profession should:

- (k) Ensure that innovative practices or technologies that are made available to physicians meet the highest standards for scientifically sound design and clinical value.
- (~~kl~~) Require that physicians who adopt ~~innovative treatment or diagnostic techniques~~ innovations into their practice have ~~appropriate~~ relevant knowledge and skills.
- (~~lm~~) Provide meaningful professional oversight of innovation in patient care.
- (~~mn~~) Encourage physician-innovators to collect and share information about the resources needed to implement their ~~innovative therapies~~ innovations safely, effectively, and equitably.

## 2. Opinion 11.2.1, Professionalism in Health Care Systems

Containing costs, promoting high-quality care for all patients, and sustaining physician professionalism are important goals. Models for financing and organizing the delivery of health care services often aim to promote patient safety and to improve quality and efficiency. However, they can also pose ethical challenges for physicians that could undermine the trust essential to patient-physician relationships.

Payment models and financial incentives can create conflicts of interest among patients, health care organizations, and physicians. They can encourage undertreatment and overtreatment, as well as dictate goals that are not individualized for the particular patient.

Structures that influence where and by whom care is delivered—such as accountable care organizations, group practices, health maintenance organizations, and other entities that may emerge in the future—can affect patients' choices, the patient-physician relationship, and physicians' relationships with fellow health care professionals.

Formularies, clinical practice guidelines, decision support tools that rely on augmented intelligence, and other ~~tools~~ mechanisms intended to influence decision making, may impinge on physicians' exercise of professional judgment and ability to advocate effectively for their patients, depending on how they are designed and implemented.

Physicians in leadership positions within health care organizations and the profession should ~~ensure that practices for financing and organizing the delivery of care:~~

- (a) Ensure that decisions to implement practices or tools for organizing the delivery of care are transparent and reflect input from key stakeholders, including physicians and patients.
- (~~b~~) ~~Reflect input from key stakeholders, including physicians and patients.~~
- (~~eb~~) Recognize that over reliance on financial incentives or other tools to influence clinical decision making may undermine physician professionalism.
- (~~ec~~) Ensure ~~ethically acceptable incentives~~ that all such tools:
  - (i) are designed in keeping with sound principles and solid scientific evidence.
  - a. Financial incentives should be based on appropriate comparison groups and cost data and adjusted to reflect complexity, case mix, and other factors that affect physician practice profiles.

- b. Practice guidelines, formularies, and ~~other~~ similar tools should be based on best available evidence and developed in keeping with ethics guidance.
  - c. Clinical prediction models, decision support tools, and similar tools such as those that rely on AI technology must rest on the highest-quality data and be independently validated in relevantly similar populations of patients and care settings.
    - (ii) are implemented fairly and do not disadvantage identifiable populations of patients or physicians or exacerbate health care disparities;
    - (iii) are implemented in conjunction with the infrastructure and resources needed to support high-value care and physician professionalism;
    - (iv) mitigate possible conflicts between physicians' financial interests and patient interests by minimizing the financial impact of patient care decisions and the overall financial risk for individual physicians.
  - (ed) Encourage, rather than discourage, physicians (and others) to:
    - (i) provide care for patients with difficult to manage medical conditions;
    - (ii) practice at their full capacity, but not beyond.
  - (fe) Recognize physicians' primary obligation to their patients by enabling physicians to respond to the unique needs of individual patients and providing avenues for meaningful appeal and advocacy on behalf of patients.
  - (gf) ~~Are~~ Ensure that the use of financial incentives and other tools is routinely monitored to:
    - (i) identify and address adverse consequences;
    - (ii) identify and encourage dissemination of positive outcomes.
- All physicians should:
- (hg) Hold physician-leaders accountable to meeting conditions for professionalism in health care systems.
  - (ih) ~~Advocate for changes in health care payment and delivery models~~ how the delivery of care is organized to promote access to high-quality care for all patients.

### 3. Opinion 11.1.2, Physician Stewardship of Health Care Resources

Physicians' primary ethical obligation is to promote the well-being of individual patients. Physicians also have a long-recognized obligation to patients in general to promote public health and access to care. This obligation requires physicians to be prudent stewards of the shared societal resources with which they are entrusted. Managing health care resources responsibly for the benefit of all patients is compatible with physicians' primary obligation to serve the interests of individual patients.

To fulfill their obligation to be prudent stewards of health care resources, physicians should:

- (a) Base recommendations and decisions on patients' medical needs.
- (b) Use scientifically grounded evidence to inform professional decisions when available.
- (c) Help patients articulate their health care goals and help patients and their families form realistic expectations about whether a particular intervention is likely to achieve those goals.

- (d) Endorse recommendations that offer reasonable likelihood of achieving the patient's health care goals.
- (e) Use technologies that have been demonstrated to meaningfully improve clinical outcomes to Choose the course of action that requires fewer resources when alternative courses of action offer similar likelihood and degree of anticipated benefit compared to anticipated harm for the individual patient but require different levels of resources.
- (f) Be transparent about alternatives, including disclosing when resource constraints play a role in decision making.
- (g) Participate in efforts to resolve persistent disagreement about whether a costly intervention is worthwhile, which may include consulting other physicians, an ethics committee, or other appropriate resource.

Physicians are in a unique position to affect health care spending. But individual physicians alone cannot and should not be expected to address the systemic challenges of wisely managing health care resources. Medicine as a profession must create conditions for practice that make it feasible for individual physicians to be prudent stewards by:

- (h) Encouraging health care administrators and organizations to make cost data transparent (including cost accounting methodologies) so that physicians can exercise well-informed stewardship.
- (i) Advocating that health care organizations make available well-validated technologies to enhance diagnosis, treatment planning, and prognosis and support equitable, prudent use of health care resources.
- (j) Ensuring that physicians have the training they need to be informed about health care costs and how their decisions affect resource utilization and overall health care spending.
- (jk) Advocating for policy changes, such as medical liability reform, that promote professional judgment and address systemic barriers that impede responsible stewardship.

#### 4. Opinion 1.1.6, Quality

As professionals dedicated to promoting the well-being of patients, physicians individually and collectively share the obligation to ensure that the care patients receive is safe, effective, patient centered, timely, efficient, and equitable.

While responsibility for quality of care does not rest solely with physicians, their role is essential. Individually and collectively, physicians should actively engage in efforts to improve the quality of health care by:

- (a) Keeping current with best care practices and maintaining professional competence.
- (b) Holding themselves accountable to patients, families, and fellow health care professionals for communicating effectively and coordinating care appropriately.
- (c) Using new technologies and innovations that have been demonstrated to improve patient outcomes and experience of care, in keeping with ethics guidance on innovation in clinical practice and stewardship of health care resources.
- (ed) Monitoring the quality of care they deliver as individual practitioners—e.g., through personal case review and critical self-reflection, peer review, and use of other quality improvement tools.

(Modify HOD/CEJA policy)

Limited testimony was heard that generally supported Council on Ethical and Judicial Affairs Report 2, acknowledging the timeliness of this issue in providing guidance to individual physicians and institutions alike. One speaker who supported the report reminded physicians that implicit bias exists in certain algorithms, and that it is essential to keep this in mind when considering the use of emerging technologies. Speakers suggested adding

clarifying language with regard to “augmented intelligence” and “artificial intelligence,” and suggested avoiding referring to augmented intelligence as “AI” to prevent confusion. However, your Reference Committee notes that our American Medical Association has adopted the use of the term “augmented intelligence”. Testimony was also offered that seems to transfer accountability of patient needs away from the physician and to the health care organization. Your Reference Committee believes that this is appropriate, given the employed status of many physicians which necessitates them using technologies adopted by their institutions. Your Reference Committee recommends that Council on Ethical and Judicial Affairs Report 2 be adopted and the remainder of the report be filed.

(12) **SPEAKERS REPORT 2 - ESTABLISHING AN ELECTION COMMITTEE**

**RECOMMENDATION:**

Recommendations in Speakers Report 2 be adopted and the remainder of the report be filed.

**HOD ACTION:** Recommendations in Speakers Report 2 referred for decision.

It is recommended that the following recommendations be adopted and the remainder of the report be filed.

1. A Campaign Complaint Reporting, Validation, and Resolution Process shall be established as follows:

Campaign violation complaints should be directed to the Speaker, the Vice Speaker, or the AMA General Counsel and should include the following details:

- The name of the person(s) thought to have violated the rules
- The date of the alleged violation and the location if relevant
- The specific violation being alleged (i.e., the way the rules were violated)
- The materials, if any, that violate the rules; original materials are preferred over copies.

Where necessary, arrangements for collection of these materials will be made.

Campaign violation complaints will be investigated by the Election Committee, which will determine penalties for validated complaints as appropriate. Penalties may include an announcement of the violation by the Speaker to the House. (New HOD Policy)

2. The Election Committee will review the Campaign Complaint Reporting, Validation, and Resolution Process as implemented and make further recommendations to the House as necessary. (Directive to Take Action)

3. Policy D-610.998, Paragraph 6 be rescinded. (Rescind HOD Policy)

Your Reference Committee heard testimony that generally supported this report. Speakers suggested that any validated election violations that may occur should be delineated and reported, and that the potential exists for misunderstandings, false accusations and accusations not made in good faith. In response, an amendment was offered suggesting the inclusion of the language “in accordance with due process”. However, this term can be confused with legal due process. Your Reference Committee believes that the language of the report is acceptable as written, and existing mechanisms exist to report violations. Your Reference Committee recommends that the recommendations in Speakers Report 2 be adopted and the remainder of the report be filed.

Policy D-610.998, “Directives from the Election Task Force”

**Campaign Receptions**

1. Our AMA will investigate the feasibility of a two- (2) year trial of sponsoring a welcome reception open to all candidates and all meeting attendees. Any candidate may elect to be “featured” at the AMA reception. There will not be a receiving line at the AMA reception. Other receptions sponsored by societies or coalitions, whether featuring a candidate or not, would not be prohibited, but the current rules regarding



cash bars only at campaign receptions and limiting each candidate to be featured at a single reception (the AMA reception or another) would remain. The Speakers will report back to the House after the two year trial with a recommendation for possible continuation of the AMA reception.

#### Campaign literature

2. An AMA Candidates' Page will be created on the AMA website or other appropriate website to allow each candidate the opportunity to post campaign materials. Parameters for the site will be established by the Speaker and communicated to candidates.

#### Interviews

3. The Speakers are encouraged to continue recorded virtual interviews of announced candidates in contested races, to be posted on the AMA website.

#### Voting Process and Election Session

4. The Speaker is encouraged to consider means to reduce the time spent during the HOD meeting on personal points by candidates after election results are announced, including collecting written personal points from candidates to be shared electronically with the House after the meeting or imposing time limits on such comments.

#### Election Committee

5. In accordance with Bylaw 2.13.7, the Speaker shall appoint an Election Committee of 7 individuals for 1-year terms (maximum tenure of 4 consecutive terms and a lifetime maximum tenure of 8 terms) to report to the Speaker. These individuals would agree not to be directly involved in a campaign during their tenure and would be appointed from various regions, specialties, sections, and interest groups. The primary role of the committee would be to work with the Speakers to adjudicate any election complaint. Additional roles to be determined by the Speaker and could include monitoring election reforms, considering future campaign modifications and responding to requests from the Speaker for input on election issues that arise.

6. The Speaker in consultation with the Election Committee will consider a more defined process for complaint reporting, validation, resolution, and potential penalties. This process will be presented to the House for approval.

#### Review of Implementation

7. After an interval of 2 years a review of our election process, including the adopted Recommendations from this report, be conducted by the Speaker and, at the Speaker's discretion the appointment of another election task force, with a report back to the House.

### (13) RESOLUTION 9 – BANNING THE PRACTICE OF VIRGINITY TESTING

#### RECOMMENDATION:

Resolution 9 be adopted.

#### **HOD ACTION:** Resolution 9 adopted.

RESOLVED, That our American Medical Association advocate for the elimination of the practice of virginity testing exams, physical exams purported to assess virginity (Directive to Take Action); and be it further

RESOLVED, That our AMA support culturally-sensitive counseling by health professionals to educate patients and family members about the negative effects and inaccuracy of virginity testing and where needed, referral for further psychosocial support (New HOD Policy); and be it further

RESOLVED, That our AMA support efforts to educate medical students and physicians about the continued existence of the practice of virginity testing and its detrimental effects on patients. (New HOD Policy)

Testimony was heard in strong support of Resolution 9. Speakers noted the timeliness of the resolution, as the topic has been part of recent national conversation. Speakers noted that virginity is not a scientific or medical term, and the practice of virginity testing is not evidence-based nor does it exist in medical literature. Further, speakers noted that the practice is unreliable, intrusive, harmful and is often performed without consent. Your Reference Committee recommends that Resolution 9 be adopted.

#### RECOMMENDED FOR ADOPTION AS AMENDED

#### (14) SPEAKERS REPORT 1 - REPORT OF THE ELECTION TASK FORCE

##### RECOMMENDATION A:

Paragraph 12(e)(ii) be amended by addition and deletion to read as follows:

ii. It is encouraged that interviews be 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.

##### RECOMMENDATION B:

Recommendations in Speakers Report 1 be adopted as amended and the remainder of the report be filed.

**HOD ACTION:** Recommendations in Speakers Report 1 adopted as amended and the remainder of the report filed.

(12) Interviews conducted with current candidates must comply with the following rules:

- a. Interviews may be arranged between the parties once active campaigning is allowed.
- b. Groups conducting interviews with candidates for a given office must offer an interview to all individuals that have officially announced their candidacy at the time the group's interview schedule is finalized.
  - i. A group may meet with a candidate who is a member of their group without interviewing other candidates for the same office.
  - ii. Interviewing groups may, but are not required to, interview late announcing candidates. Should an interview be offered to a late candidate, all other announced candidates for the same office (even those previously interviewed) must be afforded the same opportunity and medium.
  - iii. 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.
- c. Groups may elect to conduct interviews virtually or in-person, but not both. All interviews for an office must be conducted using the same format and platform.
- d. In-person interviews may be conducted between Friday and Monday of the meeting at which elections will take place.
- e. Virtual interviews are subject to the following constraints:
  - i. Interviews may be conducted only during a window beginning on the Thursday Friday evening two weeks end prior to the scheduled Opening Session of the House of Delegates meeting at which elections will take place and must be concluded by that Sunday (four days later) evening one week before the scheduled Opening Session of the House.

- ii. 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.
- iii. Caucuses and delegations scheduling interviews for candidates within the parameters above ~~are not obligated to must~~ offer alternatives to those candidates who have conflicts with the scheduled time but are encouraged to do so if possible.

This report from your speakers spells out the expectations for interviews, particularly virtual interviews, conducted with those seeking election to leadership positions within our AMA. It is recommended that Policy G-610.020 be amended by addition and deletion to read as follows and the remainder of this report be filed. [Note: Paragraph numbers will be editorially corrected as required.]

(4) Candidates may notify the HOD Office of their intention to run for potential newly opened positions, as well as any scheduled open positions on any council or the Board of Trustees, at any time by submitting an announcement card ~~and their conflict of interest statement~~ to the House Office. They will then be included in all subsequent projections of announcements before the House, "Official Candidate Notifications," and in any campaign activity that had not yet been finalized. All previously announced candidates will continue to be included on each Official Announcement Date. Any candidate may independently announce their candidacy after active campaigning is allowed, but no formal announcement from the HOD office will take place other than at the specified times.

...

(11) The Speaker's Office will coordinate the scheduling of candidate interviews 1 for general officer positions (Trustees, President-Elect, Speaker and Vice Speaker). Groups wishing to conduct interviews must designate their interviewing coordinator and provide the individual's contact information to the Office of House of Delegates Affairs. The Speaker's Office will collect contact information for groups wishing to conduct interviews as well as for candidates and their campaign teams and will provide the information as requested.

(12) Interviews conducted with current candidates must comply with the following rules:

a. Interviews may be arranged between the parties once active campaigning is allowed.

b. Groups conducting interviews with candidates for a given office must offer an interview to all individuals that have officially announced their candidacy at the time the group's interview schedule is finalized.

i. A group may meet with a candidate who is a member of their group without interviewing other candidates for the same office.

ii. Interviewing groups may, but are not required to, interview late announcing candidates. Should an interview be offered to a late candidate, all other announced candidates for the same office (even those previously interviewed) must be afforded the same opportunity.

iii. 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.

c. Groups may elect to conduct interviews virtually or in-person, but not both. All interviews for an office must be conducted using the same format and platform.

d. In-person interviews may be conducted between Friday and Monday of the meeting at which elections will take place.

e. Virtual interviews are subject to the following constraints:

i. Interviews may be conducted only during a window beginning on the Friday evening two weekends prior to the scheduled Opening Session of the House of Delegates meeting at which elections will take place and must be

concluded by the Sunday evening one week before the scheduled Opening Session of the House.

ii. 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.

iii. Caucuses and delegations scheduling interviews for candidates within the parameters above are not obligated to offer alternatives but are encouraged to do so if possible.

f. Recording of interviews is allowed only with the knowledge and consent of the candidate.

g. Recordings of interviews may be shared only among members of the group conducting the interview.

h. A candidate is free to decline any interview request.

i. In consultation with the Election Committee, the Speaker, or where the Speaker is in a contested election, the Vice Speaker, may issue special rules for interviews to address unexpected situations.

Testimony unanimously supported the intentions of Speakers Report 1. There were concerns, however, that the timing delineated in (e) did not work for individuals who work overnight shifts, third shifts, or who have family and other obligations. Several amendments were offered to address this, including to begin the interview window one weekend prior to the scheduled opening session of the House of Delegates rather than two, and to conclude the interview window by the opening session of the HOD, rather than the Sunday evening one weekend before. Others suggested removing defined times during which interviews should be scheduled to minimize conflict with candidate's working hours and to allow interviews during times mutually acceptable by the interviewers and interviewee. The sentiment of these amendments was supported, but others noted that the interviewers' schedules would be burdened by a lack of defined interview windows. The authors of the report noted that the proposed changes to the interview window had been considered, and that the times ultimately selected and delineated in the report were the result of extensive testimony from the HOD during discussion at the June 2021 Special Meeting. Your Reference Committee believes that the language suggested in the above amendment, which *encourages* interviews to take place during the stated times, sufficiently names the guardrail times without being overly proscriptive, still allows for a mutually acceptable alternate time to interview, and thus respects both the interviewer and interviewee's schedules. Your Reference Committee recommends that Speakers Report 1 be adopted as amended and the remainder of the report be filed.

(15) RESOLUTION 18 – SUPPORT FOR SAFE AND EQUITABLE ACCESS TO VOTING

RECOMMENDATION A:

The first Resolve in Resolution 18 be amended by addition to read as follows:

(g) use of a P.O. box for voter registration (New HOD Policy);

RECOMMENDATION B:

Resolution 18 be adopted as amended.

**HOD ACTION:** Resolution 18 adopted as amended.

RESOLVED, That our AMA support measures to facilitate safe and equitable access to voting as a harm-reduction strategy to safeguard public health and mitigate unnecessary risk of infectious disease transmission by measures including but not limited to:

- (a) extending polling hours;
- (b) increasing the number of polling locations;

- (c) extending early voting periods;
- (d) mail-in ballot postage that is free or prepaid by the government;
- (e) adequate resourcing of the United States Postal Service and election operational procedures;
- (f) improve access to drop off locations for mail-in or early ballots (New HOD Policy); and be it further

RESOLVED, That our AMA oppose requirements for voters to stipulate a reason in order to receive a ballot by mail and other constraints for eligible voters to vote-by-mail. (New HOD Policy)

Testimony was heard in general support of this resolution. While most speakers noted their support for the intent of the resolution, several speakers noted that the process of voting in the United States is decentralized, with voting procedures largely determined by the states. Speakers in support noted that the COVID-19 pandemic has highlighted the issues with current voting infrastructure, and the resolution represents both a harm reduction strategy and a measure to improve equity for those for whom voting is difficult. An amendment was offered to add another provision to the resolution allowing for use of a P.O. box for voter registration to address individuals with nontraditional addresses or non-numbered addresses (such as on American Indian or Alaska Native reservations and in rural areas) and subsequent testimony was supportive. Your Reference Committee recommends that Resolution 18 be adopted as amended.

(16) RESOLUTION 19 – DISAGGREGATION OF DEMOGRAPHIC DATA FOR INDIVIDUALS OF MIDDLE EASTERN AND NORTH AFRICAN (MENA) DESCENT

RECOMMENDATION A:

Resolution 19 be amended by addition of a third Resolve to read as follows:

RESOLVED, that our AMA study methods to further improve disaggregation of data by race which most accurately represent the diversity of our patients.

RECOMMENDATION B:

Resolution 19 be adopted as amended.

**HOD ACTION:** Resolution 19 adopted as amended.

RESOLVED, That our American Medical Association add “Middle Eastern/North African (MENA)” as a separate racial category on all AMA demographics forms (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate for the use of “Middle Eastern/North African (MENA)” as a separate race category in all uses of demographic data including but not limited to medical records, government data collection and research, and within medical education. (Directive to Take Action)

Your Reference Committee heard testimony in strong support of Resolution 19. Speakers suggested that the resolution is important for accurate data collection, and that much of our misunderstanding of health disparities is the result of grouping individuals into broad race categories. It was also noted that while the economic impact of this resolution on the AMA is minimal, the social impact of no longer classifying those of Middle Eastern/North African (MENA) descent as “white” or “other” is significant. Limited testimony in opposition suggested that a standard definition of MENA does not currently exist and needs to be established, and an amendment was offered suggesting that the AMA “define and” add MENA as a separate racial category. Subsequent testimony insisted that further study was unnecessary given that definitions not only exist, but this data is self-reported. Finally, your Reference Committee agreed with the addition of a third resolve asking for study of methods to further improve disaggregation of data in general. Your Reference Committee recommends that Resolution 19 be adopted as amended.

(17) RESOLUTION 20 – RECOGNIZING AND REMEDYING “STRUCTURAL URBANISM” BIAS AS A FACTOR IN RURAL HEALTH DISPARITIES

RECOMMENDATION A:

The first Resolve in Resolution 20 be amended by deletion to read as follows:

RESOLVED: that our AMA ~~1) formally~~ recognize that systemic bias in healthcare financing ~~{called “Structural Urbanism”}~~, has been one of many a factors ~~in~~ leading to rural health disparities; ~~2)~~ and advocate for elimination of these biases through payment policy reform ~~in future AMA strategic planning to reduce all of America’s health disparities, include plans to reduce/remedy the {structural urbanism} bias~~ 3) in advocating for health equity for all Americans, ~~point out that Medicare payment policies have played a role in~~ to help reduce the shortage of rural physicians and eliminate ~~the poorer~~ health inequities ~~outcomes~~ in rural America (Directive to Take Action); and be it further

RECOMMENDATION B:

Resolution 20 be adopted as amended.

RECOMMENDATION D:

The title of Resolution 20 be changed to:

RECOGNIZING AND REMEDYING PAYMENT SYSTEM BIAS AS A FACTOR IN RURAL HEALTH DISPARITIES

**HOD ACTION:** Resolution 20 adopted as amended with a change in title.

RESOLVED, That our American Medical Association: (1) formally recognize that systemic bias in healthcare financing, called “Structural Urbanism,” has been a factor in leading to rural health disparities; (2) in future AMA strategic planning to reduce all of America’s health disparities, include plans to reduce/remedy the structural urbanism bias; and (3) point out, in advocating for health equity for all Americans, 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, as part of our current advocacy for telehealth reform, specify that geographic payment equity be required in any telehealth legislation. (Directive to Take Action)

Your Reference Committee heard testimony in unanimous support of Resolution 20. Speakers noted two main issues: the long standing rural/urban health care financing disparity, and that persons who live in rural areas have been shown in research to have considerable health inequities. The authors submitted amended language to make these points clearer, and to avoid any confusion regarding the term “structural urbanism”. Subsequent testimony supported those proposed resolutions. Your Reference Committee recommends that Resolution 20 be adopted as amended.

(18) RESOLUTION 23 – AMA COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS (CEJA) REPORT ON PHYSICIAN RESPONSIBILITIES TO IMPAIRED COLLEAGUES: CEJA E-9.3.2

RECOMMENDATION A:

The first Resolve of Resolution 23 be amended by addition and deletion to read as follows:

Resolved, that our AMA advocate that health system, corporate, and academic organizations provide for fair, objective, ~~and external and independent review evaluations~~ review for physicians who are requested ~~or required~~ to be assessed for a ~~potential impairment~~ potentially impairing health condition, and that such evaluations are independent of conflicts of interest by the examining and entity, and be it further

RECOMMENDATION B:

The second Resolve of Resolution 23 be amended by addition and deletion to read as follows:

~~Resolved, that our AMA support the availability of Pphysician Hhealth Pprograms to enable physicians who require assistance to receive provide safe and effective care; and be it further for physicians who are requested to be assessed for a potential impairment; and be it further~~

RECOMMENDATION C:

Resolution 23 be amended by addition of a third Resolve to read as follows:

Resolved, that our AMA support that any clinical evaluation of a physician-in-training that is required by their academic institution regarding a potentially impairing health condition, be fair, objective, free of conflicts, and external to said trainee's own academic institution or location where they may be placed for clinical rotations, and be it further

RECOMMENDATION D:

The final Resolve of Resolution 23 be amended by addition and deletion to read as follows:

RESOLVED, That the Council on Ethical and Judicial Affairs consider the following amendment to Opinion E-9.3.2, "Physician Responsibilities to Colleagues with Illness, Disability or Impairment":

(i) Advocating for supportive services including physician health programs and accommodations to enable physicians and physicians in training who require assistance to provide safe, effective care.

...

(k) Advocating for fair, objective, external, and independent review evaluations for physicians when a review is requested or required to assess a potential impairment and its duration by an employer, academic medical center, or hospital/health system where said physician has clinical privileges or where said physician-in training is placed for a clinical rotations.

## RECOMMENDATION E:

Resolution 23 be adopted as amended.

**HOD ACTION:** Resolution 23 adopted as amended.

Resolved, that our AMA advocate that health system, corporate, and academic organizations provide for fair, objective, and external and independent review evaluations ~~review~~ for physicians who are requested or required to be assessed for a potential impairment-potentially impairing due to a health condition, and that such evaluations are independent of conflicts of interest by the examining ~~and~~ entity, and be it further

Resolved, that our AMA support the availability of ~~P~~physician ~~H~~health ~~P~~programs to enable physicians who require assistance to receive ~~provide~~ safe and effective care; and be it further ~~for physicians who are requested to be assessed for a potential impairment; and be it further~~

Resolved, that our AMA support that any clinical evaluation of a physician-in-training that is required by their academic institution regarding a potential impairment-potentially impairing due to a health condition, be fair, objective, free of conflicts, and external to said trainee's own academic institution or location where they may be placed for clinical rotations, and be it further

RESOLVED, That the Council on Ethical and Judicial Affairs consider the following amendment to Opinion E-9.3.2, "Physician Responsibilities to Colleagues with Illness, Disability or Impairment":

(i) Advocating for supportive services including physician health programs and accommodations to enable physicians and physicians in training who require assistance to provide safe, effective care.

...

(l) Advocating for fair, objective, external, and independent review evaluations for physicians when a review is requested or required to assess a potential impairment and its duration by an employer, academic medical center, or hospital/health system where said physician has clinical privileges or where said physician-in training is placed for a clinical rotations.

RESOLVED, That our American Medical Association support a fair, objective, external and independent review for physicians who are requested to be assessed for a potential impairment, and support the availability of physician health programs to enable physicians who require assistance to provide safe and effective care (New HOD Policy); and be it further

RESOLVED, That our AMA advocate that health system, corporate, and academic organizations provide a fair, objective, external and independent review for physicians who are requested to be assessed for a potential impairment (Directive to Take Action); and be it further

(h) RESOLVED, That the Council on Ethical and Judicial Affairs consider the following amendment to Opinion E-9.3.2, "Physician Responsibilities to Colleagues with Illness, Disability or Impairment":

(i)

(j) (i) Advocating for supportive services including physician health programs and accommodations to enable physicians who require assistance to provide safe, effective care.

...



**(k) Advocating for fair, objective, external, and independent review for physicians when a review is requested to assess a potential impairment and its duration.**

Testimony was in favor of this resolution. Those who testified mentioned the importance of a fair, objective and independent review of physicians who require assessment for potential impairments. Several amendments were proffered on the online forum and received widespread support in the hearing. Further, there was support for including physicians-in-training, which is reflected in the added resolve. Lastly, several people testified that they would like the Council on Ethical and Judicial Affairs to consider including physician health programs specifically in Opinion 9.3.2 “Physician Responsibilities to Colleagues with Illness, Disability or Impairment”, as well as guidance regarding advocating for the fair, objective and independent reviews mentioned in the earlier resolves. Your Reference Committee recommends that Resolution 23 be adopted as amended.

**Ethical Opinion E-9.3.2, “Physician Responsibilities to Impaired Colleagues”**

Physical or mental health conditions that interfere with a physician’s ability to engage safely in professional activities can put patients at risk, compromise professional relationships, and undermine trust in medicine. While protecting patients’ well-being must always be the primary consideration, physicians who are impaired are deserving of thoughtful, compassionate care.

To protect patient interests and ensure that their colleagues receive appropriate care and assistance, individually physicians have an ethical obligation to:

- (a) Intervene in a timely manner to ensure that impaired colleagues cease practicing and receive appropriate assistance from a physician health program.
- (b) Report impaired colleagues in keeping with ethics guidance and applicable law.
- (c) Assist recovered colleagues when they resume patient care.

Collectively, physicians have an obligation to ensure that their colleagues are able to provide safe and effective care. This obligation is discharged by:

- (d) Promoting health and wellness among physicians.
- (e) Establishing mechanisms to assure that impaired physicians promptly cease practice.
- (f) Supporting peers in identifying physicians in need of help.
- (g) Establishing or supporting physician health programs that provide a supportive environment to maintain and restore health and wellness.

**RECOMMENDED FOR REFERRAL**

- (19) **RESOLUTION 8 – AMENDMENT TO TRUTH AND TRANSPARENCY IN PREGNANCY COUNSELING CENTERS, H-420.954**

**RECOMMENDATION:**

Resolution 8 be referred.

**HOD ACTION:** Resolution 8 referred.

**RESOLVED**, That our American Medical Association amend 1 Policy H-420.954, “Truth and Transparency in Pregnancy Counseling Centers,” by addition and deletion to read as follows, to further strengthen our AMA policy against the dissemination of purposely incomplete or deceptive information intended to mislead patients and the utilization of state and federal funds for potentially biased services provided by pregnancy counseling centers:

#### Truth and Transparency in Pregnancy Counseling Centers H-420.954

1. Our AMA ~~supports~~ advocates that any entity offering crisis pregnancy services disclose information on site, in its advertising; and before any services are provided concerning medical services, contraception, termination of pregnancy or referral for such services, adoption options or referral for such services that it does and does not provide, as well as fully disclose any financial, political, or religious associations which such entities may have;

2. Our AMA discourages the use of marketing, counseling, or coercion (by physical, emotional, or financial means) by any agency offering crisis pregnancy services that aim to discourage or interfere with a pregnant woman's pursuit of any medical services for the care of her unplanned pregnancy;

3. Our AMA advocates that any entity providing medical or health services to pregnant women that markets medical or any clinical services abide by licensing requirements and have the appropriate qualified licensed personnel to do so and abide by federal health information privacy laws, and additionally disclose their level of compliance to such requirements and laws to patients receiving services;

4. Our AMA opposes the utilization of state and federal funding to finance such entities offering crisis pregnancy services, which do not provide statistically validated evidence-based medical information and care to pregnant women. (Modify Current HOD Policy)

Testimony was heard in general support of the goals of the resolution, but a number of speakers expressed concern with the specific amendments in this resolution as written. Amendments were offered suggesting the removal of the term “marketing” in the proposed added part 2 of H-420.954 and removing the amendment by addition in part 3, with the speaker noting that it could not be monitored or enforced. Other amendments were proposed with the goal of preserving the intent of the resolution while mitigating unintended consequences. However, your Reference Committee heard compelling testimony that described the predatory actions by non-clinical pregnancy counseling centers, and given the complexity of jurisdiction and enforcement, your Reference Committee believes that a report examining these issues is the best approach for our AMA to make an impact. Your Reference Committee recommends that Resolution 8 be referred.

#### Policy H-420.954, “Truth and Transparency in Pregnancy Counseling Centers”

1. Our AMA supports that any entity offering crisis pregnancy services disclose information on site, in its advertising, and before any services are provided concerning the medical services, contraception, termination of pregnancy or referral for such services, adoption options or referral for such services that it provides; and be it further

2. Our AMA advocates that any entity providing medical or health services to pregnant women that markets medical or any clinical services abide by licensing requirements and have the appropriate qualified licensed personnel to do so and abide by federal health information privacy laws.

#### RECOMMENDED FOR NOT ADOPTION

#### (20) RESOLUTION 2 – DISAGGREGATION OF RACE DATA FOR INDIVIDUALS OF MIDDLE EASTERN AND NORTH AFRICAN (MENA) DESCENT

#### RECOMMENDATION:

Resolution 2 be not adopted.

**HOD ACTION:** Resolution 2 not adopted.

**RESOLVED,** That our American Medical Association add “Middle Eastern/North African (MENA)” as a separate race category on all AMA demographics forms (Directive to Take Action); and be it further

RESOLVED, That our AMA work with relevant stakeholders to promote the inclusion of “Middle Eastern/North African (MENA)” as a separate race category on all surveys conducted by the U.S. Census Bureau, and for all federally funded research using race categories (Directive to Take Action); and be it further

RESOLVED, That our AMA work with relevant stakeholders to promote the inclusion of “Middle Eastern/North African (MENA)” as a separate race category on all medical school and residency demographics forms. (Directive to Take Action)

Testimony for Resolution 2 was in strong support of the need of MENA as separate race category on both medical and governmental forms that ask for demographic data. Testimony reflected on the need for such a category while also referencing that the U.S. Federal government completed significant research on the topic and has taken steps to add this category to its census form. While testimony for the intent of Resolution 2 was positive, testimony was largely unanimous that the nearly analogous Resolution 19 better accomplishes the objectives of the authors and that Resolution 2 should not be adopted in favor of Resolution 19 being adopted instead. Notably, the authors of Resolution 2 agreed with this action. Therefore, your Reference Committee recommends that Resolution 2 be not adopted.

(21) RESOLUTION 21 – FREE SPEECH AND CIVIL DISCOURSE IN THE AMERICAN MEDICAL ASSOCIATION

RECOMMENDATION:

Resolution 21 be not adopted.

**HOD ACTION:** Resolution 21 not adopted.

RESOLVED, That it be the policy of our American Medical Association that:

Our American Medical Association unequivocally commits to truly open discourse, debate, exchange of ideas, and argument;

Our American Medical Association unequivocally commits to a culture which recognizes the inherent dignity and worth of its members, which resolves that freedom of expression and civility must coexist, and where those who disagree will do so without enmity;

Our American Medical Association unequivocally commits to the principle that dissenting and unpopular voices must be afforded the opportunity to be heard;

Our American Medical Association unequivocally commits that members of the American Medical Association of different faiths, philosophies, and persuasions may speak their minds and honor their deepest convictions without fear of punishment or retaliation;

Our American Medical Association unequivocally commits that the mere exposure to ideas that some may find offensive is not an act of violence or hatred;

Our American Medical Association unequivocally commits to a prohibition of the listing of people or organizations to be regarded as unacceptable, untrustworthy, excluded, or avoided based on ideological positions or differences;

Our American Medical Association unequivocally commits that ideological demonization of opponents to block debate and to silence disagreement in the proceedings of the American Medical Association is unprofessional conduct subject to appropriate disciplinary action;

Our American Medical Association unequivocally commits that defamation, obscenity, intimidation, threats, and incitement to violence, have no place in the proceedings of the American Medical Association, and if exhibited are unprofessional conduct subject to appropriate disciplinary action. (New HOD Policy)

Your Reference Committee heard overwhelming testimony in strong opposition to Resolution 21. Speakers noted that the AMA has a Code of Conduct in place with an extensive reporting system to investigate and discipline individuals who engage in intimidation, threats or violence. Limited testimony was heard supporting reaffirmation of AMA policies G-600.054, “Procedures of the House of Delegates” and H-140.837, “Policy on Code of Conduct at AMA Meetings and Events” in lieu of the resolution. Your Reference Committee recommends that Resolution 21 be not adopted.

Policy G-600.054, “Procedures of the House of Delegates”

1. Our AMA reaffirms The American Institute of Parliamentarians Standard Code of Parliamentary Procedure as our parliamentary authority, including the use of the motion to table and the motion to adopt in-lieu-of, and treat amendments by substitution as first-order amendments.

2. The rules and procedures of the House of Delegates will be amended as follows:

A. The motion to table a report or resolution that has not yet been referred to a reference committee is not permitted and will be ruled out of order.

B. A new motion is added to the House of Delegates Reference Manual, Object to Consideration. If a Delegate objects to consideration of an item of business by our HOD, the correct motion is to Object to Consideration. The motion cannot interrupt a speaker, requires a second, cannot be amended, takes precedence over all subsidiary motions and cannot be renewed. The motion requires a 3/4 vote for passage. Debate is restricted to why the item should not be considered.

3. The procedures of our House of Delegates distinguish between a motion to refer, which is equivalent to a motion to refer for report, and a motion to refer for decision and that the motion to refer for decision be one step higher in precedence.

4. The procedures of our House of Delegates specify that both sides must have been heard before a motion to close debate is in order and that absent an express reference to “all pending matters” the motion applies only to the matter under debate.

5. The procedures of our House of Delegates clarify that adjournment of any House of Delegates meeting finalizes all matters considered at that meeting, meaning that items from one meeting are not subject to a motion to recall from committee, a motion to reconsider or any other motion at a succeeding meeting.

6. The Council on Constitution and Bylaws, in consultation with the speakers, will review the House of Delegates Reference Manual and revise it accordingly.

Policy H-140.837, “Policy on Conduct at AMA Meetings and Events”

It is the policy of the 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 an AMA hosted meeting, event and other activity, including but not limited to dinners, receptions and social gatherings held in conjunction with an AMA hosted meeting, event or activity, is prohibited conduct and is not tolerated. The 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 his/her 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; or (3) otherwise adversely affects an individual's participation in such meetings or proceedings or, in the case of AMA staff, such individual's employment opportunities or tangible job benefits.

Harassing conduct includes, but is not limited to: epithets, slurs or negative stereotyping; threatening, intimidating or hostile acts; denigrating jokes; and written, electronic, or graphic material that denigrates or shows hostility or aversion toward an individual or group and that is placed on walls or elsewhere on the AMA's premises or at the site of any AMA meeting or circulated in connection with any AMA meeting.

## Sexual Harassment

Sexual harassment also constitutes discrimination, and is unlawful and is absolutely prohibited. For the purposes of this policy, sexual harassment includes:

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

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

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

## Operational Guidelines

The 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.

The 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 an 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 the AMA. The vendor will advise the 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.]

#### (22) RESOLUTION 22 – PROHIBITION OF RACIST CHARACTERIZATION BASED ON PERSONAL ATTRIBUTES

##### RECOMMENDATION:

Resolution 22 be not adopted.

**HOD ACTION:** Resolution 22 not adopted.

RESOLVED, That it be the policy of our American Medical Association that no person or group of persons shall be considered or characterized as racist based on personal attributes of race, color, religion, sex (including pregnancy, sexual orientation, or gender identity), national origin, age, disability, or genetic information. (New HOD Policy)

Significant testimony was heard in opposition to Resolution 22. Speakers noted that racism is structural, not personal, and passing this resolution could undermine recent and ongoing work by the AMA to address systemic racism in the health care system. It was noted that the AMA has established policy on racism, and limited testimony suggested reaffirmation of existing AMA policy in lieu of this resolution. It was also noted that our AMA has extensive guidelines on ethical and professional behavior to which all should adhere. Limited supporting testimony suggested that the resolution should pass, and that no physician should be considered to be racist based on personal attributes. Your Reference Committee does not believe that it is the place of the AMA or AMA policy to determine who is or is not racist on an individual level, and therefore recommends that Resolution 22 be not adopted.



## REPORT OF REFERENCE COMMITTEE A

## RECOMMENDED FOR ADOPTION

- (1) COUNCIL ON MEDICAL SERVICE REPORT 5 – INTEGRATING CARE FOR INDIVIDUALS DUALY ELIGIBLE FOR MEDICARE AND MEDICAID

## RECOMMENDATION:

Recommendations in Council on Medical Service Report 5 be adopted and the remainder of the Report be filed.

**HOD ACTION:** Recommendations in Council on Medical Service Report 5 adopted and the remainder of the Report filed.

1. That our American Medical Association (AMA) support integrated care for individuals dually eligible for Medicare and Medicaid that aligns with AMA policy and meets the following criteria:

- a. Care is grounded in the diversity of dually eligible enrollees and services are tailored to individuals' needs and preferences.
- b. Coverage of medical, behavioral health, and long-term services and supports is aligned.
- c. Medicare and Medicaid eligibility and enrollment processes are simplified, with enrollment assistance made available as needed.
- d. Enrollee choice of plan and physician is honored, allowing existing patient-physician relationships to be maintained.
- e. Services are easy to navigate and access, including in rural areas.
- f. Care coordination is prioritized, with quality case management available as appropriate.
- g. Barriers to access, including inadequate networks of physicians and other providers and prior authorizations, are minimized.
- h. Administrative burdens on patients, physicians and other providers are minimized.
- i. Educational materials are easy to read and emphasize that the ability and power to opt in or out of integrated care resides solely with the patient.
- j. Physician participation in Medicare or Medicaid is not mandated nor are eligible physicians denied participation. (New HOD Policy)

2. That our AMA reaffirm Policy H-290.967, which establishes principles on the delivery of care and financing reform for Medicare and Medicaid dually eligible patients. (Reaffirm HOD Policy)

3. That our AMA reaffirm Policy D-290.978, which calls on the Centers for Medicare & Medicaid Services to require all states to develop processes to facilitate opting out of managed care programs by dual eligible individuals. (Reaffirm HOD Policy)

4. That our AMA reaffirm Policy H-165.822, which encourages new and continued partnerships to address non-medical health needs and the underlying social determinants of health; supports continued efforts by public and private health plans to address social determinants of health in health insurance benefit designs; and encourages public and private health plans to examine implicit bias and the role of racism and social determinants of health. (Reaffirm HOD Policy)

5. That our AMA reaffirm Policy H-180.944, which states that health equity, defined as optimal health for all, is a goal toward which our AMA will work by advocating for health services, research and data collection; promoting equity in care; increasing health workforce diversity; influencing social determinants of health; and voicing and modeling commitment to health equity. (Reaffirm HOD Policy)

There was supportive testimony on Council on Medical Service Report 5. A member of the Council on Medical Service emphasized that integrated care that abides by the criteria outlined in Recommendation 1 can improve care

and life quality for individuals dually eligible for Medicare and Medicaid. Speakers highlighted the complex health needs of many dually eligible people as well as the disproportionate impact of COVID-19. Testimony also supported the report recommendations' focus on reducing barriers to care, preserving patient choice, and ensuring adequate access to care in rural areas.

Your Reference Committee agrees with testimony offered against a proffered amendment to add "evidence-based" to Recommendation 1(b) because this amendment could allow payers to deny coverage of necessary and appropriate services for dually eligible enrollees. Accordingly, your Reference Committee believes that the recommendations of Council on Medical Service Report 5 should be adopted.

#### RECOMMENDED FOR ADOPTION AS AMENDED

#### (2) COUNCIL ON MEDICAL SERVICE REPORT 1 – END-OF-LIFE CARE

##### RECOMMENDATION A:

Recommendation 3 in Council on Medical Service Report 1 be amended by addition to read as follows:

3. That our AMA support increased access to comprehensive interdisciplinary palliative care services by Medicare patients in skilled nursing facilities. (New HOD Policy)

##### RECOMMENDATION B:

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 filed.

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 101-Nov-20, and that the remainder of the report be filed:

1. That our American Medical Association (AMA) support Medicare coverage of and appropriate payment for supportive care services, including assistance with activities of daily living, as needed, under Medicare's hospice benefit. (New HOD Policy)
2. That our AMA support study and pilot testing by the Centers for Medicare & Medicaid Services of care models that allow concurrent use of Medicare's hospice and skilled nursing facility (SNF) benefits for the same condition. (New HOD Policy)
3. That our AMA support increased access to palliative care services by Medicare patients in skilled nursing facilities. (New HOD Policy)
4. That our AMA reaffirm Policy H-85.966, which maintains that hospice care should provide the patient and family with appropriate physical and emotional support, but not preclude the use of appropriate palliative therapies to continue to treat underlying disease. (Reaffirm HOD Policy)
5. That our AMA reaffirm Policy H-70.915, which recognizes the importance of palliative care, encourages the education of health professionals and the public in caring for dying patients, and supports improved payment for health care practices that are important to good care of the dying patient. (Reaffirm HOD Policy)

There was testimony that was supportive of Council on Medical Service Report 1. A member of the Council on Medical Service introduced the report by highlighting the challenges of trying to find placements for terminally ill

patients in need of custodial care. The Council member stated that the provision of supportive services, as determined by patient need, may improve quality of life and prevent utilization of higher-cost care.

Speakers supported the report recommendations' focus on helping patients at the end of their lives who, under current Medicare rules, cannot enroll in Medicare's skilled nursing and hospice benefits at the same time for the same condition. Your Reference Committee believes an amendment proffered in the online member forum strengthens Recommendation 3 by aligning that recommendation with clinical practice guidelines for palliative care. Therefore, your Reference Committee believes that the recommendations of Council on Medical Service Report 1 should be adopted as amended.

(3) COUNCIL ON MEDICAL SERVICE REPORT 3 – COVERING THE  
REMAINING UNINSURED

RECOMMENDATION A:

Recommendation 3 in Council on Medical Service Report 3 be amended by deletion to read as follows:

3. That our AMA support extending eligibility to purchase ~~unsubsidized~~ Affordable Care Act (ACA) marketplace coverage to undocumented immigrants and Deferred Action for Childhood Arrivals (DACA) recipients, with the guarantee that health plans and ACA marketplaces will not collect and/or report data regarding enrollee immigration status. (New HOD Policy)

RECOMMENDATION B:

Recommendations in Council on Medical Service Report 3 be adopted as amended and the remainder of the Report be filed.

**HOD ACTION:** Recommendations in Council on Medical Service Report 3 adopted as amended and the remainder of the Report filed.

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 123-J-21, and that the remainder of the report be filed.

1. That our American Medical Association (AMA) advocate that any federal approach to cover uninsured individuals who fall into the “coverage gap” in states that do not expand Medicaid—having incomes above Medicaid eligibility limits but below the federal poverty level, which is the lower limit for premium tax credit eligibility—make health insurance coverage available to uninsured individuals who fall into the coverage gap at no or nominal cost, with significant cost-sharing protections. (New HOD Policy)

2. That our AMA advocate that any federal approach to cover uninsured individuals who fall into the coverage gap provide states that have already implemented Medicaid expansions with additional incentives to maintain their expansions. (New HOD Policy)

3. That our AMA support extending eligibility to purchase unsubsidized Affordable Care Act (ACA) marketplace coverage to undocumented immigrants and Deferred Action for Childhood Arrivals (DACA) recipients, with the guarantee that health plans and ACA marketplaces will not collect and/or report data regarding enrollee immigration status. (New HOD Policy)

4. That our AMA recognize the potential for state and local initiatives to provide coverage to immigrants without regard to immigration status. (New HOD Policy)

5. That our AMA reaffirm Policy H-290.983, which opposes federal and state legislation denying or restricting lawfully present immigrants Medicaid and immunizations. (Reaffirm HOD Policy)

6. That our AMA amend Policy H-165.828 by addition and deletion to read as follows:

- a. Our AMA 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 ~~that which applies to the exemption from the individual mandate of the level at which premiums are capped for individuals with the highest incomes eligible for subsidized coverage in Affordable Care Act (ACA) marketplaces.~~
- b. 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 with respect to the cost of family-based or employee-only coverage and household income. ... (Modify Current HOD Policy)

7. That our AMA reaffirm Policy D-290.979, which states that our AMA will work with state and specialty medical societies in advocating at the state level in support of Medicaid expansion. (Reaffirm HOD Policy)

8. That our AMA reaffirm Policy H-290.965, which supports states that newly expand Medicaid being made eligible for three years of full federal funding. (Reaffirm HOD Policy)

9. That our AMA reaffirm Policy H-165.823, which supports auto-enrolling individuals in health insurance coverage if they are eligible for coverage options that would be of no cost to them after the application of any subsidies, including zero-premium marketplace coverage and Medicaid/Children's Health Insurance Program (CHIP); and outlines standards that any public option to expand health insurance coverage must meet. (Reaffirm HOD Policy)

10. That our AMA reaffirm Policy H-165.838, which states that insurance coverage options offered in a health insurance exchange should 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. (Reaffirm HOD Policy)

11. That our AMA reaffirm Policy H-165.824, which supports: (1) adequate funding for and expansion of outreach efforts to increase public awareness of advance premium tax credits; (2) providing young adults with enhanced premium tax credits while maintaining the current premium tax credit structure which is inversely related to income; (3) 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; (4) eliminating the subsidy "cliff," thereby expanding eligibility for premium tax credits beyond 400 percent of the federal poverty level (FPL); (5) increasing the generosity of premium tax credits; (6) expanding eligibility for cost-sharing reductions; and (7) increasing the size of cost-sharing reductions. (Reaffirm HOD Policy)

12. That our AMA reaffirm Policies H-290.976, H-290.971, H-290.982 and D-290.982, which support investments in Medicaid/CHIP outreach and enrollment assistance activities. (Reaffirm HOD Policy)

13. That our AMA reaffirm Policy H-165.848, which supports a requirement that individuals and families earning greater than 500 percent FPL obtain, at a minimum, coverage for catastrophic health care and evidence-based preventive health care, using the tax structure to achieve compliance. (Reaffirm HOD Policy)

14. That our AMA rescind Policy H-290.966, as it is superseded by Policy H-165.823 as well as the recommendations of this report. (Rescind HOD Policy)

15. That our AMA reaffirm Policy H-330.896, which supports restructuring Medicare age-eligibility requirements and incentives to match the Social Security schedule of benefits. (Reaffirm HOD Policy)

There was generally supportive testimony on Council on Medical Service Report 3. Your Reference Committee appreciates all of the testimony provided on the online member forum and during the live hearing, and all of the amendments proffered, on the recommendations of Council on Medical Service Report 3. Your Reference Committee underscores that our AMA establishing new policy addressing the uninsured who are ineligible for ACA

financial assistance due to falling into the coverage gap, immigration status, or having an affordable offer of employer coverage is critical to expanding the coverage reach of our AMA proposal for reform, as well as achieving the Association's longstanding goal of covering the uninsured.

In introducing the report, a member of the Council on Medical Service underscored that in assessing the options available to cover the uninsured ages 60 to 64, the AMA plan to cover the uninsured, as well as the recommendations of this report, are preferable to other options, including lowering the Medicare eligibility age to 60. The Council member noted that, of the roughly 1.6 million uninsured ages 60 to 64, nearly half are eligible for premium tax credits. Further, nearly 20 percent are eligible for Medicaid, 15 percent are ineligible for ACA financial assistance due to having an affordable offer of employer coverage, 10 percent fall in the coverage gap and seven percent are ineligible for ACA financial assistance due to immigration status. As such, covering most of the uninsured in this age group could be accomplished without causing health system disruptions associated with lowering the Medicare eligibility age to 60 – including potentially shifting nearly 12 million individuals with employer coverage and 2.4 million with non-group coverage into Medicare.

Your Reference Committee appreciates testimony provided that outlined that lowering the Medicare eligibility age not only addresses covering the uninsured ages 60 to 64, but also is critical to addressing underinsurance in this age group, as well as promoting health equity. However, your Reference Committee notes that lowering the Medicare eligibility age to 60 would eliminate subsidized marketplace coverage eligibility for individuals ages 60 to 64. This restriction in health plan choice would hit those with the lowest incomes the hardest. In light of the premium tax credit enhancements included in the American Rescue Plan, lower-income individuals currently enrolled in a marketplace plan may face higher premiums in traditional Medicare. As outlined in the Council report, Avalere found that current marketplace subsidies are consistently more generous for lower-income individuals than the subsidies available to Medicare beneficiaries.

Addressing underinsurance, most current traditional Medicare beneficiaries are enrolled in supplemental insurance through either a Medicare supplemental plan, Medicaid, or an employer to provide more comprehensive cost-sharing protections than what is offered in the traditional Medicare program. The sheer need for supplemental insurance shows that Medicare coverage by itself leaves many beneficiaries underinsured. As such, your Reference Committee agrees with the Council on Medical Service and does not accept the proposed amendment to the recommendations of the report to lower the Medicare eligibility age to 60.

Your Reference Committee did accept the amendment to remove “unsubsidized” from the third recommendation of the report. Of note, the amendment to remove “unsubsidized” did not replace it with “subsidized.” Your Reference Committee agrees with testimony that this amendment proffered to the third recommendation of the report would provide the AMA with additional flexibility in its advocacy efforts to expand eligibility for marketplace coverage to undocumented immigrants and Deferred Action for Childhood Arrivals (DACA) recipients (Dreamers), who currently are shut out from marketplace coverage, even if they pay the full cost. Your Reference Committee also notes that this flexibility of language may be important if the immigration status of Dreamers changes in the near future. There was a call to refer the third and fourth recommendations of the report, which would be new HOD policy. Your Reference Committee does not support referral, as providing a key pathway to coverage to the undocumented immigrant population is in line with our AMA's pursuit of health equity, as well as testimony stressing the need for this population to seek preventive care versus relying on emergency care.

There were also amendments offered to Recommendation 6(b) of the report addressing the ACA's “family glitch.” A member of the Council on Medical Service clarified that this recommendation of the report does not preclude the AMA from supporting the solution to the family glitch that makes a change so that if family coverage offered through an employer is unaffordable, the worker and their family would become eligible for ACA premium tax credits to purchase marketplace coverage. It would, however, enable the AMA to support an additional solution to the glitch that can arguably be addressed through administrative action, which would in effect decouple the worker from their family in determining eligibility for premium tax credits to purchase coverage. As such, a spouse and/or child in a family offered “affordable” employee-only coverage but unaffordable family coverage would become eligible for premium subsidies to purchase marketplace coverage. But, the worker would remain enrolled in the employer plan. Your Reference Committee agrees with the assessment of the Council on Medical Service, as Recommendation 6(b) would enable the AMA to support 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 – regardless of whether the worker remains covered by the employer plan or becomes eligible for subsidies for marketplace coverage as well.

Your Reference Committee believes that the recommendations of Council on Medical Service Report 3 should be adopted as amended, serving as a critical next step to cover the remaining uninsured. Your Reference Committee agrees with the member of the Council on Legislation that the recommendations of the report are especially timely, given congressional consideration of the Build Back Better Act.

#### RECOMMENDED FOR ADOPTION IN LIEU OF

#### (4) RESOLUTION 101 – STANDARDIZED CODING FOR TELEHEALTH SERVICES

##### RECOMMENDATION:

Alternate Resolution 101 be adopted in lieu of Resolution 101.

RESOLVED, That our American Medical Association support legislation, regulation and/or outreach, whichever is relevant, to ensure that public and private payors utilize one consistent set of reporting and coding rules to identify telehealth services in claims. (Directive to Take Action)

**HOD ACTION:** Alternate Resolution 101 referred for decision.

RESOLVED, That our American Medical Association advocate by regulation and/or legislation that telehealth services are uniformly identified by using place of service (02) without any additional requirements, such as modifiers imposed by third party payors, for claim submission and reimbursement. (Directive to Take Action)

Your Reference Committee heard mixed testimony on Resolution 101. There was consensus, however, on the need for administrative simplification of the various methods to report and code telehealth services that were used and modified as payors coped with the demands created by the COVID-19 pandemic. Testimony highlighted experiences with administrative burdens and denied claims in this space. However, concerns were raised with the original and alternate resolution language submitted by the sponsor of Resolution 101. A member of the Council on Medical Service stated that, while having consistency in reporting and coding rules to identify telehealth services in claims is important, being overly prescriptive would undermine our advocacy in this arena.

A member of the RVS Update Committee (RUC) and AMA Digital Medicine Payment Advisory Group, who introduced the alternate resolution language proposed by the Reference Committee on behalf of his delegation, testified that a Place of Service (POS) 02 is not necessarily the optimal choice as it is specific to Medicare telehealth policies that are being waived due to the public health emergency. In fact, today, use of 02 in Medicare results in lower payment than the use of the POS code where the patient is normally seen with use of CPT® modifier 95. Additional speakers raised concerns with the consequence of original Resolution 101 in immediately decreasing physician payment for telehealth services. As such, your Reference Committee recommends that Alternate Resolution 101 be adopted in lieu of Resolution 101.

#### (5) RESOLUTION 113 – SUPPORTING MEDICARE DRUG PRICE NEGOTIATION

##### RECOMMENDATION:

Alternate Resolution 113 be adopted in lieu of Resolution 113.

RESOLVED, That our American Medical Association reaffirm Policy D-330.954, which states that our AMA will (1) support federal legislation which gives the Secretary of the Department of Health and Human Services the authority to negotiate contracts with manufacturers of covered Part D drugs, (2)

work toward eliminating Medicare prohibition on drug price negotiation, and (3) prioritize its support for the Centers for Medicare & Medicaid Services to negotiate pharmaceutical pricing for all applicable medications covered by CMS (Reaffirm HOD Policy); and be it further

RESOLVED, That our AMA reaffirm Policy H-110.980, which outlines principles guiding the use of international price indices and averages in determining the price of and payment for drugs, including those covered in Medicare Parts B and D (Reaffirm HOD Policy); and be it further

RESOLVED, That our AMA support legislation that limits Medicare annual drug price increases to the rate of inflation. (New HOD Policy)

**HOD ACTION:** Resolves 1 and 3 of Alternate Resolution 113 adopted in lieu of Resolution 113, with Resolve 2 and proffered amendment referred.

Adopted Resolves 1 and 3:

RESOLVED, That our American Medical Association reaffirm Policy D-330.954, which states that our AMA will (1) support federal legislation which gives the Secretary of the Department of Health and Human Services the authority to negotiate contracts with manufacturers of covered Part D drugs, (2) work toward eliminating Medicare prohibition on drug price negotiation, and (3) prioritize its support for the Centers for Medicare & Medicaid Services to negotiate pharmaceutical pricing for all applicable medications covered by CMS (Reaffirm HOD Policy); and be it further

RESOLVED, That our AMA support legislation that limits Medicare annual drug price increases to the rate of inflation. (New HOD Policy)

Resolve 2 of Alternate Resolution 113 and proffered amendment that was referred:

Resolve 2: RESOLVED, That our AMA reaffirm Policy H-110.980, which outlines principles guiding the use of international price indices and averages in determining the price of and payment for drugs, including those covered in Medicare Parts B and D (Reaffirm HOD Policy); and be it further

Amendment: Amend Alternate Resolution 113 by addition and deletion as follows:

~~RESOLVED, That our AMA reaffirm Policy H-110.980, which outlines principles guiding the use of international price indices and averages in determining the price of and payment for drugs, including those covered in Medicare Parts B and D (Reaffirm HOD Policy); and be it further~~

RESOLVED, That our AMA will advocate for Medicare drug price negotiation to reduce prices paid by Medicare for medications in Part B and Part D and physician acquisition costs for medications in Part B.

Amend Policy H-110.980, “Additional Mechanisms to Address High and Escalating Pharmaceutical Prices,” by addition and deletion to read as follows:

2. Our AMA will advocate that any use of international price indices and averages in determining the price of and payment for drugs should abide by the following principles:

~~a. Any international drug price index or average should exclude countries that have single payer health systems and use price controls;~~

a. Any international drug price index used to determine Medicare Part D drug prices should be based on a reasonable percentage of the drug's volume weighted net average price in at least six large western industrialized nations;

RESOLVED, That our American Medical Association aggressively advocate for passage of legislation that authorizes Medicare to negotiate drug prices with pharmaceutical companies to bring down the cost of prescription drugs for our patients (Directive to Take Action); and be it further

RESOLVED, That our AMA amend Policy H-110.980, "Additional Mechanisms to Address High and Escalating Pharmaceutical Prices" to support indexing Medicare Part D drug prices to a reasonable percentage of the prices paid in other large western industrialized nations by addition and deletion to read as follows:

H-110.980 - Additional Mechanisms to Address High and Escalating Pharmaceutical Prices

2. Our AMA will advocate that any use of international price indices and averages in determining the price of and payment for drugs should abide by the following principles:

~~a. Any international drug price index or average should exclude countries that have single payer health systems and use price controls;~~

~~b. Any international drug price index or average should not be used to determine or set a drug's price, or determine whether a drug's price is excessive, in isolation;~~

a. Any international drug price index used to determine Medicare Part D drug prices should be based on a reasonable percentage of the drug's volume-weighted net average price in at least six large western industrialized nations;

~~e-b.~~ The use of any international drug price index or average should preserve patient access to necessary medications;

~~d-c.~~ The use of any international drug price index or average should limit burdens on physician practices; and

~~e-d.~~ Any data used to determine an international price index or average to guide prescription drug pricing should be transparent and updated regularly; and

e. Any international drug price index used to determine Medicare Part D drug prices should ensure that American taxpayers are not unnecessarily subsidizing drug costs in other large western industrialized nations. (Modify Current HOD Policy); and be it further

RESOLVED, That our AMA support legislation that limits Medicare annual drug price increases to the rate of inflation (New HOD Policy); and be it further

RESOLVED, That our AMA support legislation that reinvests a portion of any savings from Medicare drug price negotiation into the Medicare physician fee schedule and other Medicare physician value-based payments. (New HOD Policy)

There was mixed testimony on Resolution 113. There was consensus in testimony as to the need to address high drug prices that are becoming increasingly unaffordable for our patients, as well as enthusiasm for the momentum behind Medicare drug price negotiation in Congress. A member of the Council on Legislation testified that the first resolve of the resolution is already addressed by Policy D-330.954. Your Reference Committee agrees, and is recommending reaffirmation of the policy in lieu of the first resolve.

A member of the Council on Medical Service clarified the scope of Policy H-110.980, recommended for amendment in the second resolve of Resolution 113. The Council member noted that the scope of Policy H-110.980 goes beyond the prices of drugs in Medicare Part D; it also serves as the foundational policy guiding AMA advocacy in response to initiatives proposing international price averages pertaining to the pricing of drugs in Medicare Part B. A past president of our AMA testified that if international price averages were applied in Medicare Part B, it is not clear where said limitations on pricing would occur. Her testimony highlighted that physicians could be reimbursed at a lower amount than the purchase price of the drug, which would raise significant access concerns for our patients. Testimony of the Council on Medical Service member also raised the concern that the provisions of Policy H-110.980 suggested for deletion in the second resolve would impact our stance pertaining to Medicare Part B.

A member of the Council on Legislation noted that during the previous Administration, we saw the potential for the burden of negotiation and international index pricing in Medicare Part B to be placed on physicians. In addition, the



Council member stated that the current version of the Build Back Better bill has moved away from using international pricing indices as part of Medicare drug price negotiation. In addition, qualifying Part B and Part D drugs would be subject to negotiation under the current version of the Build Back Better bill, if enacted into law. As such, the Council member questioned the need to consider the amendments to Policy H-110.980 as outlined in the second resolve of Resolution 113, considering the potential for severe unintended consequences. Accordingly, your Reference Committee recommends reaffirmation of Policy H-110.980 in lieu of the second resolve, to ensure consistency of AMA policy on the use of international price averages/indices for the pricing of drugs across health plans.

While there was generally supportive testimony on the third resolve of Resolution 113, there were questions raised by speakers as to which inflation rate would be used. Your Reference Committee notes that specifying an inflation rate may be overly prescriptive. Significantly, existing AMA policy in the drug pricing arena does not specify a specific inflation rate to be used, but there is precedent for referring to inflation generally in existing policy. Policy H-110.987 supports legislation to require generic drug manufacturers to pay an additional rebate to state Medicaid programs if the price of a generic drug rises faster than inflation – a policy which has since become law. Therefore, your Reference Committee felt that the inclusion of “inflation” in the language of the third resolve was appropriate.

While concerns surrounding physician payment were raised in testimony on the fourth resolve of Resolution 113, many speakers were opposed. Testimony stressed that AMA policy historically has not dictated where savings from legislative proposals should be directed. And, such policy could preclude the AMA from supporting drug pricing proposals, even if such savings benefited physicians and physician practices in other ways, or instead were directed to our patients to help with cost-sharing, or to fund ACA improvements to cover the remaining uninsured. Finally, concerns around the optics of the fourth resolve were raised, in that the AMA could be seen as self-serving. Your Reference Committee agrees, and did not include the fourth resolve in the alternate resolution presented, recommended to be adopted in lieu of Resolution 113.

#### Prescription Drug Prices and Medicare D-330.954

1. Our AMA will support federal legislation which gives the Secretary of the Department of Health and Human Services the authority to negotiate contracts with manufacturers of covered Part D drugs.
2. Our AMA will work toward eliminating Medicare prohibition on drug price negotiation.
3. Our AMA will prioritize its support for the Centers for Medicare & Medicaid Services to negotiate pharmaceutical pricing for all applicable medications covered by CMS.

#### Additional Mechanisms to Address High and Escalating Pharmaceutical Prices H-110.980

1. Our AMA will advocate that the use of arbitration in determining the price of prescription drugs meet the following standards to lower the cost of prescription drugs without stifling innovation:
  - a. The arbitration process should be overseen by objective, independent entities;
  - b. The objective, independent entity overseeing arbitration should have the authority to select neutral arbitrators or an arbitration panel;
  - c. All conflicts of interest of arbitrators must be disclosed and safeguards developed to minimize actual and potential conflicts of interest to ensure that they do not undermine the integrity and legitimacy of the arbitration process;
  - d. The arbitration process should be informed by comparative effectiveness research and cost-effectiveness analysis addressing the drug in question;
  - e. The arbitration process should include the submission of a value-based price for the drug in question to inform the arbitrator’s decision;
  - f. The arbitrator should be required to choose either the bid of the pharmaceutical manufacturer or the bid of the payer;
  - g. The arbitration process should be used for pharmaceuticals that have insufficient competition; have high list prices; or have experienced unjustifiable price increases;
  - h. The arbitration process should include a mechanism for either party to appeal the arbitrator’s decision; and
  - i. The arbitration process should include a mechanism to revisit the arbitrator’s decision due to new evidence or data.
2. Our AMA will advocate that any use of international price indices and averages in determining the price of and payment for drugs should abide by the following principles:

- a. Any international drug price index or average should exclude countries that have single-payer health systems and use price controls;
  - b. Any international drug price index or average should not be used to determine or set a drug's price, or determine whether a drug's price is excessive, in isolation;
  - c. The use of any international drug price index or average should preserve patient access to necessary medications;
  - d. The use of any international drug price index or average should limit burdens on physician practices; and
  - e. Any data used to determine an international price index or average to guide prescription drug pricing should be updated regularly.
3. Our AMA supports the use of contingent exclusivity periods for pharmaceuticals, which would tie the length of the exclusivity period of the drug product to its cost-effectiveness at its list price at the time of market introduction.

## REPORT OF REFERENCE COMMITTEE B

## RECOMMENDED FOR ADOPTION

## (1) BOARD OF TRUSTEES REPORT 2 –POLICING REFORM

## RECOMMENDATION:

Recommendations in Board of Trustees Report 2 be adopted and the remainder of the report be filed.

**HOD ACTION:** Board of Trustees Report 2 adopted and the remainder of the report filed.

The Board recommends that the following be adopted in lieu of the Third, Fourth, and Eighth Resolve Clauses of Resolution 410-NOV-20, and that the remainder of the report be filed.

1. That our AMA advocate for efforts to implement evidence-based policing and the creation of evidence-based standards for law enforcement. (New HOD Policy)
2. That our AMA advocate for sentinel event reviews in the criminal justice system following an adverse event, such as an in-custody death. (New HOD Policy)
3. That our AMA encourage further research by subject matter experts on the issues related to the transfer of military equipment to law enforcement agencies, including the impact on communities, particularly those in minoritized and marginalized communities. (New HOD Policy)
4. That our AMA support greater police accountability, procedurally just policing models, and greater community involvement in policing policies and practices. (New HOD Policy)
5. That Policy H-65.954, “Policing Reform,” be reaffirmed. (Reaffirm HOD Policy)
6. That Policy H-515.955, “Research the Effects of Physical or Verbal Violence Between Law Enforcement Officers and Public Citizens on Public Health Outcomes,” be reaffirmed. (Reaffirm HOD Policy)
7. That Policy H-345.972, “Mental Health Crisis Interventions,” be reaffirmed. (Reaffirm HOD Policy)
8. That Policy H-145.969, “Less-Lethal Weapons and Crowd Control,” be reaffirmed. (Reaffirm HOD Policy).

Your Reference Committee heard passionate testimony on the impact of police violence on health, particularly among minoritized and marginalized communities. Your Reference Committee also heard testimony that emphasized that changes to policing practices are needed to remedy inequities. Your Reference Committee was offered an amendment that asked our AMA to support demilitarization of law enforcement agencies. However, your Reference Committee did not hear any additional testimony in support of the amendment. Your Reference Committee was also offered an amendment concerning the qualified immunity of police officers; however, your Reference Committee was not offered concrete suggestions on exactly how qualified immunity should be altered or the legal implications of altering qualified immunity for police officers. Overall, your Reference Committee heard overwhelming testimony in support of the recommendations as written including support for the recommendations to further research the transfer of military equipment to law enforcement agencies, as well as develop policy to advance evidence-based policing, the creation of evidence-based standards for law enforcement, sentinel event reviews in the criminal justice system, greater police accountability, procedurally just policing models, and greater community involvement in policing policies and practices. Your Reference Committee agrees with the supportive testimony and, therefore, recommends that the recommendations in Board of Trustees Report 2 be adopted and the remainder of the report be filed.

(2) BOARD OF TRUSTEES REPORT 8 –IMPROVED ACCESS AND COVERAGE TO NON-OPIOID MODALITIES TO ADDRESS PAIN

RECOMMENDATION:

Recommendation in Board of Trustees Report 8 be adopted and the remainder of the report be filed.

**HOD ACTION:** Board of Trustees Report 8 adopted and the remainder of the report filed.

The Board recommends that the referred resolves in Alternate Resolution 218-A-19 not be adopted and the remainder of the report be filed.

Your Reference Committee heard testimony strongly in support of patients with pain receiving the care recommended by their physician. Your Reference Committee heard that health insurance companies and other payers should provide affordable access to those treatments. Your Reference Committee also heard that our Board and the new AMA Substance Use and Pain Care Task Force is heavily focusing on protecting patients with pain. Your Reference Committee considered testimony on how the nation's drug overdose epidemic has focused too much on simply reducing opioid prescriptions without actually providing access to evidence-based pain care options for patients or their physicians. Your Reference Committee heard about the work of physicians whom advocate for patients with pain and finds it disconcerting that health insurance companies have not helped to increase access to non-opioid pain care options while patients' access to opioid therapy has decreased by more than 44 percent over the past decade. Your Reference Committee heard and considered the concerns of the authors of the original resolution that stated that specific procedures have suffered from payer, administrative, and other barriers. However, your Reference Committee heard significant testimony in favor of Board of Trustees Report 8. Your Reference Committee heard that the recommendation in Board of Trustees Report 8 is guided by current AMA policy and provides clear and strong guidance to our AMA advocacy efforts that benefit all physicians who provide care to patients with pain. Your Reference Committee, therefore, recommends that the recommendation in Board of Trustees Report 8 be adopted and the remainder of the report be filed.

(3) BOARD OF TRUSTEES REPORT 10 –PHYSICIAN ACCESS TO THEIR MEDICAL AND BILLING RECORDS

RECOMMENDATION:

Recommendations in Board of Trustees Report 10 be adopted and the remainder of the report be filed.

**HOD ACTION:** Board of Trustees Report 10 adopted and the remainder of the report filed.

The Board recommends that the following be adopted in lieu of Resolution 226-A-19 and the remainder of this report be filed:

1. That our AMA advocate that licensed physicians have unrestricted access to all their patients' billing records and associated medical records during employment or while under contract to provide medical or health care items or services. The records should also include any billing records submitted under the physician's name, regardless of whether the physician directly provided the item or service. (Directive to Take Action)
2. That our AMA advocate that, where physician possession of all his or her billing records is not already required by state law, the employment or other contractual arrangement between a physician and entity submitting claims on behalf of the physician should specify that the physician is entitled to copies of his or her billing records subsequent to the termination of employment or contractual arrangement, when such

records are necessary for the physician's defense in malpractice actions, administrative investigations, or other proceedings against the physician. (Directive to Take Action)

3. That our AMA advocate for legislation or regulation to eliminate contractual language that bars or limits the treating physician's access to his or her billing records and associated medical records, such as treating these records as trade secrets or proprietary. (Directive to Take Action)

Your Reference Committee heard unanimously supportive testimony in favor of Board of Trustees Report 10. Your Reference Committee heard testimony that the Office of the Inspector General of the U.S. Department of Health and Human Services states that physicians are responsible for claims sent to Medicare, even if the physician had no actual knowledge of a billing impropriety. Your Reference Committee heard that physicians need to have access to records regarding claims that have been submitted on their behalf or under their name both during and after employment or a contractual arrangement so that they can protect themselves from non-compliance with Medicare and other program requirements and defend themselves from other actions that might be taken against them. Your Reference Committee heard that it is vital that unnecessary barriers, such as claims of trade secrets or proprietary information, not be allowed to hinder a physician from having timely access to patient medical and billing records relating to services that a physician has provided. Your Reference Committee, therefore, recommends that the recommendation in Board of Trustees Report 10 be adopted and the remainder of the report be filed.

(4) BOARD OF TRUSTEES REPORT 12 –DIRECT-TO-CONSUMER GENETIC TESTS

RECOMMENDATION:

Recommendations in Board of Trustees Report 12 be adopted and the remainder of the report be filed.

**HOD ACTION:** Board of Trustees Report 12 adopted and the remainder of the report filed.

The Board of Trustees recommends that the following statements be adopted in lieu of Resolution 207-A-19, and that the remainder of this report be filed.

1. That our AMA adopt the following new policy:

“Consumer Genetic Testing and Privacy”

Our AMA:

- (1) will work with relevant stakeholders to advance laws and regulations that prevent genetic testing entities without explicit, informed, and non-coerced user consent from transferring information about a user such as birthdates and state of residence to third parties which may result in the re-identification of the user based on surname inference (New HOD Policy).
- (2) supports privacy standards that would prohibit pharmaceutical companies, biotechnology companies, universities, and all other entities with financial ties to the genetic testing company from sharing identifiable information, including DNA, with other parties without informed consent of the user. An exception would be made when requested for a duly executed court order or when compelled for public health or safety reasons as outlined in existing AMA policy including H-315.983, “Privacy and Confidentiality,” and Medical Code of Ethics 4.1.4, “Forensic Genetics.” If a data security or privacy breach occurs with a direct-to-consumer (DTC) genetic company or its collaborators, then the company has the responsibility to inform all users and relevant regulatory bodies of the breach and the impact of the unprotected private data on those individuals (New HOD Policy).
- (3) will advocate that research using consumer genomic data derived from saliva or cheek swabs or other human samples should be treated as research on human subjects requiring informed consent consistent with

- or similar to those required by the Health and Human Services (HHS) Office for Human Research Protection (OHRP), and recommend an “opt in” option to allow more consumer choice in the consent process (New HOD Policy).
- (4) will advocate for extending the consumer protections of the Genetic Information Non-Discrimination Act (GINA) of 2008 by adding long-term care, disability insurance, and life insurance to the Act, modeled after the laws of other states, such as California (New HOD Policy).
2. That the following policies be reaffirmed: H-65.969, “Genetic Discrimination and the Genetic Information Nondiscrimination Act,” H-185.972, “Genetic Information and Insurance Coverage,” D-480.987, “Direct-to-Consumer Marketing and Availability of Genetic Testing,” H-480.941, “Direct-to-Consumer Laboratory Testing,” H-460.916, “Protection of Human Subjects in Research,” H-460.980, “Ethical and Societal Considerations in Research,” and H 315.983, “Patient Privacy and Confidentiality” (Reaffirm HOD Policy).

Your Reference Committee heard overwhelmingly positive testimony in support of Board of Trustees Report 12. Your Reference Committee heard testimony which emphasized that informed consent is a crucial step in protecting patient rights, and that the transferring of genetic information to third parties which do not participate in the process is not appropriate. Your Reference Committee heard testimony that was also supportive of requiring direct-to-consumer genetic testing companies to report data or privacy breaches to their customers and that such a position aligns with our current AMA policy on privacy of medical information. Your Reference Committee also heard testimony in support of an opt-in consent process for research, treating consumer genetics data similarly to any other human-derived sample. Your Reference Committee also heard that opt-in consent may reduce participation in research, but the protection of patient rights and privacy should take priority.

Additionally, your Reference Committee heard testimony which emphasized that, because of patients’ fear of financial repercussions in insurance markets, patients forgo genetic counseling or genetic testing, resulting in serious health implications for individuals for whom genetic testing could be beneficial. Your Reference Committee heard that, given the rapid advancement of genomic testing available to inform diagnostic and therapeutic decision-making across a wide and growing spectrum of diseases, this fear leaves physicians with incomplete information to inform clinical decision-making and curtails the range of treatment options available to patients. Your Reference Committee heard testimony which also expressed concern that fears of discrimination hinder the open and honest patient-physician communication that is foundational in the patient-physician relationship. Your Reference Committee also heard that insurer discrimination based on genetic information financially incentivizes patients to forgo necessary testing and treatment and interferes with physicians’ ability to render optimal patient care, and believes that prohibiting genetic discrimination by life, disability, and long-term care insurers is necessary public policy. Your Reference Committee, therefore, recommends that the recommendations in Board of Trustees Report 12 be adopted and the remainder of the report to be filed.

(5) RESOLUTION 209 –INCREASING ACCESS TO HYGIENE AND MENSTRUAL PRODUCTS

RECOMMENDATION:

Resolution 209 be adopted.

**HOD ACTION:** Resolution 209 adopted.

RESOLVED, That our American Medical Association recognize the adverse physical and mental health consequences of limited access to menstrual products for school-aged individuals (New HOD Policy); and be it further

RESOLVED, That our AMA support the inclusion of medically necessary hygiene products, including, but not limited to, menstrual hygiene products and diapers, within the benefits covered by appropriate public assistance programs (New HOD Policy); and be it further

RESOLVED, That our AMA advocate for federal legislation and work with state medical societies to increase access to menstrual hygiene products, especially for recipients of public assistance (Directive to Take Action); and be it further

RESOLVED, That our AMA encourage public and private institutions as well as places of work and education to provide free, readily available menstrual care products to workers, patrons, and students (New HOD Policy); and be it further

RESOLVED, That our AMA amend H-525.974, “Considering Feminine Hygiene Products as Medical Necessities,” by addition and deletion to read as follows:

**CONSIDERING FEMININE HYGIENE PRODUCTS AS MEDICAL NECESSITIES, H-525.974**

Our AMA will: (1) encourage the Internal Revenue Service to classify feminine hygiene products as medical necessities; ~~and~~ (2) work with federal, state, and specialty medical societies to advocate for the removal of barriers to feminine hygiene products in state and local prisons and correctional institutions to ensure incarcerated women be provided free of charge, the appropriate type and quantity of feminine hygiene products including tampons for their needs.; and (3) encourage the American National Standards Institute, the Occupational Safety and Health Administration, and other relevant stakeholders to establish and enforce a standard of practice for providing free, readily available menstrual care products to meet the needs of workers. (Modify Current HOD Policy)

Your Reference Committee heard testimony primarily in strong support of Resolution 209. Your Reference Committee heard that the economic downturn and public shutdown, as a result of the COVID-19 public health emergency, significantly impacted the ability for individuals to access menstrual hygiene resources. Your Reference Committee also heard that our existing AMA policy recognizes menstrual hygiene products as medical necessities, and that adoption of Resolution 209 would build on our AMA policy that is supportive of reducing barriers to accessing menstrual hygiene products. Your Reference Committee also heard that being able to access menstrual hygiene products aligns with our AMA’s goals of pursuing policy and advocacy efforts through a health equity framework and that access to menstrual hygiene products is a matter of equity and dignity, as well as health, for vulnerable populations. Your Reference Committee believes that the public health benefits of Resolution 209 outweigh concerns raised about making menstrual hygiene products available for free. Your Reference Committee, therefore, recommends that Resolution 209 be adopted.

**(6) RESOLUTION 226 –ADDRESS ADOLESCENT TELEHEALTH  
CONFIDENTIALITY CONCERNS**

**RECOMMENDATION:**

Resolution 226 be adopted.

**HOD ACTION:** Resolution 226 adopted.

RESOLVED, That our American Medical Association amend Policy H-60.965, “Confidential Health Services for Adolescents,” by addition to read as follows:

**Confidential Health Services for Adolescents H-60.965**

Our AMA:

- (1) reaffirms that confidential care for adolescents is critical to improving their health;
- (2) encourages physicians to allow emancipated and mature minors to give informed consent for medical, psychiatric, and surgical care without parental consent and notification, in conformity with state and federal law;
- (3) encourages physicians to involve parents in the medical care of the adolescent patient, when it would be in the best interest of the adolescent. When, in the opinion of the physician, parental involvement would not be beneficial, parental consent or notification should not be a barrier to care;

- (4) urges physicians to discuss their policies about confidentiality with parents and the adolescent patient, as well as conditions under which confidentiality would be abrogated. This discussion should include possible arrangements for the adolescent to have independent access to health care (including financial arrangements);
- (5) encourages physicians to offer adolescents an opportunity for examination and counseling apart from parent. The same confidentiality will be preserved between the adolescent patient and physician as between the parent (or responsible adult) and the physician;
- (6) encourages state and county medical societies to become aware of the nature and effect of laws and regulations regarding confidential health services for adolescents in their respective jurisdictions. State medical societies should provide this information to physicians to clarify services that may be legally provided on a confidential basis;
- (7) urges undergraduate and graduate medical education programs and continuing education programs to inform physicians about issues surrounding minors' consent and confidential care, including relevant law and implementation into practice;
- (8) encourages health care payers to develop a method of listing of services which preserves confidentiality for adolescents; and
- (9) encourages medical societies to evaluate laws on consent and confidential care for adolescents and to help eliminate laws which restrict the availability of confidential care; and
- (10) encourages physicians to recognize the unique confidentiality concerns of adolescents and their parents associated with telehealth visits; and
- (11) encourages physicians in a telehealth setting to offer a separate examination and counseling apart from others and to ensure that the adolescent is in a private space. (Modify current HOD Policy)

Your Reference Committee heard testimony in strong support of Resolution 226. Your Reference Committee heard that Resolution 226 builds on existing AMA policy on the confidentiality of health care services for adolescents and addresses the unique concern around confidentiality of health care services provided to adolescents via telehealth. Your Reference Committee heard that adolescents believe confidentiality is one of the most important aspects of their health care and that physicians also recognize that confidentiality is critical to improving adolescent health. Your Reference Committee heard that Resolution 226 is both timely and necessary as more adolescents are seeking care via telehealth, particularly for sensitive issues such as mental health care. Your Reference Committee also heard that this resolution addresses a current gap in our AMA policy. Your Reference Committee, therefore, recommends that Resolution 226 be adopted.

(7) RESOLUTION 229 –CMS ADMINISTRATIVE REQUIREMENTS

RECOMMENDATION:

Resolution 229 be adopted.

**HOD ACTION:** Resolution 229 adopted.

RESOLVED, That our American Medical Association forcefully advocate that the Centers for Medicare and Medicaid Services (CMS) investigate all valid allegations of HIPAA Administrative simplification requirements thoroughly and offers transparency in its processes and decisions as required by the Administrative Procedure Act (APA) (Directive to Take Action); and be it further

RESOLVED, That our AMA forcefully advocate that the CMS resolve all complaints related to the non-compliant payment methods including opt-out virtual credit cards, charging processing fees for electronic claims and other illegal electronic funds transfer (EFT) fees (Directive to Take Action); and be it further

RESOLVED, That our AMA communicate its strong disapproval of the failure by the CMS Office of Burden Reduction to effectively enforce the HIPAA administrative simplification requirements as required by the law and its failure to impose financial penalties for non-compliance by health plans (Directive to Take Action); and be it further

RESOLVED, That our AMA, through legislation, regulation or other appropriate means, advocate for the prohibition of health insurers charging physicians and other providers to process claims and make payment. (Directive to Take Action)



Your Reference Committee heard testimony in strong support of Resolution 229. Your Reference Committee heard that the Affordable Care Act required all health plans to offer standard Automated Clearing House electronic funds transfer (EFT) payments effective January 1, 2014. Your Reference Committee heard EFT promotes administrative simplification by reducing the manual burdens involved in practices accepting and processing paper checks. Your Reference Committee also heard testimony that some health plans contract with payment vendors that charge percentage-based fees to deliver EFT payments to physician practices. Your Reference Committee heard testimony that our AMA has long advocated that the Centers for Medicare and Medicaid Services has the regulatory authority to enforce our physicians' right to free (aside from minimal banking fees) EFT payments. Additionally, your Reference Committee heard testimony that as recently as October 2021, our AMA initiated a sign-on letter with numerous specialty and state medical societies urging the current Administration to swiftly address this problem by issuing guidance that affirms physicians' right to choose and receive basic EFT payments without paying for additional services and undertaking the associated enforcement activities. Your Reference Committee, therefore, recommends that Resolution 229 be adopted.

#### RECOMMENDED FOR ADOPTION AS AMENDED

#### (8) BOARD OF TRUSTEES REPORT 9 –MEDICAL MARIJUANA LICENSE SAFETY

##### RECOMMENDATION A:

Recommendation 1 in Board of Trustees Report 9 be amended by addition and deletion to read as follows:

1. That our American Medical Association support efforts to ~~limit information about~~ include medical cannabis license certification in states' prescription drug monitoring programs ~~to only whether a patient has been certified to receive medical cannabis when~~ consistent with AMA principles safeguarding patient privacy and confidentiality; (New HOD Policy)

##### RECOMMENDATION B:

Board of Trustees Report 9 be amended by addition of a third recommendation to read as follows:

3. That our AMA review existing state laws that require information about medical cannabis to be shared with or entered into a state prescription drug monitoring program. The review should address impacts on patients, physicians and availability of information including types, forms, THC concentration, quantity, recommended usage, and other medical cannabis details that may be available from a dispensary.

##### RECOMMENDATION C:

Recommendations in Board of Trustees Report 9 be adopted as amended and the remainder of the report be filed.

**HOD ACTION:** Board of Trustees Report 9 adopted as amended and the remainder of the report filed.

The Board recommends that the following be adopted in lieu of Resolution 219-A-19 and the remainder of the report be filed.

1. That our American Medical Association (AMA) support efforts to limit information about medical cannabis in states' prescription drug monitoring programs to only whether a patient has been certified to receive medicinal cannabis consistent with AMA principles safeguarding patient privacy and confidentiality; (New HOD Policy)

2. That our AMA continue its monitoring of state legislation relating to the inclusion of cannabis and related information in state PDMPs. (Directive to Take Action)

Your Reference Committee heard supportive testimony regarding Board of Trustees Report 9. Your Reference Committee heard that Board of Trustees Report 9 provided a thorough review of many of the issues presented by the original resolution. Your Reference Committee heard that physicians should know whether a patient has been certified for medical cannabis use. Your Reference Committee also heard strong support for including this information in a state prescription drug monitoring program (PDMP). Your Reference Committee heard that if a physician knows that a patient has been certified as qualifying for medical cannabis, then the physician can ask as many follow-up questions as necessary.

Your Reference Committee heard that every state and the District of Columbia has a PDMP, but not every state authorizes cannabis for medical use. Your Reference Committee also heard that most PDMPs are interoperable, that is, they can “talk” to other state PDMPs to learn whether a patient in another state has received a prescription for a controlled substance from a prescriber or a pharmacy in a different state. Your Reference Committee further heard that each state has different requirements for law enforcement and other non-health care entities to access the state PDMP. Your Reference Committee heard concerns surrounding the variability in state laws and access by law enforcement and others to registries. Your Reference Committee also heard that PDMPs raise multiple unknown and potentially unintended consequences of having cannabis-related information in a state PDMP given that law enforcement has often used state PDMPs to data mine physician and patient records. Your Reference Committee heard testimony on the importance of limiting information to only patient certification out of a shared concern for patient privacy and confidentiality.

Your Reference Committee also heard limited, but supportive testimony that physicians need to know more than just whether a patient has been certified as having a medical condition that qualifies that patient for medical cannabis—if the state has legalized cannabis for medical use. Your Reference Committee also heard supportive testimony about the need to know about duration, dosage, type, frequency, amount, date, prescriber, and other information related to medical cannabis. Your Reference Committee also heard that PDMPs should be limited to actionable information.

Your Reference Committee received a proposed amendment from Oklahoma concerning supporting efforts to include medical cannabis license certification in states’ prescription drug monitoring programs and supporting AMA state model legislation on this topic. Your Reference Committee also heard mixed testimony on creating AMA state model legislation including concerns that additional information is needed to determine what actually could be reported by a medical cannabis dispensary, and how it would be displayed in a state PDMP. Your Reference Committee also heard persuasive testimony that AMA model legislation on this topic is premature since we do not know the effects of current legislation on physicians and patients. Your Reference Committee, therefore, recommends that Board of Trustees Report 9 be adopted as amended and the remainder of the report filed.

(9) BOARD OF TRUSTEES REPORT 14 –NET NEUTRALITY AND PUBLIC HEALTH

RECOMMENDATION A:

Your Reference Committee recommends Board of Trustees Report 14 be amended by addition of a recommendation to read as follows:

That our American Medical Association support (1) policies ensuring that the transmission speed of essential healthcare data is no slower than other data using the same transmission modality, and (2) data speeds sufficient for high quality, real-time video and audio Telehealth, without paid prioritization.

RECOMMENDATION B:

2. Recommendation in Board of Trustees Report 14 be adopted as amended and the remainder of the report be filed.

**HOD ACTION:** Board of Trustees Report 14 adopted as amended and the remainder of the report filed.

The Board of Trustees recommends that Resolution 211-I-19, “Effects of Net Neutrality on Public Health,” and Resolution 208-I-19, “Net Neutrality and Public Health,” not be adopted and that the remainder of the report be filed.

Your Reference Committee heard mixed testimony regarding Board of Trustees Report 14. Your Reference Committee heard strong testimony favoring maintaining the rules of net neutrality, as repeal could lead companies to place limits on how, where, and when patients and providers are able to access health care data. Your Reference Committee also heard concerns regarding repeal of net neutrality which focused on the potential for companies to pursue policies that could lessen both innovation and competition in health care technology. Your Reference Committee also heard concerns that the repeal of net neutrality could increase the cost of health care delivery, thus negatively impacting both physicians and patients. Your Reference Committee also heard that, as a result of the COVID-19 pandemic and public health emergency, net neutrality is no longer an immediate priority issue for the U.S. Congress. Your Reference Committee heard testimony that Congress has turned its attention to expanding broadband access and affordability, which our AMA policy strongly supports. Additionally, your Reference Committee heard testimony that our AMA should support both the expansion of broadband and the expansion of net neutrality. Your Reference Committee heard testimony in support of re-addressing net neutrality in Board of Trustees Report 14 and understands that this issue is constantly evolving as technology is rapidly changing. Your Reference Committee agrees with testimony in support of adopting policy that would supplement current AMA policy on increasing access to broadband by also ensuring that the transmission of essential healthcare data is no slower than other data using the same transmission modality. Your Reference Committee, therefore, recommends that Board of Trustees Report 14 be adopted as amended and the remainder of the report be filed.

(10) RESOLUTION 207 –AUTHORITY TO GRANT VACCINE EXEMPTIONS

RECOMMENDATION A: Resolution 207 be amended by deletion to read as follows:

RESOLVED, That our AMA opposes medical vaccine exemptions by non-physicians by amending H-440.970, “Nonmedical Exemptions from Immunizations,” by addition as follows:

Nonmedical Exemptions from Immunizations, H-440.970

1. Our AMA believes that nonmedical (religious, philosophic, or personal belief) exemptions from immunizations endanger the health of the unvaccinated individual and the health of those in his or her group and the community at large.

Therefore, our AMA (a) supports the immunization recommendations of the Advisory Committee on Immunization Practices (ACIP) for all individuals without medical contraindications; (b) supports legislation eliminating nonmedical exemptions from immunization; (c) encourages state medical associations to seek removal of nonmedical exemptions in statutes requiring mandatory immunizations, including for childcare and school attendance; (d) encourages physicians to grant vaccine exemption requests only when medical contraindications are present; (e) encourages state and local medical associations to work with public health officials to develop contingency plans for controlling outbreaks in medically-exempt populations and to intensify efforts to achieve high immunization rates in communities where nonmedical exemptions are common; and (f) recommends that states have in place: (i) an established mechanism, which includes the involvement of qualified public health physicians, of determining which vaccines will be mandatory for admission to school and other identified public venues (based upon the recommendations of the ACIP); and (ii) policies that permit immunization exemptions for medical reasons only.

2. Our AMA will actively advocate for legislation, regulations, programs, and policies that incentivize states to (a) eliminate non-medical exemptions from mandated ~~pediatric~~ immunizations and (b) limit medical vaccine exemption authority to only licensed physicians.

## RECOMMENDATION B:

Resolution 207 be adopted as amended.

**HOD ACTION:** Resolution 207 adopted as amended.

RESOLVED, That our American Medical Association oppose medical vaccine exemptions by non-physicians by amending Policy H-440.970, “Nonmedical Exemptions from Immunizations,” by addition to read as follows:  
Nonmedical Exemptions from Immunizations, H-440.970

1. Our AMA believes that nonmedical (religious, philosophic, or personal belief) exemptions from immunizations endanger the health of the unvaccinated individual and the health of those in his or her group and the community at large. Therefore, our AMA: (a) supports the immunization recommendations of the Advisory Committee on Immunization Practices (ACIP) for all individuals without medical contraindications; (b) supports legislation eliminating nonmedical exemptions from immunization; (c) encourages state medical associations to seek removal of nonmedical exemptions in statutes requiring mandatory immunizations, including for childcare and school attendance; (d) encourages physicians to grant vaccine exemption requests only when medical contraindications are present; (e) encourages state and local medical associations to work with public health officials to develop contingency plans for controlling outbreaks in medically-exempt populations and to intensify efforts to achieve high immunization rates in communities where nonmedical exemptions are common; and (f) recommends that states have in place: (i) an established mechanism, which includes the involvement of qualified public health physicians, of determining which vaccines will be mandatory for admission to school and other identified public venues (based upon the recommendations of the ACIP); and (ii) policies that permit immunization exemptions for medical reasons only.
2. Our AMA will actively advocate for legislation, regulations, programs, and policies that incentivize states to: (a) eliminate non-medical exemptions from mandated pediatric immunizations; and (b) limit medical vaccine exemption authority to only licensed physicians. (Modify Current HOD Policy)

Your Reference Committee heard testimony in strong support of Resolution 207. Your Reference Committee heard that limiting the determination of medical exemptions of vaccines to physicians is in line with current AMA policy on vaccines and our policy on scope of practice. Your Reference Committee heard testimony expressing concern about the qualification of non-physicians to authorize medical exemptions for vaccines, despite being permitted to do so in some states. Your Reference Committee considered an amendment to add the terms “allopathic and osteopathic” to the resolution; however, our AMA has existing policy ([H-405.951](#) - Definition and Use of the Term Physician) that already defines “physicians” as allopathic and osteopathic physicians. Your Reference Committee also received an amendment to allow select non-physicians to authorize medical exemptions; however, your Reference Committee agrees with the weight of the testimony which did not support the addition of this amendment. Finally, your Reference Committee received an amendment to remove the word “pediatric” from the original resolution and believes this is consistent with the testimony heard which was not limited to pediatric vaccines. Your Reference Committee, therefore, recommends that Resolution 207 be adopted as amended.

- (11) RESOLUTION 212 –SEQUESTRATION  
RESOLUTION 221 –PROMOTING SUSTAINABILITY IN MEDICARE  
PHYSICIAN PAYMENTS  
RESOLUTION 224 –IMPROVE PHYSICIAN PAYMENTS  
RESOLUTION 225 END BUDGET NEUTRALITY

## RECOMMENDATION A:

Alternative Resolution 212 be adopted in lieu of Resolutions 212, 221, 224, and 225.

RESOLVED, That our AMA: continue to prioritize and actively pursue vigorous and strategic advocacy to prevent sequester and other cuts in Medicare payments due to take effect on January 1, 2022; seek positive inflation-adjusted annual physician payment updates that keep pace with rising practice costs; ensure Medicare physician payments are sufficient to safeguard beneficiary access to care; work towards the

elimination of budget neutrality requirements within Medicare Part B; eliminate, replace, or supplement budget neutrality in MIPS with positive incentive payments; advocate strongly to the current administration and Congress that additional funds must be put into the Medicare physician payment system to address increasing costs of physician practices, and that continued budget neutrality is not an option; advocate for payment policies that allow the Centers for Medicare & Medicaid Services to retroactively adjust overestimates of volume of services.

#### RECOMMENDATION B:

That the following HOD policies be reaffirmed: D-165.941—Sequestration Budget Cuts, H-330.932—Cuts in Medicare and Medicaid Reimbursement, H-400.972—Physician Payment Reform, H-330.888—Exempt Physician-Administered Drugs from Medicare Sequestration, H-400.990—Refinement of Medicare Physician Payment System, H-400.991—Guidelines for the Resource-Based Relative Value Scale, H-385.905—Merit-based Incentive Payment System (MIPS) Update, H-390.838—MIPS and MACRA Exemption, D-390.963—Improving the Medicare Economic Index, D-390.988—Patient Access Jeopardized By Senate Failure to Correct Medicare Payment Error, H-390.849—Physician Payment Reform.

#### **HOD ACTION:** Alternative Resolution 212 adopted in lieu of Resolutions 212, 221, 224, and 225.

Policies D-165.941—Sequestration Budget Cuts, H-330.932—Cuts in Medicare and Medicaid Reimbursement, H-400.972—Physician Payment Reform, H-330.888—Exempt Physician-Administered Drugs from Medicare Sequestration, H-400.990—Refinement of Medicare Physician Payment System, H-400.991—Guidelines for the Resource-Based Relative Value Scale, H-385.905—Merit-based Incentive Payment System (MIPS) Update, H-390.838—MIPS and MACRA Exemption, D-390.963—Improving the Medicare Economic Index, D-390.988—Patient Access Jeopardized By Senate Failure to Correct Medicare Payment Error, H-390.849—Physician Payment Reform reaffirmed.

#### Resolution 212

RESOLVED, That our American Medical Association prioritize strong advocacy in opposition to the application of sequestration to Medicare, including to drugs administered under Medicare Part B. (Directive to Take Action)

#### Resolution 221

RESOLVED, That our American Medical Association continue to advocate for legislation that prevents Medicare cuts from taking place prior to Jan. 1, 2022 (Directive to Take Action); and be it further

RESOLVED, That our AMA seek annual and full Medicare Economic Index updates for Medicare Part B physician payments (Directive to Take Action); and be it further

RESOLVED, That our AMA seek legislation that provides only for positive performance incentives (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate for payment policies that allow the Centers for Medicare & Medicaid Services to retroactively adjust overestimates of volume of services by instituting a three-year look-back period to correct Medicare conversion factor estimations. (Directive to Take Action)

#### Resolution 224

RESOLVED, That our American Medical Association make avoiding the Medicare payment cuts on physician practices a top priority (Directive to Take Action); and be it further

RESOLVED, That our AMA utilize the necessary resources to avoid the pending Medicare physician payment cuts (Directive to Take Action); and be it further

RESOLVED, That our AMA modify policy D-165.941, “Sequestration Budget Cuts,” by addition and deletion to read as follows:

#### Sequestration Budget Cuts D-165.941

1. Our AMA will urge Congress to develop a fiscally responsible alternative that would prevent the automatic budget sequestration cuts that would endanger critical programs related to medical research, public health, workforce, food and drug safety, and health care for uniformed service members, as well as trigger cuts in Medicare payments to graduate medical education programs, hospitals, and physicians that will endanger access to care and training of physicians.
2. Our AMA will take all necessary legislative and administrative steps to prevent extended ~~or~~ and deeper sequester cuts in Medicare payments to physician practices using the financial means necessary to do so and make this a top priority. (Modify Current HOD Policy); and be it further

RESOLVED, That our AMA reaffirm and take immediate action on policy H-330.932, “Cuts in Medicare and Medicaid Reimbursement,” that:

- (1) supports the concept that the Medicare and Medicaid budgets need to expand adequately to adjust for factors such as cost of living, the growing size of the Medicare population, and the cost of new technology;(calls for elimination of budget neutrality) (current policy)
- (2) aggressively encourages CMS to affirm the patient’s and the physician’s constitutional right to privately contract for medical services; (freedom of choice for patients), (current policy)
- (3) if the reimbursement is not improved, the AMA declares the Medicare reimbursement unworkable and intolerable, and seek immediate legislation to allow the physician to balance bill the patient according to their usual and customary fee; (current policy); and
- (4) supports a mandatory annual “cost-of-living” or COLA increase in Medicaid, Medicare, and other appropriate health care reimbursement programs, in addition to other needed payment increases. (current policy) (Reaffirm HOD Policy); and be it further

RESOLVED, That our AMA reach out to the physicians of the United States via all possible means, to include but not be limited to email, US mail, social media, to encourage physicians to participate in the AMA campaign to improve physician payments (Directive to Take Action); and be it further

RESOLVED, That our AMA have an open and transparent dialogue with Congressional leaders and the Centers for Medicare and Medicaid Services regarding continued devaluation of the American physician and communicate such with America’s physicians (both member and non-member). (Directive to Take Action)

#### Resolution 225

RESOLVED, That our American Medical Association work towards the elimination of budget neutrality requirements under federal law (Directive to Take Action); and be it further

RESOLVED, That our AMA amend Policy H-385.905, “Merit-based Incentive Payment System (MIPS) Update,” by addition and deletion to read as follows:

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

Our AMA will work toward creating and pursuing ~~supports~~ legislation that ensures Medicare physician payments ~~are~~ is sufficient to safeguard beneficiary access to care, ~~replaces or supplements budget~~ eliminate budget neutrality requirements within the MPFS and with respect to ~~in~~ MIPS ~~with~~ incentive payments ~~or~~ and implements ~~positive~~ annual Medicare physician payment updates that keep pace with rising practice costs. (Modify Current HOD Policy); and be it further

RESOLVED, That our AMA reaffirm D-400.989, “Equal Pay for Equal Work,” with a special emphasis on the third bullet point and work to create legislation to eliminate budget neutrality:

Our AMA: (1) shall make its first legislative priority to fix the Medicare payment update problem because this is the

most immediate means of increasing Medicare payments to physicians in rural states and will have the greatest impact; (2) shall seek enactment of legislation directing the General Accounting Office to develop and recommend to Congress policy options for reducing any unjustified geographic disparities in Medicare physician payment rates and improving physician recruitment and retention in underserved rural areas; and (3) shall advocate strongly to the current administration and Congress that additional funds must be put into the Medicare physician payment system and that continued budget neutrality is not an option.(Reaffirm HOD Policy); and be it further

RESOLVED, That our AMA reaffirm and take action on H-400.972, “Physician Payment Reform”

#### H-400.972, “Physician Payment Reform

It is the policy of the AMA to (1) 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 RBRVS conversion factor updates that are not subject to budget neutrality requirements; (g) the inadequacy of payment for services of assistant surgeons; and (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; and (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; and

(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. (created in 1992, reaffirmed 10 times) (Reaffirm HOD Policy)

Your Reference Committee heard testimony in strong support of Resolutions 212, 221, 224, and 225. Your Reference Committee heard that the looming payment cuts facing physician practices at the end of this year, including sequester and budget neutrality, must be addressed to ensure that practices can remain fiscally viable. Your Reference Committee also heard that physician practices have not yet recovered from the financial strain of the COVID-19 pandemic. Your Reference Committee also heard that these upcoming cuts place an unreasonable burden on physician practices and severely impact patient access to care as many practices will struggle to keep their doors open.

Your Reference Committee heard testimony that extensive Medicare Payment cuts totaling 9.75 percent are scheduled to go into effect on January 1, 2021. Your Reference Committee heard testimony that these payment cuts are a result of the 2 percent sequester stemming from the Budget Control Act of 2011, the 4 percent Statutory Pay As You Go (PAYGO) sequester resulting from the passage of the American Rescue Plan Act of 2021, and the expiration of the Congressionally enacted 3.75 percent temporary increase in the Medicare physician fee schedule conversion factor to avoid payment cuts associated with budget neutrality adjustments tied to physician fee schedule policy changes. Your Reference Committee also heard that in addition to these expected Medicare cuts, potential penalties under the Merit-Based Incentive Payment System (MIPS), which apply to Medicare Physician Fee Schedule services, will increase to 9 percent in 2022. Your Reference Committee heard testimony that these expected payment cuts also threaten the fiscal viability of physician practices in 2022.

Your Reference Committee heard testimony that our AMA has been ringing the alarm bell on this looming fiscal cliff. Your Reference Committee heard that our AMA has been engaged in comprehensive advocacy and legislative activities aimed at eliminating these payment cuts, including several letters to Congress (e.g., [July 15 letter](#), [July 21 letter](#), [July 23 letter](#), [July 30 letter](#), [August 30 letter](#), [September 15 letter](#).) Your Reference Committee heard testimony that our AMA is committing substantial resources to reach policy makers and the public, including digital advertisements, online articles, targeted electronic information pieces to policy makers, op-eds from patients, physicians, and local policy leaders. Your Reference Committee also heard that our AMA's advocacy activities have been widely reported to the Federation and AMA membership through [Advocacy Update](#), [AMA News Articles](#), and the [AMA website](#). Your Reference Committee further heard that our AMA is currently engaged in a [grass roots campaign](#) to urge Congress to take action to stop these devastating Medicare cuts from going into effect. In addition, your Reference Committee heard that our AMA continues to advocate that the Centers for Medicare and Medicaid Services (CMS) exercise the full breadth and depth of its administrative authority to avert or, at a minimum, mitigate these payment cuts. Your Reference Committee heard that our AMA has held several stakeholder meetings with Federation members and provided CMS with extensive comments on the need to mitigate the Medicare cuts.

Your Reference Committee agrees with the online and oral testimony that urged your Reference Committee to blend these important Resolutions into a "Perfect Whole." Your Reference Committee, therefore, recommends that Alternative Resolution 212 be adopted in lieu of Resolutions 212, 221, 224, and 225.

#### Sequestration Budget Cuts D-165.941

1. Our AMA will urge Congress to develop a fiscally responsible alternative that would prevent the automatic budget sequestration cuts that would endanger critical programs related to medical research, public health, workforce, food and drug safety, and health care for uniformed service members, as well as trigger cuts in Medicare payments to graduate medical education programs, hospitals, and physicians that will endanger access to care and training of physicians.
2. Our AMA will take all necessary legislative and administrative steps to prevent extended or deeper sequester cuts in Medicare payments.

#### Cuts in Medicare and Medicaid Reimbursement H-330.932



- Our AMA: (1) continues to oppose payment cuts in the Medicare and Medicaid budgets that may reduce patient access to care and undermine the quality of care provided to patients;
- (2) supports the concept that the Medicare and Medicaid budgets need to expand adequately to adjust for factors such as cost of living, the growing size of the Medicare population, and the cost of new technology;
- (3) aggressively encourages CMS to affirm the patient's and the physician's constitutional right to privately contract for medical services;
- (4) if the reimbursement is not improved, the AMA declares the Medicare reimbursement unworkable and intolerable, and seek immediate legislation to allow the physician to balance bill the patient according to their usual and customary fee; and
- (5) supports a mandatory annual "cost-of-living" or COLA increase in Medicaid, Medicare, and other appropriate health care reimbursement programs, in addition to other needed payment increases.

#### Physician Payment Reform H-400.972

It is the policy of the AMA to (1) 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; and (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; and (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; and

(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.

#### Exempt Physician-Administered Drugs from Medicare Sequestration H-330.888

Our AMA supports passage of federal legislation 1) exempting payments for biologics and other drugs provided under Medicare Part B from sequestration cuts, and 2) reimbursing providers for reductions in payments for biologics and other drugs furnished under Medicare Part B on or after April 1, 2013.

#### Refinement of Medicare Physician Payment System H-400.990

The AMA: (1) reaffirms its support for development and implementation of a Medicare indemnity payment schedule according to the policies established in Policy 400.991; (2) supports reasonable attempts to remedy geographic Medicare physician payment inequities that do not substantially interfere with the AMA’s support for an RBRVS-based indemnity payment system; (3) supports continued efforts to ensure that implementation of an RBRVS-based Medicare payment schedule occurs upon the expansion, correction, and refinement of the Harvard RBRVS study and data as called for in Board Report AA (I-88), and upon AMA review and approval of the relevant proposed enabling legislation; and (4) continues to oppose any effort to link the acceptance of an RBRVS with any proposal that is counter to AMA policy, such as expenditure targets or mandatory assignment.

#### Guidelines for the Resource-Based Relative Value Scale H-400.991

(1) The AMA 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; and (c) an appropriate set of conversion factor multipliers.

(2) The 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) The 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) The AMA reaffirms its opposition to the continuation of the Medicare maximum allowable actual charge (MAAC) limits.
- (5) The AMA promotes enhanced physician discussion of fees with patients as an explicit objective of a Medicare indemnity payment system.
- (6) The AMA supports expanding its activities in support of state and county medical society-initiated voluntary assignment programs for low-income Medicare beneficiaries.
- (7) The 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) The 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) The 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; and (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) The 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) The 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.

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

Our AMA 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.

#### MIPS and MACRA Exemption H-390.838

Our AMA will advocate for an exemption from the Merit-Based Incentive Payment System (MIPS) and Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) for small practices.

#### Improving the Medicare Economic Index D-390.963

Our AMA will urge the Centers for Medicare and Medicaid Services and the Medicare Payment Advisory Commission to review the Medicare Economic Index productivity offset and consider eliminating it or revising it so that it more accurately reflects the effects of productivity increase in medical practice.

Patient Access Jeopardized By Senate Failure to Correct Medicare Payment Error, D-390-988

Our AMA will: (1) aggressively promote expanded grassroots participation in the Medicare Update Campaign through the use of blast fax, e-mails and the toll-free grassroots hotline (1-800-833-6354); (2) continue to work with state and national medical specialty societies, as well as group practices, on physician surveys to measure the effect on patient access to care; (3) immediately disseminate the latest information to physicians regarding Medicare participation, non-participation and private contracting arrangements; and (4) concurrent with all of the above legislative, grassroots and targeted political actions, continue to evaluate aggressive, appropriate legal remedies through court action that could serve to rectify physician concerns about Medicare payment cuts and their impact on patient care.

Physician Payment Reform, H-390.849

1. Our AMA will advocate for the development and adoption of physician payment reforms that adhere to the following principles:

- a) promote improved patient access to high-quality, cost-effective care;
- b) be designed with input from the physician community;
- c) ensure that physicians have an appropriate level of decision-making authority over bonus or shared-savings distributions;
- d) not require budget neutrality within Medicare Part B;
- e) be based on payment rates that are sufficient to cover the full cost of sustainable medical practice;
- f) ensure reasonable implementation timeframes, with adequate support available to assist physicians with the implementation process;
- g) make participation options available for varying practice sizes, patient mixes, specialties, and locales;
- h) use adequate risk adjustment methodologies;
- i) incorporate incentives large enough to merit additional investments by physicians;
- j) provide patients with information and incentives to encourage appropriate utilization of medical care, including the use of preventive services and self-management protocols;
- k) provide a mechanism to ensure that budget baselines are reevaluated at regular intervals and are reflective of trends in service utilization;
- l) attribution processes should emphasize voluntary agreements between patients and physicians, minimize the use of algorithms or formulas, provide attribution information to physicians in a timely manner, and include formal mechanisms to allow physicians to verify and correct attribution data as necessary; and
- m) include ongoing evaluation processes to monitor the success of the reforms in achieving the goals of improving patient care and increasing the value of health care services.

2. Our AMA opposes bundling of payments in ways that limit care or otherwise interfere with a physician's ability to provide high quality care to patients.

3. Our AMA supports payment methodologies that redistribute Medicare payments among providers based on outcomes, quality and risk-adjustment measures only if measures are scientifically valid, verifiable, accurate, and based on current data.

4. Our AMA will continue to monitor health care delivery and physician payment reform activities and provide resources to help physicians understand and participate in these initiatives.

5. Our AMA supports the development of a public-private partnership for the purpose of validating statistical models used for risk adjustment.

(12) RESOLUTION 234 –PERMITTING THE DISPENSING OF STOCK MEDICATIONS FOR POST DISCHARGE PATIENT USE AND THE SAFE USE OF MULTI-DOSE MEDICATIONS FOR MULTIPLE PATIENTS

RECOMMENDATION A:

Resolve 2 of Resolution 234 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA work with the Food and Drug Administration, national specialty societies, state medical societies and/or other interested parties to advocate for legislative and regulatory language that permits the practice of using multi dose medications, such as eye drops, bottles injectables and topical medications post-operatively in accordance with safe handling and dispensing protocols that help ensure patient safety, minimize duplicated patient costs, and reduce medication waste. (Directive to Take Action)

RECOMMENDATION B:

Resolution 234 be adopted as amended.

**HOD ACTION:** Resolution 234 adopted as amended.

RESOLVED, That our American Medical Association work with national specialty societies, state medical societies and/or other interested parties to advocate for legislative and regulatory language that permits the practice of dispensing stock-item medications to individual patients upon discharge in accordance with labeling and dispensing protocols that help ensure patient safety, minimize duplicated patient costs, and reduce medication waste (Directive to Take Action); and be it

RESOLVED, That our AMA work with the Food and Drug Administration, national specialty societies, state medical societies and/or other interested parties to advocate for legislative and regulatory language that permits the practice of using multi dose eye drop bottles post-operatively in accordance with safe handling and dispensing protocols that help ensure patient safety, minimize duplicated patient costs, and reduce medication waste.

Your Reference Committee heard overwhelmingly positive testimony on Resolution 234. Your Reference Committee heard that regulations governing the ability to dispense the remaining portion of topical stock-item medications for post-discharge use can be unclear or appear overly burdensome, and that many facilities do not allow the practice. Your Reference Committee heard testimony that, as a result of current regulations, patients may need to purchase duplicate agents for post-discharge use, increasing patient cost and creating medication waste. Your Reference Committee heard testimony that this is an issue that impacts many specialties, including, but not limited to, ophthalmologists. Your Reference Committee agrees and is recommending an amendment that broadens the Second Resolved. Further, your Reference Committee heard testimony that our AMA has no existing policy on this specific issue. Your Reference Committee, therefore, recommends that Resolution 234 be adopted as amended.

## (13) RESOLUTION 240 –RANSOMWARE PREVENTION AND RECOVERY

## RECOMMENDATION A:

Resolved 1 of Resolution 240 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association work with other stakeholders to seek legislation or regulation that supports resources ~~funds assistance~~ to cover cyberattack prevention and recovery expenses for physician practices, hospitals, and healthcare entities to ensure continuity of optimal patient care (Directive to Take Action); and be it further

## RECOMMENDATION B:

Resolution 240 be adopted as amended.

**HOD ACTION:** Resolution 240 adopted as amended.

RESOLVED, That our AMA work with other stakeholders to seek legislation or regulation that funds assistance to cover cyberattack prevention and recovery expenses for physician practices, hospitals, and healthcare entities to ensure continuity of optimal patient care (Directive to Take Action); and be it further

RESOLVED, That our AMA, in collaboration with appropriate stakeholders, develop a toolkit for physician practices, hospitals, and healthcare entities to include best practices on preventing cyberattacks and a plan of action for when such an attack happens to their practice or institution; the toolkit should include guides to financial resources (Directive to Take Action).

Your Reference Committee heard mixed testimony regarding Resolution 240. Your Reference Committee heard that cyberattacks on healthcare systems have spiked during the COVID-19 pandemic. Your Reference Committee heard that if a rural hospital serving several counties with thousands of people in a geographic area were attacked, patients served by that hospital may not have any other healthcare options. Your Reference Committee also heard that our AMA is well-positioned to provide physician input in cybersecurity efforts as cybersecurity infrastructure discussions move forward. Your Reference Committee heard testimony that our AMA has existing policy that speaks directly to the issues related to cybersecurity outlined in Resolution 240. Your Reference Committee heard that our AMA is a member of the Healthcare and Public Health Sector Coordinating Council (HSCC) Cybersecurity Working Group, a coalition of industry associations and their members born out of Presidential Policy Directive 21, that works jointly and collaboratively with the federal government. Your Reference Committee heard that our AMA has provided numerous cybersecurity resources to physicians, their staffs, and IT stakeholders including resources jointly developed by the AMA and the American Hospital Association (AHA) for use during the COVID-19 public health emergency and beyond. Your Reference Committee also heard that our AMA and the AHA have specifically developed [checklists, guides, and other resources](#) (toolkits) for hospitals and physician practices to protect their computers and network and to keep their patient health records and other data safe from cyberattacks. Your Reference Committee also heard that a large percentage of hospitals and practices have been hit by cyberattacks, and that the impact of these attacks can be especially problematic for rural practices. Your Reference Committee heard testimony that physician practices need assistance, via federal funding and other resources, to effectively combat the barrage of cybersecurity attacks they face on a daily basis. Your Reference Committee understands that there is not a one-size-fits all solution to combating cyberattacks and that some physician practices may prefer utilizing non-monetary resources. Your Reference Committee agrees that there is a need to provide increased flexibility for our AMA to advocate for additional resources for cyberattack prevention and the recovery of expenses. Your Reference Committee, therefore, recommends that Resolution 240 be adopted as amended.

## RECOMMENDED FOR REFERRAL

## (14) RESOLUTION 203 –POVERTY-LEVEL WAGES AND HEALTH

## RECOMMENDATION:

Resolution 203 be referred.

**HOD ACTION:** Resolution 203 referred.

RESOLVED, That our American Medical Association support federal minimum wage regulation such that the minimum wage increases at least with inflation in order to prevent full-time workers from experiencing the adverse health effects of poverty. (New HOD Policy)

Your Reference Committee heard mixed testimony regarding Resolution 203. Your Reference Committee heard testimony that increasing the federal minimum wage would raise the earnings and family income of most low-wage workers, lifting some families out of poverty. Conversely, your Reference Committee heard that increasing the federal minimum wage would cause some employers to have to let go of some of their employees, which would cause some low-wage workers to become jobless and their family income to fall. Your Reference Committee heard testimony that the federal minimum wage has been stagnant, yet the average yearly inflation has increased steadily during that time. Your Reference Committee also heard testimony that our AMA has been vocal in expressing that social determinants of health include education, housing, wealth, income, and employment. Your Reference Committee heard testimony that our AMA has stated publicly that although we all experience conditions that socially determine our health, we do not all experience them equally. Your Reference Committee heard testimony that having a living wage is essential to promoting health and equity. However, your Reference Committee also heard that a living wage in one part of the country may not be sufficient to be considered a living wage in another part of the country. Your Reference Committee also heard testimony that supporting federal minimum wage regulation tied to inflation may negatively impact the ability of small physician practices to pay their staff. Your Reference Committee understands that there is not consensus on this issue and, therefore, recommends that Resolution 203 be referred.

## REPORT OF REFERENCE COMMITTEE C

## RECOMMENDED FOR ADOPTION AS AMENDED

- (1) COUNCIL ON MEDICAL EDUCATION REPORT 1 – GUIDING PRINCIPLES AND APPROPRIATE CRITERIA FOR ASSESSING THE COMPETENCY OF LATE CAREER PHYSICIANS (CME REPORT 1-I-18)

## RECOMMENDATION A:

Recommendation 1 in Council on Medical Education Report 1 be amended by addition and deletion, to read as follows:

1. That our American Medical Association (AMA) support the following Guiding Principles on the Assessment of ~~Late Career~~ Physicians Across the Professional Continuum:

- a) Evidence-based: Guidelines for screening and assessing ~~and screening late career physicians across the professional continuum~~ should be based on evidence of the importance of cognitive changes associated with aging and other factors that are relevant to ~~may impact~~ physician performance. Some physicians may suffer from declines in practice performance with advancing age, acquired disability, or other influences. Research ~~also~~ suggests that the effect of age on an individual physician's competency can be highly variable, ~~and~~ Since wide variations are seen in cognitive performance with aging, age alone should not be a precipitating factor.
- b) Ethical: Guidelines should be based on the principles of medical ethics. Self-regulation is an important aspect of medical professionalism. Physicians should be involved in the development of guidelines and ~~not~~ standards for monitoring and assessing both their own and their colleagues' competency.
- c) Relevant: Guidelines, procedures, or methods of assessment should be relevant to physician practices to inform judgments and provide feedback regarding physicians' ability to perform the tasks specifically required in their practice environment.
- d) Accountable: The ethical obligation of the profession to the health of the public and patient safety should be the primary drivers for establishing guidelines and informing decision making about physician screening and assessment results.
- e) Fair and equitable: The goal of screening and assessment is to optimize physician competency and performance through education, remediation, and modifications to a physician's practice environment or scope. Unless public health or patient safety is directly threatened, physicians should retain the right to modify their practice environment to allow them to continue to provide safe and effective care.
- f) Transparent: Guidelines, procedures, or methods of screening and assessment should be transparent to all parties, including the public. Physicians should be aware of the specific methods used, performance expectations, and standards against which performance will be judged and the possible outcomes of ~~the screening and~~ or assessment.



- g) Supportive: Education and/or remediation practices that result from screening and/or assessment procedures should be ~~proactive, ongoing, and be~~ supportive of physician ~~well-being~~ wellness, ongoing, and proactive.
- h) ~~Cost-conscious~~ **Nonburdensome**: Procedures and screening mechanisms that are distinctly different from “for cause” assessments should not result in undue cost or burden to ~~late-career~~ physicians ~~providing patient care~~. Hospitals and health care systems should provide easily accessible screening assessments for their employed ~~late-career~~ physicians. Similar procedures and screening mechanisms should be available to ~~late-career~~ physicians who are not employed by hospitals and health care systems.
- i) Due Process: Physicians subjected to screening and assessment must be afforded due process protections, including a fair and objective hearing, before any action may be taken against the physician. (Directive to Take Action)

#### RECOMMENDATION B:

Recommendation 2 in Council on Medical Education Report 1 be amended by addition and deletion, to read as follows:

2. That our AMA encourage the Council of Medical Specialty Societies and other interested organizations to develop educational materials regarding decline of cognitive and psychomotor performance throughout a physician’s career and the resulting impact on the quality and safety of on the effects of age on physician practice. (Directive to Take Action)

#### RECOMMENDATION C:

Recommendations in Council on Medical Education Report 1 be adopted as amended and the remainder of the report be filed.

#### RECOMMENDATION D:

The title of Council on Medical Education Report 1 be changed, to read as follows:

#### GUIDING PRINCIPLES AND APPROPRIATE CRITERIA FOR ASSESSING THE COMPETENCY OF PHYSICIANS ACROSS THE PROFESSIONAL CONTINUUM

**HOD ACTION:** Recommendations in Council on Medical Education Report 1 adopted as amended with a change in title.

1. That our American Medical Association (AMA) support the following Guiding Principles on the Assessment of Late Career Physicians:

- a) Evidence-based: Guidelines for assessing and screening late career physicians should be based on evidence of the importance of cognitive changes associated with aging that are relevant to physician performance. Some physicians may suffer from declines in practice performance with advancing age. Research also suggests that the effect of age on an individual physician’s competency can be highly variable; and since wide variations are seen in cognitive performance with aging, age alone should not be a precipitating factor.
- b) Ethical: Guidelines should be based on the principles of medical ethics. Self-regulation is an important aspect of medical professionalism. Physicians should be involved in the development of guidelines/standards for monitoring and assessing both their own and their colleagues’ competency.

- c) Relevant: Guidelines, procedures, or methods of assessment should be relevant to physician practices to inform judgments and provide feedback regarding physicians' ability to perform the tasks specifically required in their practice environment.
  - d) Accountable: The ethical obligation of the profession to the health of the public and patient safety should be the primary driver for establishing guidelines and informing decision making about physician screening and assessment results.
  - e) Fair and equitable: The goal of screening and assessment is to optimize physician competency and performance through education, remediation, and modifications to a physician's practice environment or scope. Unless public health or patient safety is directly threatened, physicians should retain the right to modify their practice environment to allow them to continue to provide safe and effective care.
  - f) Transparent: Guidelines, procedures, or methods of screening and assessment should be transparent to all parties, including the public. Physicians should be aware of the specific methods used, performance expectations, and standards against which performance will be judged and the possible outcomes of the screening or assessment.
  - g) Supportive: Education and/or remediation practices that result from screening and /or assessment procedures should be supportive of physician wellness, ongoing, and proactive.
  - h) Cost conscious: Procedures and screening mechanisms that are distinctly different from "for cause" assessments should not result in undue cost or burden to late career physicians providing patient care. Hospitals and health care systems should provide easily accessible screening assessments for their employed late career physicians. Similar procedures and screening mechanisms should be available to late career physicians who are not employed by hospitals and health care systems. (Directive to Take Action)
2. That our AMA encourage the Council of Medical Specialty Societies and other interested organizations to develop educational materials on the effects of age on physician practice. (Directive to Take Action)
3. That Policy D-275.956, "Assuring Safe and Effective Care for Patients by Senior/Late Career Physicians," be rescinded, as having been fulfilled by this report. (Rescind HOD Policy)

Your Reference Committee received supportive testimony, with amendments offered to remove or replace language as well as to specify alignment with current policy. Testimony questioned the definition of "late career"; your Reference Committee agrees with this concern and offers substitute language to the title and Recommendations which applies to the professional continuum. Your Reference Committee concurs with language offered in testimony, which replaces "Cost-conscious" with "Nonburdensome" in Recommendation 1 (h), and supports testimony to acknowledge alignment of 1 (b) with [AMA Ethical Opinion 9.3.2](#). Your Reference Committee also notes the importance of developing education materials as stated in Recommendation 2 and offers clarifying language. Testimony was offered to add a clause to Recommendation 1 regarding "due process" as being foundational to fairness, which your Reference Committee supports. Therefore, your Reference Committee recommends that Council on Medical Education Report 1 be adopted as amended.

(2) COUNCIL ON MEDICAL EDUCATION REPORT 2 – STUDY TO  
EVALUATE BARRIERS TO MEDICAL EDUCATION FOR TRAINEES  
WITH DISABILITIES

RECOMMENDATION A:

Recommendation 2 in Council on Medical Education Report 2 be amended by addition and deletion, to read as follows:

2. That our AMA urge all medical schools and GME institutions to a) make available to students and trainees a designated, qualified person or committee knowledgeable trained in the application of the Americans with Disabilities Act,

Section 504 of the Rehabilitation Act of 1973, and available support services, and b) encourage students and trainees to avail themselves of any needed support services, and c) foster a supportive and inclusive environment where students and trainees with disabilities feel comfortable accessing support services. (Directive to Take Action)

#### RECOMMENDATION B:

Recommendation 3 in Council on Medical Education Report 2 be amended by addition and deletion, to read as follows:

3. That our AMA encourage the National Board of Medical Examiners, ~~and~~ National Board of Osteopathic Medical Examiners, and member boards of the American Board of Medical Specialties to evaluate and enhance their processes for reviewing requests for accommodations from applicants with disabilities in order to reduce delays in completion of licensing the USMLE and COMLEX and initial board certification examinations. ~~This should include~~ an assessment of the experience of those applicants and the development of a transparent communication process that keeps applicants informed about the expected timeline to address their requests. These processes should require neither proof of accommodation nor proof of poor academic performance prior to the time at which a need for accommodation was requested. (Directive to Take Action)

#### RECOMMENDATION C:

Council on Medical Education Report 2 be amended by the addition of a sixth Recommendation, to read as follows:

6. That AMA Policy D-90.991, “Advocacy for Physicians with Disabilities,” be reaffirmed (Reaffirm HOD Policy)

#### RECOMMENDATION D:

Recommendations in Council on Medical Report 2 be adopted as amended and the remainder of the report be filed.

**HOD ACTION:** Recommendations in Council on Medical Report 2 adopted as amended and the remainder of the report filed.

Recommendation 3 in Council on Medical Education Report 2 amended by addition and deletion, to read as follows:

3. That our AMA encourage the National Board of Medical Examiners, ~~and~~ National Board of Osteopathic Medical Examiners, and member boards of the American Board of Medical Specialties and the American Osteopathic Association to evaluate and enhance their processes for reviewing requests for accommodations from applicants with disabilities in order to reduce delays in completion of licensing the USMLE and COMLEX and initial board certification examinations. ~~This should include~~ an assessment of the experience of those applicants and the development of a transparent communication process that keeps applicants informed about the expected timeline to address their requests. These processes should require neither proof of accommodation nor proof of poor academic performance prior to the time at which a need for accommodation was requested. (Directive to Take Action)

1. That our American Medical Association (AMA) urge that all medical schools and graduate medical education (GME) institutions and programs create, review, and revise technical standards, concentrating on replacing

“organic” standards with “functional” standards that emphasize abilities rather than limitations, and that those institutions also disseminate these standards and information on how to request accommodations for disabilities in a prominent and easily found location on their websites. (Directive to Take Action)

2. That our AMA urge all medical schools and GME institutions to a) make available to students and trainees a designated, qualified person or committee knowledgeable of the Americans with Disabilities Act and available support services and b) encourage students and trainees to avail themselves of support services. (Directive to Take Action)

3. That our AMA encourage the National Board of Medical Examiners and National Board of Osteopathic Medical Examiners to evaluate and enhance their processes for reviewing requests for accommodations from applicants with disabilities in order to reduce delays in completion of the USMLE and COMLEX, including an assessment of the experience of those applicants and the development of a transparent communication process that keeps applicants informed about the expected timeline to address their requests. (Directive to Take Action)

4. That our AMA encourage research and broad dissemination of results in the area of disabilities accommodation in the medical environment that includes: the efficacy of established accommodations; innovative accommodation models that either reduce barriers or provide educational approaches to facilitate the avoidance of barriers; impact of disabled learners and physicians on the delivery of health care to patients with disabilities; and research on the safety of established and potential accommodations for use in clinical programs and practice. (Directive to Take Action)

5. That our AMA rescind Policy D-295.929, “A Study to Evaluate Barriers to Medical Education for Trainees with Disabilities,” as having been fulfilled by this report. (Rescind HOD Policy)

Your Reference Committee received largely supportive testimony for this report. Testimony in the online forum offered amendments for consideration, namely inclusion of language regarding fostering a supportive and inclusive environment for medical students, trainees, and faculty with disabilities and Section 504 of the Rehabilitation Act of 1973. Testimony also supported considerations for an equitable evaluation process for requesting accommodations for completion of USMLE, COMLEX-USA, and initial board certification based on the recognition that one may become disabled and needing of accommodations. Your Reference Committee believes that some of the amendments, while valid, are not germane to the body of the report and can be addressed via reaffirmation of existing AMA policy D-90.991, “Advocacy for Physicians with Disabilities.” Therefore, your Reference Committee recommends that Council on Medical Education Report 2 be adopted as amended.

#### Policy D-90.991, “Advocacy for Physicians with Disabilities”

1. Our AMA will study and report back on eliminating stigmatization and enhancing inclusion of physicians with disabilities including but not limited to: (a) enhancing representation of physicians with disabilities within the AMA, and (b) examining support groups, education, legal resources and any other means to increase the inclusion of physicians with disabilities in the AMA.

2. Our AMA will identify medical, professional and social rehabilitation, education, vocational training and rehabilitation, aid, counseling, placement services and other services which will enable physicians with disabilities to develop their capabilities and skills to the maximum and will hasten the processes of their social and professional integration or reintegration.

3. Our AMA supports physicians and physicians-in-training education programs about legal rights related to accommodation and freedom from discrimination for physicians, patients, and employees with disabilities.

(3) COUNCIL ON MEDICAL EDUCATION REPORT 3 – RURAL HEALTH PHYSICIAN WORKFORCE DISPARITIES

RECOMMENDATION A:

Recommendation 3 in Council on Medical Education Report 3 be amended by addition and deletion, to read as follows:

3. That our AMA amend Policy H-200.954, “US Physician Shortage,” by addition and deletion to read as follows: “(13) will monitor work to augment the impact of initiatives to address rural physician workforce shortages.” (Modify Current HOD Policy)

RECOMMENDATION B:

Council on Medical Education Report 3 be amended by the addition of a fifth Recommendation, to read as follows:

5. That our AMA amend Policy H-465.981, “Enhancing Rural Physician Practices,” by addition to read: “(5) Our AMA will undertake a study of structural urbanism, federal payment policies, and the impact on rural workforce disparities.” (Modify Current HOD Policy)

RECOMMENDATION C:

Recommendations in Council on Medical Education Report 3 be adopted as amended and the remainder of the report be filed.

**HOD ACTION:** Recommendations in Council on Medical Education Report 3 adopted as amended and the remainder of the report filed.

1. That our AMA amend Policy H-465.988, “Educational Strategies for Meeting Rural Health Physician Shortage,” by addition and deletion to read as follows: ~~Our AMA will undertake a study of issues regarding rural physician workforce shortages, including federal payment policy issues, and other causes and potential remedies (such as telehealth) to alleviate rural physician workforce shortages.~~ (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. (Modify Current HOD Policy)

2. That our AMA monitor the status and outcomes of the 2020 Census to assess the impact of physician supply and patient demand in rural communities. (Directive to Take Action)

3. That our AMA amend Policy H-200.954, “US Physician Shortage,” by addition to read as follows: “(13) will monitor the impact of initiatives to address rural physician workforce shortages.” (Modify Current HOD Policy)

4. That our AMA reaffirm Policy H-465.988, “Educational Strategies for Meeting Rural Health Physician Shortage,” which states, in part “(1.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. (1.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.” (Reaffirm HOD Policy).

Your Reference Committee received predominately supportive testimony on this report. Testimony in the online forum expressed concern that the report did not address the intent of the original resolution and noted opposition to

striking language calling for study of federal payment policy issues. Your Reference Committee is sensitive to this point. The Council on Medical Education (CME) testified during the hearing to acknowledge that the study focused on educational strategies to address the rural health physician shortage, which falls under the purview of this Council. The Council appreciates the concerns from the online testimony and recognizes that federal payment issues are beyond its purview. Testimony articulated an interest in examining the declining physician availability and access in rural communities with particular attention to the lack of specialists in rural areas. Proposed amendments to the report included language to advocate for equitable incentives for physicians who work in rural areas. Your Reference Committee believes the issues raised in testimony merit further study. Therefore, your Reference Committee recommends that CME Report 3 be adopted as amended.

Policy H-200.954, “US Physician Shortage”

Our AMA:

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

Policy H-465.981, “Enhancing Rural Physician Practices”

The AMA: (1) 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 area’s Health Professional Shortage Area (HPSA) status; (2) 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) 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; and (4) 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.

(4) COUNCIL ON MEDICAL EDUCATION REPORT 4 – MEDICAL STUDENT DEBT AND CAREER CHOICE

RECOMMENDATION A:

Recommendation 3 in Council on Medical Education Report 4 be amended by addition and deletion, to read as follows:

3. That our AMA amend Policy H-305.925 (20), “Principles of and Actions to Address Medical Education Costs and Student Debt,” by addition and deletion, to read as follows:

Related to the Public Service Loan Forgiveness (PSLF) Program, our AMA supports increased medical student and physician ~~benefits~~ 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 ~~of the employer~~; (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; and (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; and (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). (Modify Current HOD Policy)

RECOMMENDATION B:

Recommendations in Council on Medical Education Report 4 be adopted as amended and the remainder of the report be filed.

**HOD ACTION:** Recommendations in Council on Medical Education Report 4 adopted as amended and the remainder of the report filed.

1. That our American Medical Association (AMA) encourage key stakeholders to collect and disseminate data on the impacts of medical education debt on career choice, especially with regard to the potentially intersecting impacts of race/ethnicity, socioeconomic status, and other key sociodemographic factors. (New HOD Policy)
2. That our AMA monitor new policies and novel approaches to influence career choice based on the key factors that affect the decision to enter a given specialty and subspecialty. (New HOD Policy)
3. That our AMA amend Policy H-305.925 (20), “Principles of and Actions to Address Medical Education Costs and Student Debt,” by addition and deletion, to read as follows:

Related to the Public Service Loan Forgiveness (PSLF) Program, our AMA supports increased medical student and physician ~~benefits~~ 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 ~~of the employer~~; (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; and (k) Undertake expanded federal advocacy, in the event denial rates for physician applicants are unacceptably 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. (Modify Current HOD Policy)

4. That our AMA rescind Policy H-305.925 (22), “Principles of and Actions to Address Medical Education Costs and Student Debt,” as having been fulfilled through this report:

~~“Formulate a task force to look at undergraduate medical education training as it relates to career choice, and develop new policies and novel approaches to prevent debt from influencing specialty and subspecialty choice.”~~  
(Rescind HOD Policy)

Your Reference Committee heard testimony in support of this report and the work of the task force, which comprised broad representation among AMA sections. An amendment by addition of two new clauses was proffered by the Medical Student Section, which reflects a resolution that the MSS had drafted for this meeting, to expand our AMA’s policy in this regard and encourage advocacy efforts in collaboration with the U.S. Department of Education, where appropriate, to reduce the complexity and bureaucratic burden of the Public Service Loan Forgiveness Program. This resolution called for changes to the same policy amended in Recommendation 3 of the Council report. In the interest of expediency and efficiency in HOD business, the Council on Medical Education agrees to this amendment as germane to its report and its recommendations, and therefore calls for adoption as amended. Your Reference Committee recommends that CME Report 4 be adopted as amended.



(5) COUNCIL ON MEDICAL EDUCATION REPORT 5 – INVESTIGATION OF EXISTING APPLICATION BARRIERS FOR OSTEOPATHIC MEDICAL STUDENTS APPLYING FOR AWAY ROTATIONS

RECOMMENDATION A:

Recommendation 1 in Council on Medical Education Report 5 be amended by addition and deletion, to read as follows:

1. That our American Medical Association (AMA) amend Policy H-295.876 (2), “Equal Fees for Osteopathic and Allopathic Medical Students,” by addition and deletion as shown below. (Modify Current HOD Policy)

Our AMA encourages equitable access to and equitable fees for clinical electives for allopathic and osteopathic medical students ~~in access to clinical electives, while respecting the rights of individual allopathic and osteopathic medical schools to set their own policies related to visiting students.~~

RECOMMENDATION B:

Recommendations in Council on Medical Education Report 5 be adopted as amended and the remainder of the report be filed.

**HOD ACTION:** Recommendations in Council on Medical Education Report 5 adopted as amended and the remainder of the report filed.

1. That our American Medical Association (AMA) amend Policy H-295.876 (2), “Equal Fees for Osteopathic and Allopathic Medical Students,” by addition and deletion as shown below. (Modify Current HOD Policy)

Our AMA encourages equitable access to and equitable fees for clinical electives for allopathic and osteopathic medical students ~~in access to clinical electives, while respecting the rights of individual allopathic and osteopathic medical schools to set their own policies related to visiting students.~~

2. That our AMA encourage the Association of American Medical Colleges to request that its member institutions promote equitable access to clinical electives for allopathic and osteopathic medical students and charge equitable fees to visiting allopathic and osteopathic medical students. (New HOD Policy)

3. That our AMA encourage the Accreditation Council for Graduate Medical Education to require its accredited programs to work with their respective affiliated institutions to ensure equitable access to clinical electives for allopathic and osteopathic medical students and charge equitable fees to visiting allopathic and osteopathic medical students. (New HOD Policy)

Your Reference Committee heard testimony in support of the recommendations in this report. Testimony suggested amendments to Recommendation 1 to clarify language and highlight our AMA’s commitment to equity for MD and DO students. Testimony also suggesting adding language to Recommendation 2 asking that our AMA request stakeholders to “mandate” equitable access to clinical electives. Your Reference Committee had concerns given that our AMA does not usually encourage such a charge and believes that the amendments offered by the Medical Student Section satisfy the intent of Recommendation 1 while ensuring equity for MD and DO students. Therefore, your Reference Committee recommends that Council on Medical Education Report 5 be adopted as amended.

Policy H-295.876 (2), “Equal Fees for Osteopathic and Allopathic Medical Students”

1. Our AMA, in collaboration with the American Osteopathic Association, discourages discrimination against medical students by institutions and programs based on osteopathic or allopathic training.

2. Our AMA encourages equitable fees for allopathic and osteopathic medical students in access to clinical electives, while respecting the rights of individual allopathic and osteopathic medical schools to set their own policies related to visiting students.

3. Our AMA will work with relevant stakeholders to explore reasons behind application barriers that result in discrimination against osteopathic medical students when applying to elective visiting clinical rotations, and generate a report with the findings by the 2020 Interim Meeting.

(6) RESOLUTION 301 – EQUITABLE REPORTING OF USMLE STEP 1 SCORES

RECOMMENDATION A:

Resolution 301 be amended by addition, to read as follows:

RESOLVED, That our American Medical Association work with appropriate stakeholders to release guidance for residency and fellowship program directors on equitably comparing students who received 3-digit United States Medical Licensing Examination Step 1 or Comprehensive Osteopathic Medical Licensing Examination of the United States Level 1 scores and students who received Pass/Fail scores. (Directive to Take Action)

RECOMMENDATION B:

Resolution 301 be adopted as amended.

RECOMMENDATION C:

The title of Resolution 301 be changed, to read as follows:

EQUITABLE REPORTING OF USMLE STEP 1 AND COMLEX-USA LEVEL 1 SCORES

**HOD ACTION:** Resolution 301 adopted as amended with a change in title.

RESOLVED, That our American Medical Association work with appropriate stakeholders to release guidance for residency and fellowship program directors on equitably comparing students who received 3-digit United States Medical Licensing Examination Step 1 or Comprehensive Osteopathic Medical Licensing Examination Level 1 scores and students who received Pass/Fail scores. (Directive to Take Action)

Your Reference Committee heard testimony in support of this item. During the transition from numeric to pass/fail scoring, it is critical to both residency applicants and residency program personnel that no unintended consequences arise that would cause bias against individuals from either the scored or the pass/fail pool. Testimony noted that this transition will take years to fully occur, with potential concerns for dual-degree applicants (e.g., MD/PhD). That said, the move to pass/fail provides a welcome opportunity for further development of holistic review, which will help to ensure a more diverse and committed cadre of resident physicians. There was some sentiment expressed in online testimony for a deadline for release of any numeric scores after a specific date, but this proposal is overly specific and could present more issues than it solves. Testimony suggested an amendment to the title to include COMLEX-USA Level 1 scores, and to specify that these examinations pertain to the United States. Your Reference Committee accepts these amendments as friendly and therefore recommends that Resolution 301 be adopted as amended.

## RECOMMENDED FOR ADOPTION IN LIEU OF

- (7) RESOLUTION 305 – INCREASE AWARENESS AMONG RESIDENCY, FELLOWSHIP, AND ACADEMIC PROGRAMS ON THE UNITED STATES-PUERTO RICO RELATIONSHIP STATUS

## RECOMMENDATION:

Alternate Resolution 305 be adopted in lieu of Resolution 305, to read as follows:

RESOLVED, That our American Medical Association work with the Liaison Committee on Medical Education (LCME), Middle States Commission on Higher Education (MSCHE), and Association of American Medical Colleges (AAMC) to inform residency and fellowship program directors and training programs in the United States that graduates of medical schools in Puerto Rico that are accredited by the LCME and MSCHE are U.S. medical school graduates (Directive to Take Action); and be it further

RESOLVED, That our AMA support policies that ensure equity and parity in the undergraduate and graduate educational and professional opportunities available to medical students and graduates from all LCME- and Commission on Osteopathic College Accreditation (COCA)-accredited medical schools. (New HOD Policy)

**HOD ACTION:** Alternate Resolution 305 adopted in lieu of Resolution 305

RESOLVED, That our American Medical Association issue an official public statement regarding the academic status of Puerto Rican medical students and schools to inform residency, fellowship, and academic programs in the continental United States that all medical schools from Puerto Rico are Liaison Committee on Medical Education (LCME), Association of American Medical Colleges (AAMC), and Middle States Commission on Higher Education (MSCHE) accredited, and their medical students are not considered international medical graduates (Directive to Take Action); and be it further

RESOLVED, That our AMA support policies that ensure equity and parity in the undergraduate and graduate educational and professional opportunities available to medical students and graduates from Puerto Rican medical schools. (New HOD Policy)

Your Reference Committee heard supportive testimony for this resolution, recognizing the frustration experienced by students from LCME-accredited medical schools located in Puerto Rico. The Council on Medical Education (CME) provided online testimony to improve the accuracy of the resolution, which was accepted by the author as a friendly amendment. Your Reference Committee appreciates the clarifying language provided by the CME and offers an additional amendment to the end of the first resolve to further clarify its intent. Therefore, your Reference Committee recommends that alternate Resolution 305 be adopted in lieu of Resolution 305.

- (8) RESOLUTION 309 – PROTECTING MEDICAL STUDENT ACCESS TO ABORTION EDUCATION AND TRAINING

## RECOMMENDATION:

Alternate Resolution 309 be adopted in lieu of Resolution 309, to read as follows:

RESOLVED, That our American Medical Association amend policy H-295.923, “Medical Training and Termination of Pregnancy,” by addition and deletion to read as follows:

**H-295.923 – MEDICAL TRAINING AND TERMINATION OF PREGNANCY**

1. Our AMA supports the education of medical students, residents and young physicians about the need for physicians who provide termination of pregnancy services, the medical and public health importance of access to safe termination of pregnancy, and the medical, ethical, legal and psychological principles associated with termination of pregnancy.
2. Our AMA supports the availability of abortion education and exposure to procedures for termination of pregnancy, including medication abortions, for medical students and resident/fellow physicians and opposes efforts to interfere with or restrict the availability of this education and training.
3. Our AMA encourages the Accreditation Council for Graduate Medical Education to consistently enforce compliance with the standardization of abortion training opportunities as per the requirements set forth by the Review Committee for Obstetrics and Gynecology and the American College of Obstetricians and Gynecologists' recommendations. (Modify Current HOD Policy)

**HOD ACTION:** Alternate Resolution 309 adopted in lieu of Resolution 309.

RESOLVED, That our American Medical Association amend policy H-295.923, "Medical Training and Termination of Pregnancy," by addition and deletion to read as follows:

**H-295.923 – MEDICAL TRAINING AND TERMINATION OF PREGNANCY**

1. Our AMA supports the education of medical students, residents and young physicians about the need for physicians who provide termination of pregnancy services, the medical and public health importance of access to safe termination of pregnancy, and the medical, ethical, legal and psychological principles associated with termination of pregnancy.
- 2., a Although observation of, attendance at, or any direct or indirect participation in an abortion procedures should not be required., our AMA does support opt-out curriculum on abortion education. Further, the AMA supports the opportunity for medical students and residents to learn procedures for termination of pregnancy and opposes efforts to interfere with or restrict the availability of this training.
23. Our AMA encourages the Accreditation Council for Graduate Medical Education to better enforce compliance with the standardization of abortion training opportunities as per the requirements set forth by the Review Committee for Obstetrics and Gynecology and the American College of Obstetricians and Gynecologists' recommendations. (Modify Current HOD Policy)

Your Reference Committee received unanimous and passionate testimony in support of the intent of this resolution, addressing great concern for recent legislative changes that violate the privacy of the patient-physician relationship and prevent resident physicians and medical students in certain states from access to education on this medical procedure. The AMA has been outspoken on this issue in recent months. It was noted that the AMA has a history of not supporting curricular mandates. Further, it was pointed out that the resolution assumes that an institution has a such a curriculum from which one can "opt-out." Your Reference Committee is cognizant that this issue goes beyond the actual procedure to include the initial counseling for and potential ramifications of such a procedure, whether physical and/or mental.

The resolution seeks to divide clause 1 of AMA Policy H-295.923 into two clauses and offers amendments to new clause 2. Testimony was largely focused on this new second clause and its support for "opt-out curriculum," with both sides of the issue having testified for or against the "opt-out." To address the concerns raised and to ensure that medical students are included in policy but without calling for institution-level obligations to offer opt-out curricula,

your Reference Committee offers substitute language for a new clause 2 and supports renumbered clauses 1 and 3. Your Reference Committee is sensitive to and appreciative of the concerns and sentiments raised in this resolution and by those who testified. Therefore, your Reference Committee recommends that alternate Resolution 309 be adopted in lieu of Resolution 309.

## REPORT OF REFERENCE COMMITTEE D

## RECOMMENDED FOR ADOPTION

(1) BOARD OF TRUSTEES REPORT 17 – DISTRACTED DRIVER  
EDUCATION AND ADVOCACY

## RECOMMENDATION:

Recommendations in Board of Trustees Report 17 be adopted and the rest of the report filed.

**HOD ACTION:** Recommendations in Board of Trustees Report 17 adopted as amended and the rest of the report filed.

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

1. Our AMA encourages physicians to educate their patients regarding the public health risks of ~~text messaging while operating motor vehicles or machinery~~ distracted driving, which includes the risks of visual distraction – taking one’s eyes off the road, manual distraction – taking one’s hands off the wheel, and cognitive distraction – taking one’s mind off what ~~he or she~~ **they are** doing. ~~and will advocate for state legislation prohibiting the use of handheld communication devices to text message while operating motor vehicles or machinery.~~

The Board of Trustees recommends that Policy H-15.952 be amended by addition and deletion to read as follows and the remainder of the report be filed.

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

1. Our AMA encourages physicians to educate their patients regarding the public health risks of ~~text messaging while operating motor vehicles or machinery~~ distracted driving, which includes the risks of visual distraction – taking one’s eyes off the road, manual distraction – taking one’s hands off the wheel, and cognitive distraction – taking one’s mind off what he or she doing, and will advocate for state legislation prohibiting the use of handheld communication devices to text message while operating motor vehicles or machinery.

2. Our AMA will: (a) endorse support legislation that would ban the use of hand-held devices while driving, as a step in the right direction towards preventing distracted driving and (b) encourage additional research to identify the most effective strategies to reduce distracted driving-related crash risks.

3. Our AMA: (a) recognizes distracted walking as a preventable hazard and encourages awareness of the hazard by physicians and the public; and (b) encourages research into the severity of distracted walking as a public health hazard as well as ways in which to prevent it.

4. Our AMA supports public education efforts regarding the dangers of distracted driving, particularly activities that take drivers’ eyes off the road, and that the use of earbuds or headphones while driving is dangerous and illegal in some states.

5. Our AMA: (a) supports education on the use of earbuds or headphones in both ears during outdoor activities requiring auditory attention, including but not limited to biking, jogging, rollerblading, skateboarding and walking; and (b) supports the use of warning labels on the packaging of hand-held devices utilized with earbuds or headphones, indicating the dangers of using earbuds or headphones in both ears during outdoor activities requiring auditory attention, including but not limited to biking, jogging, rollerblading, skateboarding and walking.

6. Our AMA will: (a) make it a priority to create a national education and advocacy campaign on distracted driving in collaboration with ~~the Centers for Disease Control and Prevention and other interested stakeholders; and (b)~~ explore developing an advertising campaign on distracted driving with report back to the House of Delegates at the 2019 Interim Meeting.

7. ~~Our AMA will escalate the distracted driving campaign to a national level of awareness in coordination with the CDC and the National Education Association to educate elementary up through high school students as well as~~

~~parents regarding the high risk behavior of driving while holding cell phones and the opportunity to save lives and avoid injuries, with a review of steps taken and report back to the House of Delegates at the 2020 Annual Meeting.~~

Your Reference Committee heard testimony in unanimous support of Board of Trustees Report 17. Testimony supported broadening the types of distracted driving referenced in AMA policy and streamlining the directives adopted at previous meetings to give the AMA flexibility in implementation. Therefore, your Reference Committee recommends that Board of Trustees Report 17 be adopted.

#### RECOMMENDED FOR ADOPTION AS AMENDED

- (2) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT 2 – FULL COMMITMENT BY OUR AMA TO THE BETTERMENT AND STRENGTHENING OF PUBLIC HEALTH SYSTEMS

##### RECOMMENDATION A:

Recommendation 1 in Council on Science and Public Health Report 2 be amended by addition and deletion to read as follows:

1. That Policy D-440.922, “Full Commitment by our AMA to the Betterment and Strengthening of Public Health Systems” be amended by addition and deletion to read as follows:

Our AMA will: (1) champion the betterment of public health by enhancing advocacy and support for programs and initiatives that strengthen public health systems, to address pandemic threats, health inequities and social determinants of health outcomes; ~~and (2) study the most efficacious manner by which our AMA can continue to achieve its mission of the betterment of public health by recommending~~ (2) develop an organization-wide strategy on public health including ways in which the AMA can to strengthen the health and public health system infrastructure and report back regularly as needed on progress; (3) work with the Federation and other stakeholders to strongly support the legal authority of health officials to enact reasonable, evidence-based public health measures, including mandates, when necessary to protect the public from serious illness, injury, and death and actively oppose efforts to strip such authority from health officials; (4) advocate for (a) consistent, sustainable funding to support our public health infrastructure, (b) incentives, including loan forgiveness and debt reduction, to help strengthen the governmental public health workforce in recruiting and retaining staff, (c) public health data modernization and data governance efforts as well as efforts to promote interoperability between health care and public health; and (d) efforts to ensure equitable access to public health funding and programs. (Modify Current AMA Policy)

##### RECOMMENDATION B:

Recommendation 2 in Council on Science and Public Health Report 2 be amended by addition and deletion to read as follows:

2. That Policy H-440.960, “Organized Medicine and Public Health Collaboration” be amended by addition and deletion to read as follows:

Our AMA (1) encourages medical societies to establish liaison committees through which physicians in private practice and officials in public health can explore issues and mutual concerns involving public health activities and private practice; (2) seeks increased dialogue, interchange, and

cooperation among national organizations representing public health professionals, including representatives from governmental public health, and those representing physicians in private practice, or those employed in health systems, and employed in academic medicine, and working in other clinical settings.

#### RECOMMENDATION C:

Recommendation 5 in Council on Science and Public Health Report 2 be amended by addition and deletion to read as follows:

5. That our AMA reaffirm Policies D-305.964, “Support for the Epidemic Intelligence Service (EIS) Program and Preventive Medicine Residency Expansion,” ~~and~~ D-295.327, “Integrating Content Related to Public Health and Preventive Medicine Across the Medical Education Continuum,” and D-305.974 “Funding for Preventive Medicine Residencies.” (Reaffirm Current AMA Policy)

#### RECOMMENDATION D:

Recommendations in Council on Science and Public Health Report 2 be adopted as amended and the remainder of the report be filed.

**HOD ACTION:** Recommendations in Council on Science and Public Health Report 2 adopted as amended 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:

1. That Policy D-440.922, “Full Commitment by our AMA to the Betterment and Strengthening of Public Health Systems” be amended by addition and deletion to read as follows:

Our AMA will: (1) champion the betterment of public health by enhancing advocacy and support for programs and initiatives that strengthen public health systems, to address pandemic threats, health inequities and social determinants of health outcomes; ~~and (2) study the most efficacious manner by which our AMA can continue to achieve its mission of the betterment of public health by recommending~~ (2) develop an organization-wide strategy on public health including ways in which the AMA can to strengthen the health and public health system infrastructure and report back as needed on progress; (3) work with the Federation and other stakeholders to strongly support the legal authority of health officials to enact reasonable, evidence-based public health measures, including mandates, when necessary to protect the public from serious illness, injury, and death and actively oppose efforts to strip such authority from health officials; (4) advocate for (a) consistent, sustainable funding to support our public health infrastructure, (b) incentives, including loan forgiveness and debt reduction, to help strengthen the governmental public health workforce in recruiting and retaining staff, (c) public health data modernization and data governance efforts as well as efforts to promote interoperability between health care and public health; and (d) efforts to ensure equitable access to public health funding and programs. (Modify Current AMA Policy)

2. That Policy H-440.960, “Organized Medicine and Public Health Collaboration” be amended by addition and deletion to read as follows:

Our AMA (1) encourages medical societies to establish liaison committees through which physicians in private practice and officials in public health can explore issues and mutual concerns involving public health activities and private practice; (2) seeks increased dialogue, interchange, and cooperation among national organizations representing public health professionals, including representatives from governmental public health, and those representing physicians in private practice or those employed in health systems and in academic medicine (3) actively supports promoting and contributing to increased attention to public health issues in its programs in medical



science and education; ~~(4) continues to support the providing of medical care to poor and indigent persons through the private sector and the financing of this care through an improved Medicaid program;~~ (54) encourages public health agencies to focus on assessment of problems, assurance of healthy living conditions, policy development, and other related activities; and (65) encourages physicians in private practice and those in public health to work cooperatively, striving to ensure better health for each person and an improved community as enjoined in the Principles of Medical Ethics; and (6) encourages state and local health agencies to communicate directly with physicians licensed in their jurisdiction about the status of the population's health, the health needs of the community, and opportunities to collectively strengthen and improve the health of the public. (Modify Current AMA Policy)

3. That AMA Policy H-440.912, "Federal Block Grants and Public Health" which calls on the AMA to collaborate with national public health organizations to explore ways in which public health and clinical medicine can become better integrated and urges Congress and responsible federal agencies to: (a) establish set-asides or stable funding to states and localities for essential public health programs and services, (b) provide for flexibility in funding but ensure that states and localities are held accountable for the appropriate use of the funds; be reaffirmed. (Reaffirm Current AMA Policy)

4. That AMA Policy H-440.989, "Continuation of the Commissioned Corps," be amended by addition to read as follows:

Our AMA strongly supports the expansion and continuation of the Commissioned Corps of the US Public Health Service and recognize the need for it to be adequately funded. (Modify Current AMA Policy)

5. That our AMA reaffirm Policies D-305.964, "Support for the Epidemic Intelligence Service (EIS) Program and Preventive Medicine Residency Expansion," and D-295.327, "Integrating Content Related to Public Health and Preventive Medicine Across the Medical Education Continuum." (Reaffirm Current AMA Policy)

6. That our AMA reaffirm Policy H-440.89, "Support of the National Laboratory Response Network," and Policy D-460.971, "Genome Analysis and Variant Identification." (Reaffirm Current AMA Policy)

7. That our AMA amend Policy H-440.813, "Public Health Surveillance" by addition and deletion to read as follows:

Our AMA: (1) recognizes public health surveillance as a core public health function that is essential to inform decision making, identify underlying causes and etiologies, and respond to acute, chronic, and emerging health threats; (2) recognizes the important role that physicians play in public health surveillance through reporting diseases and conditions to public health authorities; (3) encourages state legislatures to engage relevant state and national medical specialty societies as well as public health agencies when proposing mandatory reporting requirements to ensure they are based on scientific evidence and meet the needs of population health; (4) recognizes the need for increased federal, state, and local funding to modernize our nation's public health data systems to improve the quality and timeliness of data; (5) supports the CDC's data modernization initiative, including electronic case reporting, which alleviates the burden of case reporting on physicians through the automatic generation and transmission of case reports from electronic health records to public health agencies for review and action in accordance with applicable health care privacy and public health reporting laws; (6) will advocate for incentives for physicians to upgrade their EHR systems to support electronic case reporting as well as incentives to submit case reports that are timely and complete; (67) will share updates with physicians and medical societies on public health surveillance and the progress made toward implementing electronic case reporting; ~~(78)~~ will advocate for increased federal coordination and funding to support the modernization and standardization of public health surveillance systems data collection by the Centers for Disease Control and Prevention and state and local health departments; and (89) supports data standardization that provides for minimum national standards, while preserving the ability of states and other entities to exceed national standards based on local needs and/or the presence of unexpected urgent situations. (Modify Current AMA Policy) (Directive to Take Action)

The Council on Science and Public Health was commended for bringing forward this excellent and timely report. Your Reference Committee heard testimony in strong support of the Council's report and its recommendations. Minor clarifying amendments were offered, that were supported by the Council, with which your Reference

Committee was also in agreement. An additional amendment was proffered to support sustained and dedicated funding for specific areas of public health, including improving the policies, systems, and environments that drive negative health outcomes, and to reduce disparities. The Council testified that these recommendations, were outside of the scope of their report, which supports public health infrastructure broadly and does not get into the details of funding for specific programs and functions. Your Reference Committee agrees with the Council that this is out of scope. Therefore, your Reference Committee recommends that Council on Science and Public Health Report 2 be adopted as amended.

(3) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT 3 – PHYSICIAN INVOLVEMENT IN STATE REGULATIONS OF MOTOR VEHICLE OPERATION AND/OR FIREARM USE BY INDIVIDUALS WITH COGNITIVE DEFICITS DUE TO TRAUMATIC BRAIN INJURY

RECOMMENDATION A:

The First Recommendation in Council on Science and Public Health Report 3 be amended by addition and deletion to read as follows:

Our AMA encourages the National Institutes of Health and other funders to expand research on cognitive impairment, including traumatic brain injury (TBI), as a risk factor for harm to self or others that may impact driving and/or firearm ownership, and the role of the physician in preventing decreasing risk of morbidity and mortality (New HOD Policy).

RECOMMENDATION B:

That Council on Science and Public Health Report 3 be adopted as amended and the remainder of the report be filed.

**HOD ACTION:** That Council on Science and Public Health Report 3 adopted as amended and the remainder of the report filed.

The First Recommendation in Council on Science and Public Health Report 3 be amended by addition and deletion to read as follows:

Our AMA encourages the National Institutes of Health and other funders to expand research on cognitive impairment, including traumatic brain injury (TBI), as a risk factor for harm to self or others that may impact driving and/or firearm ownership, and the role of the physician in policy advocacy and counseling patients so as to decrease the preventing decreasing risk of morbidity and mortality (New HOD Policy).

The Council on Science and Public Health recommends that the following be adopted, and the remainder of the report be filed:

1. Our AMA encourages research on cognitive impairment, including traumatic brain injury (TBI), as a risk factor for driving and/or firearm ownership, and the role of the physician in preventing morbidity and mortality (New HOD Policy).
2. That Policy H-15.995, “Medical Advisory Boards in Driver Licensing,” advocating for state governments to create and maintain medical advisory boards to oversee driver licensing, be reaffirmed. (Reaffirm Current HOD Policy)

3. That Policy H-145.972, “Firearms and High-Risk Individuals,” which advocates for ERPO laws and protocols for removing firearms from those deemed to be high-risk in the wake of a petition from concerned parties, be reaffirmed. (Reaffirm Current HOD Policy)

4. That Policy H-145.970, “Violence Prevention,” calling upon state and federal government entities to strengthen and promote the use of the NICS background check system, be reaffirmed. (Reaffirm Current HOD Policy)

Your Reference Committee heard testimony in support of the Council’s report and recommendations. An amendment was offered to add in specific funders, including the National Institutes of Health, and to note that the risk factors to be examined were specifically risk to self or to others. The Council supported these amendments. Another amendment was offered regarding removing the role of physicians in preventing morbidity and mortality. Your Reference Committee understands the intent of this amendment but recognizes that this report was focused specifically on physician involvement in these issues. Your Reference Committee does think that modifying the language to clarify the physician’s role as decreasing risk of morbidity or mortality, rather than preventing it would be appropriate. Therefore, your Reference Committee recommends that Council on Science and Public Health Report 3 be adopted as amended.

(4) RESOLUTION 408 – ENSURING AFFORDABILITY AND EQUITY IN COVID-19 VACCINE BOOSTERS

RECOMMENDATION A:

Resolution 408 be amended by addition to read as follows:

RESOLVED, That our American Medical Association support the public purchase and cost-free distribution and administration of COVID-19 booster vaccine doses. (New HOD Policy)

RECOMMENDATION B:

Resolution 408 be adopted as amended.

RECOMMENDATION C:

Policy D-440.981, “Appropriate Reimbursements and Carve-outs for Vaccines” be reaffirmed.

**HOD ACTION:** Resolution 408 adopted as amended with Policy D-440.981, “Appropriate Reimbursements and Carve-outs for Vaccines” reaffirmed.

RESOLVED, That our American Medical Association support the public purchase and cost-free distribution of COVID-19 booster vaccine doses. (New HOD Policy)

Your Reference Committee heard testimony in strong support of this resolution. While COVID-19 booster doses are currently available free of charge in the United States, testimony noted that we do not yet know how many COVID-19 booster doses will be needed, particularly with the possibility of emerging variants. Your Reference Committee also heard support for amending the Resolve statement to ensure it also address the cost-free administration of the vaccine for patients. Your Reference Committee concurs with that amendment, which would help ensure continued availability of COVID-19 booster doses in a manner that is equitable across the country. Testimony also raised the issue of reimbursement for administration of the COVID-19 vaccines. Your Reference Committee felt that this was out of scope but noted that existing policy broadly addresses reimbursement for vaccines. We recommend adopting Resolution 408 as amended and reaffirming existing policy.

## D-440.981 Appropriate Reimbursements and Carve-outs for Vaccines

Our AMA will: (1) continue to work with the Centers for Medicare and Medicaid Services (CMS) and provide comment on the Medicare Program payment policy for vaccine services; (2) continue to pursue adequate reimbursement for vaccines and their administration from all public and private payers; (3) encourage health plans to recognize that physicians incur costs associated with the procurement, storage and administration of vaccines that may be beyond the average wholesale price of any one particular vaccine; (4) seek legislation mandating that health insurance companies in applicable states either adequately pay for vaccines recommended by the Advisory Committee on Immunization Practices, or clearly state in large bold font in their notices to patients and businesses that they do not follow the federal advisory body on vaccine recommendations, the Advisory Committee on Immunization Practices; and (5) advocate that a physician's office can bill Medicare for all vaccines administered to Medicare beneficiaries and that the patient shall only pay the applicable copay to prevent fragmentation of care.

(5) RESOLUTION 410 – AFFIRMATIVELY PROTECTING THE SAFETY AND DIGNITY OF PHYSICIANS AND MEDICAL STUDENTS AS WORKERS

## RECOMMENDATION A:

That the second Resolve of Resolution 410 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA develop and distribute ~~specific guidelines~~ guidance on how physicians and trainees may make public comments on working conditions and legal options to promote workplace safety (e.g. filing formal OSHA complaints), as well as other workplace protection issues as appropriate; and be it further

## RECOMMENDATION B:

That the third Resolve of Resolution 410 be amended by addition and deletion to read as follows:

RESOLVED, That AMA policy H-440.810, "Availability of PPE," be amended by addition to read as follows:

1. Our AMA affirms that the medical staff of each health care institution should be integrally involved in disaster planning, strategy and tactical management of ongoing crises.
2. Our AMA supports evidence-based standards and national guidelines for PPE use, reuse, and appropriate cleaning/decontamination during surge conditions.
3. 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.
4. 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.
5. Our AMA supports the rights of physicians and trainees ~~right~~ 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; resident physicians and medical students must

~~have the right to participate in public commentary addressing the adequacy of resources for their own safety in such conditions.~~

6. 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.

7. Our AMA encourages the diversification of personal protective equipment design to better fit all body types, cultural expressions and practices among healthcare personnel (Modify Current HOD Policy);

#### RECOMMENDATION C:

That the fifth Resolve of Resolution 410 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA support legislation and other policies protecting physicians and ~~medical students~~ trainees from violence and unsafe working conditions.

#### RECOMMENDATION D:

Resolution 410 be adopted as amended.

#### RECOMMENDATION E:

That the title of Resolution 410 be changed to read as follows:

AFFIRMATIVELY PROTECTING THE SAFETY AND DIGNITY OF  
PHYSICIANS AND TRAINEES AS WORKERS

**HOD ACTION:** Resolution 410 adopted as amended with a change in title.

RESOLVED, That our AMA review reports of unsafe working conditions and unfair retaliation for public expression of safety concerns on the part of physicians and trainees and consider methods to provide logistical and legal support to such aggrieved parties; and be it further

RESOLVED, That our AMA develop and distribute specific guidelines on how physicians and trainees may make public comments on working conditions and legal options to promote workplace safety (e.g. filing formal OSHA complaints), as well as other workplace protection issues as appropriate; and be it further

RESOLVED, That AMA policy H-440.810 be amended by addition to read as follows:

1. Our AMA affirms that the medical staff of each health care institution should be integrally involved in disaster planning, strategy and tactical management of ongoing crises.
2. Our AMA supports evidence-based standards and national guidelines for PPE use, reuse, and appropriate cleaning/decontamination during surge conditions.
3. Our AMA will AMA 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.
4. 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.
5. Our AMA supports a physician's right 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; resident physicians and medical students must have

the right to participate in public commentary addressing the adequacy of resources for their own safety in such conditions.

6. 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.

7. Our AMA encourages the diversification of personal protective equipment design to better fit all body types, cultural expressions and practices among healthcare personnel.; and be it further

RESOLVED, That our AMA support the inclusion of health care workers in workplace protections and programs generally applicable to employees in other sectors, barring extenuating circumstances and evidence-based reasoning supporting otherwise; and be it further

RESOLVED, That our AMA support legislation and other policies protecting physicians and medical students from violence and unsafe working conditions.

Your Reference Committee heard limited, but supportive testimony on Resolution 410. It was noted in testimony that this issue will remain complex because more physicians are employed by health systems and therefore are less likely to be able to speak freely. It was noted that the fifth Resolve statement did not include fellows and should be broadened. Your Reference Committee felt it would be appropriate to use the language physicians and trainees throughout for consistency and has suggested amendments accordingly. Your Reference Committee also thought it would be more appropriate for the AMA to issue guidance on this issue rather than guidelines. Therefore, Your Reference Committee recommends that Resolution 410 be adopted as amended with a change in title.

(6) RESOLUTION 414 – ADVOCACY ON THE US DEPARTMENT OF EDUCATION’S SPRING 2022 TITLE IX RULE ON SEXUAL HARASSMENT AND ASSAULT IN EDUCATION PROGRAMS

RECOMMENDATION A:

Resolution 414 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA communicate work with relevant stakeholders to release a statement and advocate that the US Department of Education in support of their efforts to replace reconsider their 2020 Title IX rule on sexual harassment and assault in educational settings, including undergraduate and graduate medical education, with a and encourage development of a comprehensive rule that preserves the safety and wellbeing of all people affected by sexual assault, in line with current AMA policy.

RECOMMENDATION B:

Resolution 414 be adopted as amended.

**HOD ACTION:** Resolution 414 adopted as amended

RESOLVED, That our AMA work with relevant stakeholders to release a statement and advocate that the US Department of Education replace their 2020 Title IX rule on sexual harassment and assault in educational settings, including undergraduate and graduate medical education, with a comprehensive rule that preserves the safety and wellbeing of all people affected by sexual assault.

Your Reference Committee heard testimony in support of the intent of this resolution. The Council on Legislation noted that the Department of Education is already working on replacing the 2020 Title IX rule and held five days of public hearings in June to gather feedback on the current regulations and what should or should not be changed. As a result, the Council on Legislation recommends that the Resolve statement be amended so the AMA is not calling on the Department of Education to do something we already know they are working on. Your Reference Committee

agrees, but we acknowledge that the AMA should communicate that they are supportive of current efforts to evaluate the Title IX rules of 2020 as the AMA has multiple policies regarding Title IX rules including a zero-tolerance policy for any type of harassment. Therefore, your Reference Committee recommends that Resolution 414 be adopted as amended.

RECOMMENDED FOR ADOPTION IN LIEU OF

- (7) RESOLUTION 411 – ADDRESSING PUBLIC HEALTH  
DISINFORMATION  
RESOLUTION 412 - HEALTH PROFESSIONAL DISINFORMATION  
DURING A PUBLIC HEALTH CRISIS

RECOMMENDATION A:

Alternate Resolution 411 be adopted in lieu of Resolutions 411 and 412.

ADDRESSING PUBLIC HEALTH DISINFORMATION  
DISSEMINATED BY HEALTH PROFESSIONALS

RESOLVED, That our AMA collaborate with relevant health professional societies and other stakeholders: (1) on efforts to combat public health disinformation disseminated by health professionals in all forms of media and (2) to address disinformation that undermines public health initiatives. (Directive to Take Action), and be it further

RESOLVED, That our AMA study disinformation disseminated by health professionals and its impact on public health and present a comprehensive strategy to address this issue with a report back at the next meeting of the House of Delegates. (Directive to Take Action)

**HOD ACTION:** Alternate Resolution 411 adopted in lieu of Resolutions 411 and 412.

RESOLVED, That our AMA collaborate with relevant stakeholders on efforts to combat public health disinformation on all forms of media. (Directive to Take Action)

RESOLVED, That our AMA work with health professional societies to address disinformation that undermines public health initiatives. (Directive to Take Action)

Your Reference Committee heard testimony in overwhelming support of Resolutions 411 and 412, urging the AMA to take a strong stance on disinformation. It was noted that a small number of physicians are stealing the credibility of our profession and they are using their professional license to validate the disinformation they are spreading, which has seriously undermined public health efforts. The Board of Trustees testified that a comprehensive approach to addressing disinformation is needed, and they would be open to studying this issue. Testimony highlighted the impact disinformation is having on health outcomes beyond COVID-19. The importance of addressing the use of social media and other online platforms to disseminate disinformation was also mentioned. Given the urgent nature of this issue, your Reference Committee agrees that a study on disinformation disseminated by health professionals as well as the development of a comprehensive strategy to address this issue is needed with a report back to the House of Delegates at our next meeting. Therefore, your Reference Committee recommends that Alternate Resolution 411 be adopted in lieu of Resolutions 411 and 412.

## REPORT OF REFERENCE COMMITTEE E

## RECOMMENDED FOR ADOPTION AS AMENDED

- (1) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT 4 – PHARMACOVIGILANCE (RES 518-A-19, CHEMICAL VARIABILITY IN PHARMACEUTICAL PRODUCTS)

## RECOMMENDATION A:

Recommendation 2 in Council on Science and Public Health Report 4 be amended by addition to read as follows:

2. That Policy H-120.958, “Supporting Safe Medical Products as a Priority Public Health Initiative” be amended by addition and deletion to read as follows:

Our AMA will: (1) work through the United States Adopted Names (USAN) Council to adopt methodology to help prevent “look alike-sound alike” errors in giving new drugs generic names; (2) continue participation in ~~the National Patient Safety Foundation’s~~ efforts to advance the science of safety in the medication use process, including and likewise work with the National Coordinating Council for Medication Error Reporting and Prevention; (3) support the FDA’s Medwatch program by working to improve physicians’ and pharmacists’ knowledge and awareness of the program and encouraging proper reporting of adverse events; (4) vigorously work to support the Drug Supply Chain and Security Act (DSCSA, Public Law 113-54), including provisions on product identification and verification, data sharing, detection and response, and encourage efforts to create and expeditiously implement a national machine readable coding system for prescription medicine packaging in an effort to improve patient safety; (5) participate in and report on the work of the Healthy People ~~2010~~ 2030 initiative in the area of safe medical products especially as it relates to existing AMA policy; and (6) seek opportunities to work collaboratively within the Medicine-Public Health initiative (H-440.991), with pharmacy associations, and with the Food and Drug Administration (FDA), National Institutes of Health (NIH), United States Pharmacopoeia (USP) and Centers for Disease Control and Prevention (CDC) the Agency for ~~Health Care Policy and Research (AHCPR)~~ Healthcare Research and Quality (AHRQ) and the Centers for Medicare & Medicaid Services (CMS) to provide information to individual physicians, pharmacists, other clinicians, and state medical societies on the need for public health infrastructure and local consortiums to work on problems related to medical product safety. (Modify Current HOD Policy)

## RECOMMENDATION B:

The recommendations in Council on Science and Public Health Report 4 be adopted as amended and the remainder of the report be filed.

**HOD ACTION:** The recommendations in Council on Science and Public Health Report 4 adopted as amended and the remainder of the report filed.



The Council on Science and Public Health recommends that the following be adopted in lieu of Resolution 518-A-19 and the remainder of the report be filed:

1. That Policy D-100.988, “Tracking and Punishing Distributors of Counterfeit Pharmaceuticals” be amended by addition and deletion to read as follows:

Our AMA will support the Food and Drug Administration’s efforts to evaluate and facilitate implementation of effective tracking systems for pharmaceuticals, including all outlined implementation phases of the Drug Supply Chain and Security Act (DSCSA, Public Law 113-54) also called “track and trace,” which contains extensive requirements and provisions related to supply chain participants and regulated products. (Modify Current HOD Policy)

2. That Policy H-120.958, “Supporting Safe Medical Products as a Priority Public Health Initiative” be amended by addition and deletion to read as follows:

Our AMA will: (1) work through the United States Adopted Names (USAN) Council to adopt methodology to help prevent “look alike-sound alike” errors in giving new drugs generic names;

(2) continue participation in ~~the National Patient Safety Foundation’s~~ efforts to advance the science of safety in the medication use process, including and likewise work with the National Coordinating Council for Medication Error Reporting and Prevention;

(3) support the FDA’s Medwatch program by working to improve physicians’ knowledge and awareness of the program and encouraging proper reporting of adverse events;

(4) vigorously work to support the Drug Supply Chain and Security Act (DSCSA, Public Law 113-54), including provisions on product identification and verification, data sharing, detection and response, and encourage efforts to create and expeditiously implement a national machine-readable coding system for prescription medicine packaging in an effort to improve patient safety;

(5) participate in and report on the work of the Healthy People ~~2010~~ 2030 initiative in the area of safe medical products especially as it relates to existing AMA policy; and

(6) seek opportunities to work collaboratively within the Medicine-Public Health initiative (H-440.991) and with the Food and Drug Administration (FDA), National Institutes of Health (NIH), United States Pharmacopoeia (USP) and Centers for Disease Control and Prevention (CDC) the Agency for ~~Health Care Policy and Research (AHCPR)~~ Healthcare Research and Quality (AHRQ) and the Centers for Medicare & Medicaid Services (CMS) to provide information to individual physicians and state medical societies on the need for public health infrastructure and local consortiums to work on problems related to medical product safety. (Modify Current HOD Policy)

3. That Policy D-100.977, “Pharmaceutical Quality Control for Foreign Medications,” that calls upon Congress to provide the FDA with the necessary authority and resources to ensure that imported drugs are safe for American consumers and patients, be reaffirmed. (Reaffirm HOD Policy)
4. That Policy D-100.985, “Federal Regulation and Computerized Tracking of Pharmaceuticals During Shipping and Handling from Manufacture Until Ultimately Received by Patient,” opposing illegal drug diversion, illegal Internet sales of drugs, illegal importation of drugs, and drug counterfeiting, be reaffirmed. (Reaffirm HOD Policy)
5. That Policy D-100.988, “Tracking and Punishing Distributors of Counterfeit Pharmaceuticals,” supporting the FDA’s efforts to evaluate and facilitate implementation of effective tracking systems for pharmaceuticals, be reaffirmed. (Reaffirm HOD Policy)
6. That Policy H-100.946, “Source and Quality of Medications Critical to National Health and Security,” supporting legislative and regulatory initiatives that help to ensure proper domestic capacity, production and quality of pharmaceutical and chemical substrates as a matter of public well-being and national security and encouraging the development and enforcement of standards that make the sources of pharmaceuticals and their chemical substrates used in the United States of America transparent to prescribers and the general public, be reaffirmed. (Reaffirm HOD Policy)

7. That Policy H-100.969, “Assuring the Safety and Quality of Foreign-Produced Pharmaceuticals,” supporting the inspection of all foreign manufacturers of pharmaceutical chemicals and products which are exported to the United States to assure compliance with U.S. standards, be reaffirmed. (Reaffirm HOD Policy)
8. That Policy H-100.995, “Support of American Drug Industry,” supporting the American pharmaceutical manufacturing industry in its efforts to develop and market pharmaceutical products meeting proper standards of safety and efficacy for the benefit of the American people, be reaffirmed. (Reaffirm HOD Policy)

Your Reference Committee heard limited but unanimously supportive testimony related to Council on Science and Public Health (CSAPH) Report 4. The National Institutes of Health, while supportive of the report, offered a few amendments to include pharmacists and other clinicians who play a critical role to ensure the safe use of medications. CSAPH and your Reference Committee agree that the proposed amendments strengthen the recommendations of the report. Therefore, your Reference Committee recommends that Council on Science and Public Health Report 4 be adopted as amended.

(2) RESOLUTION 502 – ADVOCATING FOR HEAT EXPOSURE PROTECTIONS FOR OUTDOOR WORKERS

RECOMMENDATION A:

Resolution 502 be be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association (AMA) advocate for all outdoor workers to have access to preventative cool-down rest periods in shaded, ventilated, and/or cooled areas for prevention of injury from sun exposure and heat injury as well as appropriate access to emergency services when signs and symptoms of heat exposure injury appear ~~exhaustion and health educational materials in their primary language~~ (Directive for Action); and be it further

RESOLVED, That our AMA advocate for support ~~creating~~ legislation that creates federal standards for protections against heat stress and sun exposure specific to the hazards of the workplace ~~including appropriate access to emergency services at signs and symptoms of heat exposure injury~~ (New HOD Policy); and be it further

RESOLVED, That our AMA support policy change at the federal level via legislation or administrative rule changes by the Occupational Safety and Health Administration (OSHA) that would require that workers receive health educational materials about prevention and recognition of heat exhaustion and heat exposure injury that is in the worker’s primary language (New HOD Policy); and be it further

RESOLVED, That our AMA work with the United States Department of Labor, ~~the Occupational Safety and Health Administration~~ OSHA, and other appropriate federal stakeholders to develop and enforce evidence-based policies, guidelines, and protections against heat injury for ~~outdoor~~ workers independent of legal status. (Directive for Action) ; and be it further

RESOLVED, That our AMA recognize there are particular medical conditions and medications, including but not limited to psychotropics, which increase an individual’s vulnerability to the negative impacts of heat and sun exposure and advocate for recognition of this, as well as additional protections as part of any guidelines, legislation or other policies. (New HOD Policy)

## RECOMMENDATION B:

Resolution 502 be adopted as amended.

## RECOMMENDATION C:

That the title of Resolution 502 be changed.

## ADVOCATING FOR HEAT EXPOSURE PROTECTIONS FOR ALL WORKERS

**HOD ACTION:** Resolution 502 adopted as amended with a change in title.

RESOLVED, That our American Medical Association (AMA) advocate for outdoor workers to have access to preventative cool-down rest periods in shaded areas for prevention of heat exhaustion and health educational materials in their primary language (Directive for Action); and be it further

RESOLVED, That our AMA support legislation creating federal standards for protections against heat stress specific to the hazards of the workplace including appropriate access to emergency services at signs and symptoms of heat exposure injury (New HOD Policy); and be it further

RESOLVED, That our AMA work with the United States Department of Labor, the Occupational Safety and Health Administration, and other appropriate federal stakeholders to develop and enforce evidence-based policies, guidelines, and protections against heat injury for outdoor workers independent of legal status. (Directive for Action)

Your Reference Committee heard unanimously supportive testimony for the intent of Resolution 502. Several amendments were proffered to improve the language of the resolution. Several amendments were suggested to expand the scope to include all workers at risk of heat exposure, both those indoor and outdoor. Other proposed amendments recommend specifically including sun as a risk factor. Another amendment proposed acknowledges that some medications or medical conditions may increase an individual's risk of heat- or sun-exposure related illness. Your Reference Committee agrees that these amendments strengthen the Resolution and have incorporated all of them. Therefore, your Reference Committee recommends that Resolution 502 be adopted as amended with a change in title.

(3) RESOLUTION 506 – ENHANCING HARM REDUCTION FOR PEOPLE WHO USE DRUGS

## RECOMMENDATION A:

Resolution 506 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association (AMA) amend Policy D-95.987 by addition and deletion as follows:

D-95.987, “Prevention of Opioid Drug-related Overdose”

1. Our AMA: (A) recognizes the great burden that ~~opioid addiction and prescription drug abuse~~ substance use disorders (SUDs) and drug-related overdoses and death places on patients and society alike and reaffirms its support for the compassionate treatment of ~~such~~ patients with a SUD and people who use drugs; (B) urges that community-based programs offering naloxone and other opioid overdose ~~and drug~~ safety and prevention services continue to be implemented in order to further develop best practices in this area; ~~and~~ (C) encourages the education of health care workers and ~~people who use drugs~~ opioid users about the use of naloxone and other harm reduction measures in preventing opioid and other drug-related overdose fatalities; and

- (D) will continue to monitor the progress of such initiatives and respond as appropriate.
2. Our AMA will: (A) advocate for the appropriate education of at-risk patients and their caregivers in the signs and symptoms of ~~opioid a~~ drug-related overdose; and (B) encourage the continued study and implementation of appropriate treatments and risk mitigation methods for patients at risk for ~~opioid a drug-related~~ overdose.
  3. Our AMA will support the development and implementation of appropriate education programs for persons receiving treatment for a SUD or in recovery from opioid addiction a SUD and their friends/families that address harm reduction measures ~~how a return to opioid use after a period of abstinence can, due to reduced opioid tolerance, result in overdose and death.~~
  4. Our AMA will advocate for and encourage state and county medical societies to advocate for harm reduction policies that provide civil and criminal immunity for the use of “drug paraphernalia” designed to support safe use of drugs, including drug contamination testing and injection drug preparation, use, and disposal supplies.  
(Modify HOD Policy)

#### RECOMMENDATION B:

Resolution 506 be adopted as amended.

**HOD ACTION:** Resolution 506 adopted as amended.

RESOLVED, That our American Medical Association (AMA) amend policy D-95.987 by addition and deletion as follows:

D-95.987, “Prevention of ~~Opioid~~ Drug-related Overdose”

1. Our AMA: (A) recognizes the great burden that ~~opioid addiction and prescription drug abuse~~ substance use disorders (SUDs) and drug-related overdoses and death places on patients and society alike and reaffirms its support for the compassionate treatment of ~~such~~ patients with a SUD and people who use drugs; (B) urges that community-based programs offering naloxone and other opioid overdose and drug safety and prevention services continue to implemented in order to further develop best practices in this area; ~~and~~ (C) encourages the education of health care workers and people who use drugs ~~opioid users~~ about the use of naloxone and other harm reduction measures in preventing opioid and other drug-related overdose fatalities; and (D) will continue to monitor the progress of such initiatives and respond as appropriate.
2. Our AMA will: (A) advocate for the appropriate education of at-risk patients and their caregivers in the signs and symptoms of ~~opioid a drug-related~~ overdose; and (B) encourage the continued study and implementation of appropriate treatments and risk mitigation methods for patients at risk for ~~opioid a drug-related~~ overdose.
3. Our AMA will support the development and implementation of appropriate education programs for persons receiving treatment for a SUD or in recovery from opioid addiction a SUD and their friends/families that address harm reduction measures ~~how a return to opioid use after a period of abstinence can, due to reduced opioid tolerance, result in overdose and death.~~
4. Our AMA will advocate for and encourage state and county medical societies to advocate for harm reduction policies that provide civil and criminal immunity for the use of “drug paraphernalia” designed to support safe use of drugs, including drug contamination testing and injection drug preparation, use, and disposal supplies.

(Modify HOD Policy)

Your Reference Committee heard largely supportive testimony regarding the intent of Resolution 506. Minor amendments were offered to clarify the focus on harm reduction and safe use of drugs while not allowing for misinterpretation that the AMA supports use of illicit drugs. An additional amendment was offered include an additional Resolve statement about the usage of the term “syringe exchange programs” in further AMA communications. While your Reference Committee thinks this is an important topic, we feel it is not germane to include with this policy. AMA Policy H-95.958, “Syringe and Needle Exchange Programs” specifically deals with

the issue, and we recommend the submission of a new Resolution at a later meeting to address this important topic directly. Furthermore, a commentor noted opposition to this Resolution because it would eliminate opioid overdose-specific policy from the AMA database. Your Reference Committee would like to note that other AMA policies address opioid-specific issues, including D-95.965, “Dispelling Myths of Bystander Opioid Overdose” and D-95.964, “Opioid Mitigation.” Your Reference Committee agrees that the proffered amendments are important and that AMA policy should reflect the changing nature of illicit drug use and overdose. Therefore, your Reference Committee recommends that Resolution 506 be adopted as amended.

#### RECOMMENDED FOR ADOPTION IN LIEU OF

#### (4) RESOLUTION 505 – REPRESENTATION OF DERMATOLOGICAL PATHOLOGIES IN VARYING SKIN TONES

##### RECOMMENDATION:

That Alternate Resolution 505 be adopted lieu of Resolution 505.

RESOLVED, That our American Medical Association encourage comprehensive, inclusive and equitable representation of a diverse range of skin tones in all dermatologic and other relevant medical educational resources for medical students, physicians, non-physician healthcare providers and patients. (New HOD Policy)

**HOD ACTION:** Alternate Resolution 505 adopted lieu of Resolution 505.

RESOLVED, That our American Medical Association (AMA) encourage the inclusion of a diverse range of skin tones in preclinical and clinical dermatologic medical education materials and evaluation (Directive to Take Action); and be it further

RESOLVED, That our AMA encourage the development of educational materials for medical students and physicians that contribute to the equitable representation of diverse skin tones (Directive to Take Action); and be it further

RESOLVED, That our AMA support the overrepresentation of darker skin tones in dermatologic medical education materials. (New HOD Policy)

Your Reference Committee heard overwhelmingly supportive testimony related to original Resolution 505 submitted by the Medical Student Section, but several commentors noted the problematic language of “overrepresentation” in Resolve 3. Several amendments were offered in an attempt to clarify the language, others recommended that Resolve 3 be eliminated because Resolves 1 and 2 successful convey the intent of the Resolution, and still others proffered an alternate Resolution that they believe to be simplified, unambiguous, and all-encompassing. Your Reference Committee agrees that some of the language in the original Resolution was problematic. While the author was able to provide an excellent discussion of why the term “overrepresentation” should be included, your Reference Committee believes that amended language would prevent future confusion. Additional amendments were put forth that asked for the Resolution be expanded to include a fourth Resolve clause calling for increased efforts to diversify the dermatology workforce. While this amendment received other supportive testimony, your Reference Committee feels that improved diversity in the dermatology workforce would best be addressed in a separate Resolution. Therefore, your Reference Committee recommends that alternate Resolution 505 be adopted in lieu of Resolution 505.

## REPORT OF REFERENCE COMMITTEE F

## RECOMMENDED FOR ADOPTION

- (1) REPORT OF THE House OF DELEGATES COMMITTEE ON THE COMPENSATION OF THE OFFICERS

## RECOMMENDATIONS:

Recommendations in 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:** Recommendations in the Report of the House of Delegates Committee on the Compensation of the Officers adopted and the remainder of the Report filed.

1. That there be no changes to the Officers' compensation for the period beginning July 1, 2021 through June 30, 2022. (Directive to Take Action)
2. That the travel policy and the Board travel and expense standing rules be amended by addition, shown with underscores as follows:

Transportation

- a. Air: AMA policy on reimbursement for domestic air travel for members of the Board is that the AMA will reimburse for coach fare only. The Presidents (President, Immediate Past President and President Elect) will each have access to an individual \$5,000 term allowance (July 1 to June 30) and during the pilot, all other Officers will each have access to \$1,250 (pilot extends from November 15, 2021 to April 15, 2022) to use for upgrades as each deems appropriate, typically when traveling on an airline with non-preferred status. The unused portion of the allowance is not subject to carry forward or use by any other Officer and remains the property of the AMA. In rare instances it is recognized that short notice assignments may require up to first class travel because of the lack of availability of coach seating, and this will be authorized when necessary by the Board Chair, prior to travel. Business Class airfare is authorized for foreign travel on AMA business. (Also see Rule IV--Invitations, B—Foreign, for policy on foreign travel). (Directive to Take Action)
3. That the remainder of the report be filed.

Your Reference Committee received limited testimony online seeking clarity regarding an increased travel upgrade allowance for our AMA President, President-Elect, and Immediate Past-President through June 30, 2022, and all other AMA Officers through April 15, 2022.

The Committee on Compensation testified that providing our AMA Officers the means with which to maintain separation on an airline is a reasonable consideration as we emerge from the pandemic and business travel resumes. Additionally, the concern that this benefit is not being extended to Councils, Governing Councils, and AMA staff was addressed as being beyond the purview of the Committee on Compensation.

Regarding Councils, Governing Councils, and AMA staff, your Reference Committee notes that our AMA continues to convene virtually all Councils and Governing Councils, and our AMA staff continue to work remotely at this time.

Your Reference Committee extends its appreciation to the Committee on Compensation for its thorough work on behalf of our House of Delegates and for providing added clarification by way of online testimony. Your Reference Committee favors adoption of the report.

(2) BOARD OF TRUSTEES REPORT 18 - FINANCIAL PROTECTIONS  
FOR DOCTORS IN TRAINING

RECOMMENDATIONS:

Recommendations in Board of Trustees Report 18 be adopted and the remainder of the Report be filed.

**HOD ACTION:** Recommendations in Board of Trustees Report 18 adopted and the remainder of the Report filed.

1. That our American Medical Association (AMA) support the availability of retirement plans for residents and fellows at all teaching institutions that are no less favorable than those offered to other institution employees. (New HOD Policy)
2. That AMA Policy H-310.912, "Residents and Fellows' Bill of Rights," be amended by addition and deletion to read as follows:
  1. Our AMA continues to advocate for improvements in the ACGME Institutional and Common Program Requirements that support AMA policies as follows:
    - a) adequate financial support for and guaranteed leave to attend professional meetings; b) submission of training verification information to requesting agencies within 30 days of the request; c) adequate compensation with consideration to local cost-of-living factors and years of training, and to include the orientation period; d) health insurance benefits to include dental and vision services; e) paid leave for all purposes (family, educational, vacation, sick) to be no less than six weeks per year; and f) stronger due process guidelines.
  2. Our AMA encourages the ACGME to ensure access to educational programs and curricula as necessary to facilitate a deeper understanding by resident physicians of the US health care system and to increase their communication skills.
  3. Our AMA regularly communicates to residency and fellowship programs and other GME stakeholders this Resident/Fellows Physicians' Bill of Rights.
  4. Our AMA: a) will promote residency and fellowship training programs to evaluate their own institution's process for repayment and develop a leaner approach. This includes disbursement of funds by direct deposit as opposed to a paper check and an online system of applying for funds; b) encourages a system of expedited repayment for purchases of \$200 or less (or an equivalent institutional threshold), for example through payment directly from their residency and fellowship programs (in contrast to following traditional workflow for reimbursement); and c) encourages training programs to develop a budget and strategy for planned expenses versus unplanned expenses, where planned expenses should be estimated using historical data, and should include trainee reimbursements for items such as educational materials, attendance at conferences, and entertaining applicants. Payment in advance or within one month of document submission is strongly recommended.
  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.
  6. Our AMA will work with the Accreditation Council for Graduate Medical Education (ACGME) and other relevant stakeholders to amend the ACGME Common Program Requirements to allow flexibility in the specialty-specific ACGME program requirements enabling specialties to require salary reimbursement or "protected time" for resident and fellow education by "core faculty," program directors, and assistant/associate program directors.
  7. Our AMA encourages teaching institutions to offer retirement plan options, retirement plan matching, financial advising and personal finance education.
  8. 7 Our AMA adopts the following "Residents and Fellows' Bill of Rights" as applicable to all resident and fellow physicians in ACGME-accredited training programs:

RESIDENT/FELLOW PHYSICIANS' BILL OF RIGHTS

Residents and fellows have a right to:

[...]

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

[...]

- (3) With Regard to Benefits, Residents and Fellows Must Be Fully Informed of and Should Receive: a. Quality and affordable comprehensive medical, mental health, dental, and vision care for residents and their families, as well as retirement plan options, professional liability insurance and disability insurance to all residents for disabilities resulting from activities that are part of the educational program; b. An institutional written policy on and education in the signs of excessive fatigue, clinical depression, substance abuse and dependence, and other physician impairment issues; c. Confidential access to mental health and substance abuse services; d. A guaranteed, predetermined amount of paid vacation leave, sick leave, family and medical leave and educational/professional leave during each year in their training program, the total amount of which should not be less than six weeks; e. Leave in compliance with the Family and Medical Leave Act; and f. The conditions under which sleeping quarters, meals and laundry or their equivalent are to be provided. (Modify Current HOD Policy)

Your Reference Committee heard testimony acknowledging the significance of medical student debt and the need for robust financial counseling. Testimony also conveyed support of retirement plans and contribution matching for residents and fellows, noting concern about the restricted amount of GME funding available to institutions. Generally, testimony favored assisting residents and fellows with financial planning.

(3) COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT  
REPORT 1 - MINORITY AFFAIRS SECTION FIVE-YEAR REVIEW

RECOMMENDATION:

Recommendation in Council on Long Range Planning and Development Report 1 be adopted and the remainder of the Report be filed.

**HOD ACTION:** Recommendation in 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 Minority Affairs Section through 2026 with the next review no later than the 2026 Interim Meeting and that the remainder of this report be filed. (Directive to Take Action)

On behalf of our AMA House of Delegates, your Reference Committee wishes to extend its appreciation to the Council on Long Range Planning and Development and the Minority Affairs Section for their cooperative and collaborative efforts, which provided for the thorough review summarized in this report. Having received no opposition to renewing delineated section status for the Minority Affairs Section, your Reference Committee supports the Council's recommendation.

During testimony, a recommendation to amend the process for delineated section review was shared. A member of the Council on Long Range Planning and Development highlighted that the process was established by the House of Delegates. Your Reference Committee wishes to highlight changes to the process are not within the scope of this report.

(4) COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT  
REPORT 2 - INTEGRATED PHYSICIAN PRACTICE SECTION FIVE-YEAR REVIEW

RECOMMENDATION:

Recommendation in Council on Long Range Planning and Development Report 2 be adopted and the remainder of the Report be filed.

**HOD ACTION:** Recommendation in Council on Long Range Planning and Development Report 2 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 Integrated Physician Practice Section through 2026 with the next review no later than the 2026 Interim Meeting and that the remainder of this report be filed. (Directive to Take Action)

As was stated in the previous item of business, your Reference Committee is appreciative of the collaboration that has occurred between the Council on Long Range Planning and Development and the Integrated Physician Practice Section, which resulted in a comprehensive review of the Section. Testimony favored the recommendation of the Council.

#### RECOMMENDED FOR ADOPTION WITH CHANGE IN TITLE

##### (5) RESOLUTION 601 - "VIRTUAL WATER COOLER" FOR OUR AMA

###### RECOMMENDATION A:

Resolution 601 be adopted.

###### RECOMMENDATION B:

The title of Resolution 601 be changed to read as follows:

###### INFORMAL INTER-MEMBER MENTORING

**HOD ACTION:** Resolution 601 adopted with a change in title.

RESOLVED, That our American Medical Association explore options facilitating the ability of members to identify and directly contact other members who are interested in participating in informal inter-member mentoring, in order that self-selected members may readily enter into collegial communications with one another; and shall report back such options to the HOD within 12 months. (Directive to Take Action)

Your Reference Committee received only supportive testimony in response to our AMA facilitating the creation of a mentoring program for AMA members. It is your Reference Committee's opinion that as we emerge from the pandemic, the desire to reconnect and network with our colleagues will drive participation in this program.

Your Reference Committee recommends a change in title to better convey the intent of this initiative.

#### RECOMMENDED FOR ADOPTION AS AMENDED

##### (6) BOARD OF TRUSTEES REPORT 19 - ADVOCACY FOR PHYSICIANS WITH DISABILITIES

###### RECOMMENDATION A:

Recommendations in Board of Trustees Report 19 be amended by addition and deletion to read as follows:

1. That our American Medical Association (AMA) establish an advisory group composed of AMA members who themselves have a disability to ~~work toward ensure additional opportunities for including inclusion for~~ physicians and medical students with disabilities in all AMA activities. (Directive to Take Action)
2. That our AMA promote and foster educational and training opportunities for AMA members and the medical community at large to better understand the role disabilities can play in the healthcare work environment, including cultivating a rich understanding of so-called invisible disabilities for which

accommodations may not be immediately apparent. (Directive to Take Action)

3. That our AMA develop and promote tools for physicians with disabilities to advocate for themselves in their own workplaces, including a deeper understanding of the legal options available to physicians and medical students to manage their own disability-related needs in the workplace. (Directive to Take Action)
4. That our AMA communicate to employers and medical staff leaders the importance of including within personnel policies and medical staff bylaws protections and reasonable accommodations for physicians and medical students with visible and invisible disabilities. (Directive to Take Action)

#### RECOMMENDATION B:

Recommendations in Board of Trustees Report 19 be adopted as amended and the remainder of the Report be filed.

#### RECOMMENDATION C:

The title of Board of Trustees Report 19 be amended to read as follows:

#### ADVOCACY FOR PHYSICIANS AND MEDICAL STUDENTS WITH DISABILITIES

**HOD ACTION:** Recommendations in Board of Trustees Report 19 adopted as amended with a change in title.

1. That our American Medical Association (AMA) establish an advisory group composed of AMA members who themselves have a disability to work toward inclusion for physicians with disabilities in all AMA activities. (Directive to Take Action)
2. That our AMA promote and foster educational and training opportunities for AMA members and the medical community at large to better understand the role disabilities can play in the healthcare work environment, including cultivating a rich understanding of so-called invisible disabilities for which accommodations may not be immediately apparent. (Directive to Take Action)
3. That our AMA develop and promote tools for physicians with disabilities to advocate for themselves in their own workplaces, including a deeper understanding of the legal options available to physicians to manage their own disability-related needs in the workplace. (Directive to Take Action)
4. That our AMA communicate to employers and medical staff leaders the importance of including within personnel policies and medical staff bylaws protections and reasonable accommodations for physicians with visible and invisible disabilities. (Directive to Take Action)
5. That part 1 of Policy D-90.991, Advocacy for Physicians with Disabilities, be rescinded as having been accomplished by this report. (Modify Current HOD Policy)

Your Reference Committee heard enthusiastic support for Board of Trustees Report 19. During testimony, an edit was proffered to the first recommendation contained in the report that significantly strengthens our AMA's commitment to including physicians with disabilities in all AMA activities. Additional testimony requested the inclusion of medical students in the first, third and fourth recommendations. Your Reference Committee wholeheartedly agrees with these changes.

(7) RESOLUTION 606 - INCREASING THE EFFECTIVENESS OF ONLINE REFERENCE COMMITTEE TESTIMONY

RECOMMENDATION A:

Resolution 606 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association conduct a trial of ~~no less than~~ two-years during which all reference committees, prior to the in-person reference committee hearing, produce a preliminary reference committee ~~report~~ document based on the written online testimony (Directive to Take Action); and be it further

RESOLVED, That the preliminary reference committee document will be used to become the agenda for inform the discussion at the in-person reference committee (Directive to Take Action); and be it further

RESOLVED, That ~~after the trial period~~ there be an evaluation to determine if this procedure should continue (Directive to Take Action); and be it further

RESOLVED, That AMA pursue any bylaw changes that might be necessary to allow this trial (Modify Bylaws); and be it further

RESOLVED, That the period for online testimony be no longer than ~~10~~ 14 days. (Directive to Take Action)

RECOMMENDATION B:

Resolution 606 be adopted as amended.

**HOD ACTION:** Resolution 606 adopted as amended.

RESOLVED, That our American Medical Association conduct a trial of no less than two-years during which all reference committees, prior to the in-person reference committee hearing, produce a preliminary reference committee report based on the written online testimony (Directive to Take Action); and be it further

RESOLVED, That the preliminary reference committee document become the agenda for discussion at the in-person reference committee (Directive to Take Action); and be it further

RESOLVED, That after the trial period there be an evaluation to determine if this procedure should continue (Directive to Take Action); and be it further

RESOLVED, That AMA pursue any bylaw changes that might be necessary to allow this trial (Modify Bylaws); and be it further

RESOLVED, That the period for online testimony be no longer than 10 days.) (Directive to Take Action)

Your Reference Committee heard considerable support for formally incorporating online reference committee testimony into AMA policy deliberations. It was noted that an official process for online testimony could lead to better integration of diverse perspectives and encourage more robust discussions.

Your Reference Committee also heard opposing testimony in addition to requests for referral due to potential unintended consequences such as anchoring bias and increased administrative burden. Your Reference Committee believes that the two-year trial and subsequent evaluation could identify concerns and develop possible solutions to implement an effective, streamlined process.

## (8) RESOLUTION 614 - INSURANCE INDUSTRY BEHAVIORS

## RECOMMENDATION A:

Resolution 614 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association step up its ongoing review of the proper use of the AMA CPT Codes and Vignettes in medical billing claims payments and its misuse by the US Health Insurance Industry (Directive to Take Action); and be it further

RESOLVED, That our AMA undertake as soon as practical a formal, legal review of ongoing grievous behaviors of the health insurance industry, including: ~~(1) a search for potential litigation partners across the medical federation; and (2) dissemination of the findings to the appropriate internal AMA divisions and Councils for review and preparation for potential civil, regulatory and/or legislative action by/in the US Court System, the US Federal or State regulatory agencies and/or the US Congress.~~ (Directive to Take Action); and be it further

RESOLVED, That our AMA communicate with AMA members outcomes in litigating egregious behaviors of the health insurance industry. (Directive to Take Action)

## RECOMMENDATION B:

Resolution 614 be adopted as amended.

**HOD ACTION:** Resolution 614 adopted as amended.

RESOLVED, That our American Medical Association step up its ongoing review of the proper use of the AMA CPT Code and Vignettes in medical billing claims payments and its misuse by the US Health Insurance Industry (Directive to Take Action); and be it further

RESOLVED, That our AMA undertake as soon as practical a formal, legal review of ongoing grievous behaviors of the health insurance industry including: (1) a search for potential litigation partners across the medical federation; and (2) dissemination of the findings to the appropriate internal AMA divisions and Councils for review and preparation for potential civil, regulatory and/or legislative action by/in the US Court System, the US Federal or State regulatory agencies and/or the US Congress. (Directive to Take Action)

Many who testified in support of Resolution 614 detailed how they believe the health insurance industry is using its growing market share, resulting from insurer consolidations, to unfairly leverage against physicians and medical practices, including new payment policies that unfairly deny or unreasonably reduce payment to providers.

Your Reference Committee also heard testimony from our Board of Trustees who indicated that the work requested by this resolution is already underway within our AMA, including our AMA Litigation Center. Our Board of Trustees further indicated that to ensure the best potential for success, it is prudent to safeguard litigation and advocacy efforts from wide dissemination at this time.

Testimony, however, overwhelmingly favored adoption of Resolution 614. Your Reference Committee proffered the amendments reflected here to acknowledge the need for confidentiality as expressed by our Board of Trustees while keeping our AMA members aware of activities occurring on behalf of physicians.

## RECOMMENDED FOR REFERRAL

- (9) RESOLUTION 605 - FORMALIZATION OF THE RESOLUTION COMMITTEE AS A STANDING COMMITTEE OF THE AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

## RECOMMENDATION:

Resolution 605 be referred.

**HOD ACTION:** Resolution 605 referred.

RESOLVED, That the Bylaws of the American Medical Association be amended to provide that the Resolution Committee be responsible for reviewing resolutions submitted for consideration at all meetings of the American Medical Association House of Delegates and determining compliance of the resolutions with the purpose of any such meeting (Modify Bylaws); and be it further

RESOLVED, That the membership of the Resolution Committee reflect the diversity of the House of Delegates (New HOD Policy); and be it further

RESOLVED, That the Resolution Committee rules be written to produce impartial results and appropriate changes be made to the AMA Bylaws as necessary to empower the committee. (Modify Bylaws)

Your Reference Committee heard robust, yet widely divided testimony on formalizing the Resolution Review Committee as a standing House of Delegates committee. Testimony reflected that the Resolution Review Committee was implemented as a temporary solution to address an unprecedented situation.

Opposition to formalizing the Resolution Review Committee entailed concerns, such as inconsistencies with evaluating resolutions, limiting discussion on ideas and emergent issues, ineffective extraction process, lack of inclusivity in policy deliberations, and exclusion of the minority voice in the parliamentary process.

Testimony favoring formalization of the resolution review process cited issues regarding members of our AMA House of Delegates not having sufficient time to review a growing volume of business and the need to triage priority items of business.

Your Reference Committee believes addressing the complexities of having a streamlined process while not marginalizing the perspectives of various groups merits further study to ensure that all aspects of this issue are properly addressed.

- (10) RESOLUTION 615 - EMPLOYED PHYSICIANS

## RECOMMENDATION:

Resolution 615 be referred.

**HOD ACTION:** Resolution 615 referred.

RESOLVED, That our American Medical Association dedicate full-time staff to the Employed Physician to aggressively address relevant AMA Policy pertaining to the Employed Physician (Directive to Take Action); and be it further

RESOLVED, That our AMA study amending Policy G-615.105 to read as follows:

Employed Physicians and the AMA G-615.105

1. Our AMA will ~~strive to become~~ the lead association for physicians who maintain employment or contractual relationships with hospitals, health systems, and other entities.
2. As a benefit of membership our AMA will provide, ~~through the Sections and Special Groups~~, assistance, such as information, ~~and advice, but not and~~ legal opinions or representation, as appropriate, to employed physicians, physicians in independent practice, and independent physician contractors in matters pertaining to their relationships with hospitals, health systems, and other entities, including, but not limited to, breach of contracts, contract negotiations and contract renewals, ~~including~~ medical staff bylaws, sham peer review, economic credentialing, and the denial of due process.
3. Our AMA will work through the Organized Medical Staff Section and other sections and special groups as appropriate to represent and address the unique needs of physicians who maintain employment or contractual relationships with hospitals, health systems, and other entities. (Directive to Take Action); and be it further

RESOLVED, That the representation of the Organized Medical Staff Section (OMSS) in the AMA House of Delegates be increased from the current one Delegate to many Delegates based on AMA membership numbers of employed physicians using the mathematical model(s), to calculate the numbers of the New OMSS Delegates, currently being used at AMA for the Medical Student and Resident and Fellows Sections to calculate the numbers of Regional Medical Students and the numbers of Regional Resident/Fellows in the AMA House of Delegates. The AMA would develop a practical meaning of the phrase “Employed Physician” for the purposes of AMA membership counting, but as an editorial comment, the SED suggests starting with employed Non-Resident/Non-Fellow physicians who have no ownership interest (or, say, less than 1% ownership each) in their employer organization (New HOD Policy); and be it further

RESOLVED, That the Organized Medical Staff Section have one designated member who is a defined employed physician on all AMA Boards and Committees and Councils to match the MSS, the RFS and the YPS. (New HOD Policy)

Your Reference Committee received testimony reflecting concerns regarding unaddressed variables identified within Resolution 615, including a need to: (a) define clearly who is an employed physician; (b) delineate the impact of providing the Organized Medical Staff Section (OMSS) with proportional representation in our AMA House of Delegates; and (c) describe the effect of providing OMSS with slotted seats on all our AMA boards, committees, and councils. It should be noted that this last concern regarding slotted seats generated opposing testimony.

For the reasons stated here, your Reference Committee recommends referral of Resolution 615 for a report outlining a workable plan for supporting employed physicians.

## REPORT OF REFERENCE COMMITTEE G

## RECOMMENDED FOR ADOPTION AS AMENDED

- (1) COUNCIL ON MEDICAL SERVICE REPORT 2 - ACCESS TO HEALTH PLAN INFORMATION REGARDING LOWER-COST PRESCRIPTION OPTIONS

## RECOMMENDATION A:

Recommendation 1 of Council on Medical Service Report 2 be amended by addition to read as follows:

1. That our American Medical Association (AMA) continue to support efforts to publish a Real-Time Prescription Benefit (RTPB) standard that meets the needs of all physicians and other prescribers, utilizing any electronic health record (EHR), and prescribing on behalf of any insured patient. (New HOD Policy)

## RECOMMENDATION B:

Recommendation 4 of Council on Medical Service Report 2 be amended by addition and deletion to read as follows:

That our AMA amend Policy H-110.990[3] by addition and deletion, as follows:

2. believes that cost-sharing requirements should be based on considerations such as: unit cost of medication; availability of therapeutic alternatives; medical condition being treated; personal income; and other factors known to affect patient compliance and health outcomes; ~~and~~

3. supports the development and use of tools and technology that enable physicians and patients to determine the actual price and patient-specific out-of-pocket costs of individual prescription drugs, taking into account insurance status or payer type, prior to making prescribing decisions, so that physicians and patients can work together to determine the most efficient and effective treatment for the patient's medical condition; and  
4. supports public and private prescription drug plans in offering patient-friendly tools and technology that allow patients to directly and securely access their individualized prescription benefit and prescription drug cost information.

## RECOMMENDATION C:

Recommendation 5 of Council on Medical Service Report 2 be amended by addition to read as follows:

That our AMA amend Policy H-125.974 by addition and deletion as follows:

Our AMA will: . . .

(4) will advocate to the Office of the National Coordinator for Health Information Technology (ONC) and the Centers for Medicare & Medicaid Services (CMS) to work with physician and hospital organizations, and health information technology developers, in identifying real-time pharmacy benefit implementations and published standards that provide real-time or near-time formulary information across all prescription drug plans, patient portals and other viewing applications, and electronic health record (EHR) vendors;  
(5) will advocate to the ONC to include proven and established real-time pharmacy benefit criteria within its certification program;

(§6) will advocate to the ONC and the CMS that any policies requiring health information technology developers to integrate real-time pharmacy benefit systems (RTPB) within their products do so without minimal disruption to EHR usability and minimal to no cost to physicians and hospitals, providing financial support if necessary; and... (Amend HOD Policy)

#### RECOMMENDATION D:

Recommendations in Council on Medical Service Report 2 be adopted as amended and the remainder of the report be filed.

**HOD ACTION:** Recommendations in Council on Medical Service Report 2 adopted as amended and the remainder of the report filed.

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 213-NOV-20 and that the remainder of the report be filed:

1. That our American Medical Association (AMA) continue to support efforts to publish a Real-Time Prescription Benefit (RTPB) standard that meets the needs of all physicians, utilizing any electronic health record (EHR), and prescribing on behalf of any insured patient. (New HOD Policy)
2. That our AMA advocate that all payers (i.e., public and private prescription drug plans) be required to implement and keep up to date an RTPB standard tool that integrates with all EHR vendors, and that any changes that must be made to accomplish RTPB tool integration be accomplished with minimal disruption to EHR usability and cost to physicians and hospitals. (New HOD Policy)
3. That our AMA develop and disseminate educational materials that will empower physicians to be prepared to optimally utilize RTPB tools and other health information technology tools that can be used to enhance communications between physicians and pharmacists to reduce the incidence of prescription abandonment. (Directive to Take Action)
4. That our AMA amend Policy H-110.990[3] by addition, as follows:

Our AMA: ... 3. supports the development and use of tools and technology that enable physicians and patients to determine the actual price and patient-specific out-of-pocket costs of individual prescription drugs, taking into account insurance status or payer type, prior to making prescribing decisions, so that physicians and patients can work together to determine the most efficient and effective treatment for the patient's medical condition. (Modify Current HOD Policy)

5. That our AMA amend Policy H-125.974 by addition and deletion as follows:

Our AMA will: . . . (4) will advocate to the Office of the National Coordinator for Health Information Technology (ONC) and the Centers for Medicare & Medicaid Services (CMS) to work with physician and hospital organizations, and health information technology developers, in identifying real-time pharmacy benefit implementations and published standards that provide real-time or near-time formulary information across all prescription drug plans, patient portals and other viewing applications, and electronic health record (EHR) vendors;

(5) will advocate to the ONC to include proven and established real-time pharmacy benefit criteria within its certification program;

(§6) will advocate to the ONC and the CMS that any policies requiring health information technology developers to integrate real-time pharmacy benefit systems (RTPB) within their products do so without minimal disruption to HER usability and minimal to no cost to physicians and hospitals; and... (Modify Current HOD Policy)

6. That our AMA reaffirm Policy H-450.938 which states that physicians should have easy access to and review the best available data associated with costs at the point of decision-making, which necessitates that cost data be



delivered in a reasonable and useable manner by third-party payers and purchasers. The policy also calls for physicians to seek opportunities to improve their information technology infrastructures to include new and innovative technologies to facilitate increased access to needed and useable evidence and information at the point of decision-making. (Reaffirm HOD Policy)

A member of the Council on Medical Service introduced the report stating that patients and their physicians are in an untenable position when they have to choose among appropriate prescription drug options without reliable access to prescription drug price information. Patients are frequently surprised at the pharmacy counter by the high cost of their medication. The goal of improved prescription drug price transparency at the point of prescribing could be accomplished via improved health information technology (HIT). Council on Medical Service Report 2 outlines how existing HIT tools, as well as tools currently under active development, can empower physicians with reliable prescription drug price information. For example, Real-Time Prescription Benefit (RTPB) technology is a prescription drug decision-making tool that allows prescribers to access, at the point of prescribing, accurate, patient-specific coverage and benefit information, including the expected out-of-pocket cost, for a chosen medication and pharmacy. The Council's recommendations strive to empower physician access to accurate, patient-specific prescription drug price information at the point of prescribing, both via continued advocacy and via new educational initiatives.

Your Reference Committee heard testimony that was unanimously supportive of Council on Medical Service Report 2. Testimony described the report as novel, well researched, and feasible, and thanked the authors, as the report will increase access to affordable medication. A speaker supported the report and suggested that Recommendation 1 be amended to specify both physicians and other prescribers, to make it clear that anyone who can legally prescribe medication should have access to RTPB tools. Another amendment was offered to further expand Policy H-110.990. The Council on Medical Service welcomed the amendment to include other prescribers and offered an amendment to incorporate both the amendments to Policy H-110.990 originally proposed in Council on Medical Service Report 2 and the Council's recommended incorporation of the second amendment. The Council explained that the additional payer-created, physician-facing tools proposed could unintentionally lead to additional administrative burden on physician practices, but the Council supports development of additional patient-friendly tools. The Council on Legislation testified supporting adoption of the report, as amended by the Council on Medical Service, emphasizing the importance of this report for continuing AMA advocacy. Your Reference Committee agrees with both Councils that amendments to Council on Medical Service Report 2 that have any potential for additional physician administrative burden is inconsistent with the goals of the Report and therefore recommends adopting the Council on Medical Service's amendment. Finally, an amendment was proposed to Recommendation 5, amended subsection 6, to specify that financial support should be provided, if necessary. Subsequent testimony supported this friendly amendment.

Your Reference Committee concludes that testimony clearly supports Council on Medical Service Report 2 with the aforementioned amendments. Accordingly, your Reference Committee recommends that Council on Medical Service Report 2 be adopted as amended and the remainder of the report be filed.

(2) COUNCIL ON MEDICAL SERVICE REPORT 4 - FINANCING OF HOME AND COMMUNITY-BASED SERVICES

RECOMMENDATION A:

Recommendation 7 in Council on Medical Service Report 4 be amended by addition and deletion to read as follows:

7. That our AMA support that the Centers for Medicare and Medicaid Services and private insurers ~~offer~~ extend flexibility to implement innovative programs including but not limited to hospital at home programs ~~for the subset of patients who meet the criteria used by hospital at home programs~~. (New HOD Policy)

## RECOMMENDATION B:

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 adopted as amended and the remainder of the report filed.

The Council on Medical Service recommends that the following be adopted and that the remainder of the report be filed:

1. That our American Medical Association (AMA) support federal funding for payment rates that promote access and greater utilization of home and community-based services (HCBS). (New HOD Policy)
2. That our AMA support policies that help train, retain, and develop an adequate HCBS workforce (New HOD Policy)
3. That our AMA support efforts to simplify state plan amendments and Medicaid waivers to allow additional state flexibility to offer HCBS. (New HOD Policy)
4. That our AMA support that Medicaid's Money Follows the Person demonstration program be extended or made permanent. (New HOD Policy)
5. That our AMA support cross-agency and federal-state strategies that can help improve coordination] among HCBS programs and streamline funding and the provision of services. (New HOD Policy)
6. That our AMA support HCBS programs tracking protocols and outcomes to make meaningful comparisons across states and identify best practices. (New HOD Policy)
7. That our AMA support that the Centers for Medicare & Medicaid Services and private insurers offer flexibility to implement hospital at home programs for the subset of patients who meet the criteria used by hospital at home programs. (New HOD Policy)
8. That our AMA reaffirm Policy H-280.945, which provides a comprehensive set of principles to improve the financing of long-term services and supports and supports incentivizing states to expand the availability of and access to HCBS and permitting Medigap and Medicare Advantage plans to offer a respite care benefit. (Reaffirm HOD Policy)
9. That our AMA reaffirm Policy H-290.958 which supports increases in states' Federal Medical Assistance Percentages or other funding during significant economic downturns to allow state Medicaid programs to continue serving Medicaid patients and cover rising enrollment. (Reaffirm HOD Policy)

Your Reference Committee heard unanimously supportive testimony on Council on Medical Service Report 4. A member of the Council on Medical Service introduced the report urging adoption of the report to seize the opportunity to rethink the flawed long-term services and supports system. Subsequent testimony echoed this sentiment. An amendment was offered to Recommendation 7 recognizing that there is currently no "subset" of patients who meet a defined criteria to be eligible for hospital at home. The Council on Medical Service agreed with the clarifying amendment and encouraged adoption. Additional testimony also supported the amendment. Therefore, your Reference Committee recommends Recommendation 7 be amended. Accordingly, your Reference Committee recommends that Council on Medical Service Report 4 be adopted as amended and the remainder of the report be filed.

(3) JOINT REPORT OF THE COUNCIL ON MEDICAL SERVICE AND  
THE COUNCIL ON SCIENCE AND PUBLIC HEALTH - REDUCING  
INEQUITIES AND IMPROVING ACCESS TO INSURANCE FOR  
MATERNAL HEALTH CARE

RECOMMENDATION A:

Recommendation 4 in Joint Report of the Council on Medical Service and the Council on Science and Public Health be amended by addition to read as follows:

4. That our AMA continue to monitor and promote ongoing research regarding the impacts of societal (e.g., racism or unaffordable health insurance), geographical, facility-level (e.g., hospital quality), clinician-level (e.g., implicit bias), and patient-level (e.g., comorbidities, chronic stress or lack of transportation) barriers to optimal care that contribute to adverse and disparate maternal health outcomes, as well as research testing the effectiveness of interventions to address each of these barriers. (New HOD Policy)

RECOMMENDATION B:

Recommendation 6 in Joint Report of the Council on Medical Service and the Council on Science and Public Health be amended by addition to read as follows:

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

RECOMMENDATION C:

Recommendation 10 in Joint Report of the Council on Medical Service and the Council on Science and Public Health be amended by addition to read as follows:

10. That our AMA amend Policy D-290.974 by addition and deletion as follows:

Our AMA will work with relevant stakeholders to support and advocate, at the state and federal levels, for extension of Medicaid and State Children's Health Insurance Program (CHIP) coverage to at least 12 months after the end of pregnancy-postpartum. (Modify Current HOD Policy)

RECOMMENDATION D:

Recommendation 12 in Joint Report of the Council on Medical Service and the Council on Science and Public Health be amended by substitution to read as follows:

That our AMA amend Policy D-420.993, by addition as follows:

Our AMA: (1) will ask the Commission to End Health Care Disparities to evaluate the issue of health disparities in maternal mortality and offer

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

#### RECOMMENDATION E:

Joint Report of the Council on Medical Service and the Council on Science and Public Health be amended by addition of a new Recommendation to read as follows:

That our AMA encourage hospitals, health systems, and states to participate in maternal safety and quality improvement initiatives such as the Alliance for Innovation on Maternal Health program and state perinatal quality collaboratives. (New HOD Policy)

#### RECOMMENDATION F:

Joint Report of the Council on Medical Service and the Council on Science and Public Health be amended by addition of a new Recommendation to read as follows:

That our AMA advocate for increased access to risk-appropriate care by encouraging hospitals, health systems, and states to adopt verified, evidence-based levels of maternal care. (New HOD Policy)

#### RECOMMENDATION G:

Recommendations in Joint Report of the Council on Medical Service and the Council on Science and Public Health be adopted as amended and the remainder of the report be filed.

**HOD ACTION:** Recommendations in Joint Report of the Council on Medical Service and the Council on Science and Public Health adopted as amended and the remainder of the report filed.

The Council on Medical Service and the Council on Science and Public Health recommend that the following be adopted and that the remainder of the report be filed:

1. That our American Medical Association (AMA) acknowledge that structural racism and bias negatively impact the ability to provide optimal health care, including maternity care, for people of color. (New HOD Policy)
2. That our AMA encourage physicians to raise awareness among colleagues, residents and fellows, staff, and hospital administrators about the prevalence of racial and ethnic inequities and the effect on health outcomes, work to eliminate these inequities, and promote an environment of trust. (New HOD Policy)
3. That our AMA encourage physicians to pursue educational opportunities focused on embedding equitable, patient-centered care for patients who are pregnant and/or within 12 months postpartum into their clinical practices and encourage physician leaders of health care teams to support similar appropriate professional education for all members of their teams. (New HOD Policy)

4. That our AMA continue to monitor and promote ongoing research regarding the impacts of societal (e.g., racism or unaffordable health insurance), facility-level (e.g., hospital quality), clinician-level (e.g., implicit bias), and patient-level (e.g., comorbidities, chronic stress or lack of transportation) barriers to optimal care that contribute to adverse and disparate maternal health outcomes, as well as research testing the effectiveness of interventions to address each of these barriers. (New HOD Policy)
5. That our AMA promote the adoption of federal standards for clinician collection of patient-identified race and ethnicity information in clinical and administrative data to better identify inequities. The federal data collection standards should be:
  - (a) informed by research (including real-world testing of technical standards and standardized definitions of race and ethnicity terms to ensure that the data collected accurately reflect diverse populations and highlight, rather than obscure, critical distinctions that may exist within broad racial or ethnic categories),
  - (b) carefully crafted in conjunction with clinician and patient input to protect patient privacy and provide non-discrimination protections, and
  - (c) lead to the dissemination of best practices to guide respectful and non-coercive collection of accurate, standardized data relevant to maternal health outcomes. (Directive to Take Action)
6. That our AMA support the development of a standardized definition of maternal mortality and the allocation of resources to states to collect and analyze maternal mortality data (i.e., Maternal Mortality Review Committees and vital statistics) to enable stakeholders to better understand the underlying causes of maternal deaths and to inform evidence-based policies to improve maternal health outcomes and promote health equity. (New HOD Policy)
7. That our AMA encourage hospitals, health systems, and state medical associations and national medical specialty societies to collaborate with non-clinical community organizations with close ties to minoritized and other at-risk populations to identify opportunities to best support pregnant persons and new families. (New HOD Policy)
8. That our AMA encourage the development and funding of resources and outreach initiatives to help pregnant individuals, their families, their communities, and their workplaces to recognize the value of comprehensive prepregnancy, prenatal, peripartum, and postpartum care. These resources and initiatives should encourage patients to pursue both physical and behavioral health care, strive to reduce barriers to pursuing care, and highlight care that is available at little or no cost to the patient. (New HOD Policy)
9. That our AMA support adequate payment from all payers for the full spectrum of evidence-based prepregnancy, prenatal, peripartum, and postpartum physical and behavioral health care. (New HOD Policy)
10. That our AMA amend Policy D-290.974 by addition and deletion as follows:
 

Our AMA will work with relevant stakeholders to support, at the state and federal levels, extension of Medicaid and State Children's Health Insurance Program (CHIP) coverage to at least 12 months after the end of pregnancy ~~postpartum~~. (Modify Current HOD Policy)
11. That our AMA reaffirm Policy H-350.974, which highlights the elimination of racial and ethnic disparities in health care as an issue of highest priority for the AMA; encourages physicians to examine how their own practices help increase the awareness within the profession of racial disparities in medical treatment decisions; supports the use of evidence-based guidelines to promote the consistency and equity of care for all persons; supports the development and implementation of training regarding implicit bias, diversity and inclusion in all medical schools and residency programs; and supports research to identify the most effective strategies for educating physicians on how to eliminate disparities in health outcomes in all at-risk populations. (Reaffirm HOD Policy)
12. That our AMA reaffirm Policy D-420.993, which states that the AMA will work with the Centers for Disease Control and Prevention, United States (US) Department of Health and Human Services, state and county health departments to decrease maternal mortality rates in the US; encourage and promote all state and county health departments to develop a maternal mortality surveillance system; and work with stakeholders to encourage

research on identifying barriers and developing strategies toward the implementation of evidence-based practices to prevent disease conditions that contribute to poor obstetric outcomes, maternal morbidity and maternal mortality in racial and ethnic minorities. (Reaffirm HOD Policy)

13. That our AMA reaffirm Policy D-290.979, which supports collaborative efforts with state and specialty medical societies to advocate at the state level for expanded Medicaid eligibility as authorized by the Affordable Care Act. (Reaffirm AMA Policy)
14. That our AMA reaffirm Policy H-165.855, which supports 12-month continuous eligibility across Medicaid, Children's Health Insurance Program, and exchange plans to limit patient churn and promote continuity and coordination of care; and also supports development of a mechanism to allow for the presumptive assessment of eligibility and retroactive coverage to the time at which an eligible person seeks medical care. (Reaffirm HOD Policy)

A member of the Council on Medical Service introduced the report stating that the US is 1 of only 13 countries in the world where the maternal mortality rate is worse now than it was 25 years ago, and it is the only industrialized country with a rising maternal mortality rate. Approximately two-thirds of these deaths are preventable. Throughout pregnancy, delivery, and postpartum, women are at risk for an array of physical and psychological challenges. Causes of maternal death vary considerably, and approximately one-third of pregnancy-related deaths occur postpartum, including almost 12 percent that occur between 43 and 365 days postpartum. The US maternal health crisis is a complex, multifactorial challenge that cannot be adequately addressed in a single report. Instead, the Councils present this narrowly focused initial report, the first in an anticipated series of reports, to strengthen the AMA's existing policy foundation and empower advocacy on two especially urgent issues: (1) expanding access to insurance for the most vulnerable new mothers, and (2) addressing inequities in maternal health care. This joint report explores challenges women face in pursuing maternal health care, highlights especially relevant AMA policy and advocacy, and presents a series of policy recommendations. A member of the Council on Science and Public Health further testified that the CDC has highlighted considerable racial/ethnic disparities in maternal health outcomes. Black women are three to four times more likely, and Indigenous women are two to three times more likely, to die from pregnancy-related causes than white women. These disparities persist after removing sociodemographic variables - college-educated Black women have been found to be at a 60 percent greater risk for maternal death than white or Hispanic women with less than high school education. In addition, Black women have more than a twofold greater risk of severe maternal morbidity than white women. As with pregnancy-related mortality, the factors underlying racial and ethnic disparities in severe maternal morbidity are unclear, but most studies have found that these differences persist after adjustment for sociodemographic and clinical characteristics. The CDC explains that racial and ethnic inequities in maternal health care may be due to several factors including access to care, quality of care, prevalence of chronic diseases, structural racism, and implicit biases.

Your Reference Committee heard testimony that unanimously supported the Joint Report. The Council on Legislation testified that the recommendations in this Joint Report will strengthen the AMA's existing policy foundation and empower further advocacy on these urgent issues and recommended that the Joint Report be adopted. The American Academy of Pediatrics praised the report as being well-written and timely, embodying many of the concerns facing maternal health, and highlighting the importance of racial and ethnic inequities on maternal fetal outcomes. The Medical Student Section thanked the authors of the Joint Report and Reference Committee and encouraged our AMA to stand in support of this eloquent report.

While supporting the Joint Report, several delegations proposed amendments to add to the Joint Report. The American College of Obstetricians and Gynecologists (ACOG), testified in strong support of the Joint Report and offered several amendments to the Joint Report. A speaker proposed amendments to Recommendations 10 and 12 and two additional recommendations to more closely align the Joint Report recommendations with the current landscape. Subsequent testimony overwhelmingly supported the amendments. Another speaker proposed that Recommendation 6 be amended by addition to also encourage allocation of direct funding and resources to Tribes. Again, subsequent testimony supported this amendment. Additionally, an amendment was proposed to Recommendation 4 by addition of the words, "geographical" to reflect the issues of limited resources and distance that impact maternal care in rural communities. Finally, testimony proposed amending Recommendation 10 by addition of the phrase, "after the end of a confirmed documented pregnancy." Subsequent testimony was overwhelmingly opposed to this proposed amendment. Notably, the Council on Medical Service testified in

opposition to this amendment, explaining that the proposed language would create a qualifier for who can receive covered care, with unintended consequences such as restricting access to coverage of care for miscarriage complications, especially jeopardizing patients in rural and marginalized communities. Additional testimony strongly opposed the amendment, stating opposition to including any qualifiers in the Recommendation, including confirmation of pregnancy, as this would add to confusion. Following the overwhelming majority of the testimony in opposition to the amendment, your Reference Committee concludes that the amendment should not be adopted.

Your Reference Committee agrees with testimony in strong support of Joint Report of the Council on Medical Service and Council on Science and Public Health as amended by and recommends that it be adopted as amended and the remainder of the report be filed.

(4) RESOLUTION 701 - COVERAGE OF PREGNANCY-ASSOCIATED HEALTHCARE FOR 12 MONTHS POSTPARTUM FOR UNINSURED PATIENTS INELIGIBLE FOR MEDICAID

RECOMMENDATION A:

Recommends that the first Resolve in Resolution 701 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association amend Policy H-290.974, “Extending Medicaid Coverage for One Year Postpartum,” by addition as follows to read as follows:

1) Our AMA will work with relevant stakeholders to support extension of Medicaid and Children’s Health Insurance Program (CHIP) coverage to at least 12 months after the end of pregnancy postpartum; and 2) Our AMA will work with relevant stakeholders to expand Medicaid and CHIP eligibility for pregnant and postpartum non-citizen immigrants. (Modify Current HOD Policy); and be it further

RECOMMENDATION B:

Resolution 701 be adopted as amended.

**HOD ACTION:** Resolution 701 adopted as amended.

RESOLVED, That our American Medical Association amend Policy H-290.974, “Extending Medicaid Coverage for One Year Postpartum,” by addition as follows to read as follows:

D-290.974 Extending Medicaid Coverage for One Year Postpartum

1) Our AMA will work with relevant stakeholders to support extension of Medicaid coverage to 12 months postpartum; and 2) Our AMA will work with relevant stakeholders to expand Medicaid eligibility for pregnant and postpartum non-citizen immigrants. (Modify Current HOD Policy); and be it further

RESOLVED, That our AMA amend H-165.828, “Health Insurance Affordability,” by addition as follows:

H-165.828 – HEALTH INSURANCE AFFORDABILITY

1. Our AMA 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 that which applies to the exemption from the individual mandate of the Affordable Care Act (ACA).

2. Our AMA supports legislation or regulation, whichever is relevant, to fix the ACA’s “family glitch,” thus determining the affordability of employer-sponsored coverage with respect to the cost of family-based or employee-only coverage.

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. (Modify Current HOD Policy)

Your Reference Committee heard mixed testimony on Resolution 701, with significant testimony in favor of adopting the Resolution. Significant testimony in favor of Resolution 701 emphasized the humane, medical professional, ethical, maternal/infant/family health outcomes, and financial benefits of the resolution. A member of the Council on Medical Service testified, expressing shared concerns about uninsured pregnant and postpartum patients, and highlighting that two reports being considered at this meeting propose new policies that address many of the issues raised by Resolution 701. CMS Report 3-N-21 recommends new policy regarding insurance coverage for immigrants, and the CMS/CSAPH Joint Report recommends new policy to support expanded access to insurance for the most vulnerable new mothers. In the interests of developing new policy consistent with the goals of Resolution 701 without overlapping with the policy development in CMS Report 3 or the CMS/CSAPH Joint Report, the Council on Medical Service offered an alternative resolution. A member of the Council on Legislation testified in strong support of the alternate resolution offered by the Council on Medical Service and urging its adoption. However, subsequent testimony did not support the amendment offered by the Council on Medical Service. Additional testimony largely was in strong support of Resolution 701, and an amendment was offered to specifically reference extended coverage under Children’s Health Insurance Program (CHIP). Another amendment was offered, suggesting that the second Resolve specify a qualifying life event for the pregnant person, but the majority of the testimony did not support this amendment. Furthermore, while some testimony supported referral of Resolution 701, many testified strongly against referral. Moreover, your Reference Committee believes that the AMA’s commitment to health equity demands that this resolution be acted upon at this time. The overwhelming majority of extended testimony supported Resolution 701 as amended. Accordingly, Your Reference Committee recommends that Resolution 701 be adopted as amended.