

**MEMORIAL RESOLUTIONS
ADOPTED UNANIMOUSLY**

William Edmund Bowman, MD
Introduced by North Carolina

Whereas, William E. “Bill” Bowman, MD, an esteemed member of the North Carolina delegation to the American Medical Association, passed away suddenly on March 6, 2021; and

Whereas, Dr. Bowman graduated from Davidson College in 1970 and received his MD degree from the University of North Carolina School of Medicine in 1974, and completed his residency in general surgery in San Francisco; and

Whereas, Dr. Bowman served his country in the US Army in active duty from 1974-1981, and left the Army with the rank of Major; and

Whereas, Dr. Bowman served his community of Greensboro, NC as a highly respected general surgeon from 1981-2008, serving as Chief of Surgery and President of the Medical and Dental Staff at Cone Health; and

Whereas, Dr. Bowman served as Vice President of Medical Affairs at Cone Health from 2008-2017; and

Whereas, Dr. Bowman served the North Carolina Medical Society and its members on numerous committees and on its Board of Directors; and

Whereas, Dr. Bowman served on the North Carolina delegation to the AMA House of Delegates from 2004 until his death, bringing his wisdom and wit to delegation discussions; and

Whereas, Dr. Bowman served on the Board of The Carolinas Center for Medical Excellence from 1996-2008; and

Whereas, Dr. Bowman served on the Board of the North Carolina Professionals Health Program from 2016 until his death in 2021, serving as board chair in 2019-2020; and

Whereas, Dr. Bowman was very supportive of the state and national Alliance activities of his wife, Gay, who served on the AMA Alliance Board from 1998-2005, and as president of the AMA Alliance in 2003-2004; and

Whereas, Dr. Bowman was often happiest working on his farm raising cattle and crops and enjoying the woods and pond; and

Whereas, Dr. Bowman dedicated many hours volunteering with The Healing Gardens at Wesley Long Hospital, Habitat for Humanity and other organizations; and

Whereas, Dr. Bowman leaves a legacy of service and leadership to his community and to the profession of medicine and will be dearly missed by so many; and

Whereas, Dr. Bowman enjoyed long and loving relationships with his wife Gay and their two children and three grandchildren; therefore be it

RESOLVED, That our American Medical Association House of Delegates recognize the many contributions made by Dr. Bowman to the medical profession and to the Greater Greensboro community; and be it further

RESOLVED, That our AMA House of Delegates express its sympathy at the passing of our friend and colleague, William E. Bowman, MD, to his wife and family and present them with a copy of this resolution.

RESOLUTIONS

The Resolutions Committee reviewed each resolution submitted for the Special Meeting and recommended that a resolution be considered or not considered based on its urgency. The Resolutions Committee recommended that the following resolutions not be considered, and the House of Delegates adopted those recommendations: 1, 3, 4, 5, 6, 7, 10, 11, 12, 13, 14, 15, 16, 17, 24, 25, 26, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 201, 204, 205, 206, 208, 210, 211, 213, 214, 215, 216, 217, 218, 219, 220, 222, 223, 227, 228, 230, 231, 232, 233, 235, 236, 237, 238, 239, 241, 302, 303, 304, 306, 307, 308, 310, 311, 312, 313, 314, 315, 316, 317, 318, 401, 402, 403, 404, 405, 406, 407, 409, 413, 415, 501, 503, 504, 507, 508, 509, 510, 602, 603, 604, 607, 608, 609, 610, 611, 612, 613, 616, 617, 618, 619, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711 and 712.

Alternate resolutions are considered to have been introduced by the reference committee.

REFERENCE COMMITTEE ON AMENDMENTS TO CONSTITUTION & BYLAWS

2. DISAGGREGATION OF RACE DATA FOR INDIVIDUALS OF MIDDLE EASTERN AND NORTH AFRICAN (MENA) DESCENT Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee on Amendments to Constitution & Bylaws.

HOD ACTION: NOT ADOPTED

RESOLVED, That our American Medical Association add “Middle Eastern/North African (MENA)” as a separate race category on all AMA demographics forms; 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; 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.

8. AMENDMENT TO TRUTH AND TRANSPARENCY IN PREGNANCY COUNSELING CENTERS, H-420.954 Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee on Amendments to Constitution & Bylaws.

HOD ACTION: REFERRED

RESOLVED, That our American Medical Association amend 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:

H-420.954, ‘Truth and Transparency in Pregnancy Counseling Centers’

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.

9. BANNING THE PRACTICE OF VIRGINITY TESTING **Introduced by Medical Student Section**

Reference committee hearing: see report of Reference Committee on Amendments to Constitution & Bylaws.

HOD ACTION: ADOPTED
See Policy D-525992

RESOLVED, That our American Medical Association advocate for the elimination of the practice of virginity testing exams, physical exams purported to assess virginity; 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; 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.

18. SUPPORT FOR SAFE AND EQUITABLE ACCESS TO VOTING **Introduced by Resident and Fellow Section, Medical Student Section**

Reference committee hearing: see report of Reference Committee on Amendments to Constitution & Bylaws.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-440.805

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;
- (g) use of a PO Box for voter registration; 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.

**19. DISAGGREGATION OF DEMOGRAPHIC DATA FOR INDIVIDUALS OF
MIDDLE EASTERN AND NORTH AFRICAN (MENA) DESCENT
Introduced by Resident and Fellow Section**

Reference committee hearing: see report of Reference Committee on Amendments to Constitution & Bylaws.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy D-350.979

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

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

**20. RECOGNIZING AND REMEDYING PAYMENT SYSTEM BIAS AS A
FACTOR IN RURAL HEALTH DISPARITIES
Introduced by Iowa**

Reference committee hearing: see report of Reference Committee on Amendments to Constitution & Bylaws.

HOD ACTION: ADOPTED AS FOLLOWS
TITLE CHANGED
See Policy H-465.978

RESOLVED, That our American Medical Association: recognize that systemic bias in healthcare financing has been one of many factors leading to rural health disparities and advocate for elimination of these biases through payment policy reform to help reduce the shortage of rural physicians and eliminate health inequities in rural America; 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.

**21. FREE SPEECH AND CIVIL DISCOURSE IN THE AMERICAN MEDICAL ASSOCIATION
Introduced by Louisiana**

Reference committee hearing: see report of Reference Committee on Amendments to Constitution & Bylaws.

HOD ACTION: 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.

22. PROHIBITION OF RACIST CHARACTERIZATION BASED ON PERSONAL ATTRIBUTES

Introduced by Louisiana

Reference committee hearing: see report of Reference Committee on Amendments to Constitution & Bylaws.

HOD ACTION: 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.

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

Introduced by Pennsylvania, New York, Michigan

Reference committee hearing: see report of Reference Committee on Amendments to Constitution & Bylaws.

HOD ACTION: ADOPTED AS FOLLOWS
See Policies D-140.952 and D-405.976

RESOLVED, That our American Medical Association advocate that health system, corporate, and academic organizations provide for fair, objective, and external evaluations for physicians who are requested or required to be assessed for a potential impairment due to a health condition, and that such evaluations are independent of conflicts of interest by the examining entity; and be it further

RESOLVED, That our AMA support the availability of physician health programs to enable physicians who require assistance to receive safe and effective care; 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 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.

...

(k) Advocating for fair, objective, external, and independent 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 rotation.

REFERENCE COMMITTEE A

101. STANDARDIZED CODING FOR TELEHEALTH SERVICES

Introduced by Virginia, American Association of Clinical Urologists, District of Columbia, Oklahoma, Tennessee, Alabama, New Jersey, North Carolina, Mississippi, Georgia, Kentucky

Reference committee hearing: see report of Reference Committee A.

HOD ACTION: REFERRED FOR DECISION

Proposed alternate resolution:

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.

Original resolution:

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.

113. SUPPORTING MEDICARE DRUG PRICE NEGOTIATION

Reference committee hearing: see report of Reference Committee A.

HOD ACTION: ALTERNATE RESOLUTION 113 ADOPTED ADDITIONAL ALTERNATE RESOLVE AND PROPOSED AMENDMENT REFERRED *See Policies H-110.987 and D-330.954*

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; and be it further

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

Following proposed resolve referred along with proposed amendment:

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.

Proposed amendment:

~~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; 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;

REFERENCE COMMITTEE B

203. POVERTY-LEVEL WAGES AND HEALTH Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: 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.

207. AUTHORITY TO GRANT VACCINE EXEMPTIONS Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED AS FOLLOWS *See Policy H-440.970*

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:

H-440.970, “Nonmedical Exemptions from Immunizations”

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.

209. INCREASING ACCESS TO HYGIENE AND MENSTRUAL PRODUCTS

Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED
See Policies H-525.973 and H-525.974

RESOLVED, That our American Medical Association recognize the adverse physical and mental health consequences of limited access to menstrual products for school-aged individuals; 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; 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; 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; 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:

H-525.974, “Considering Feminine Hygiene Products As Medical Necessities”

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.

212. SEQUESTRATION

Reference committee hearing: see report of Reference Committee B.

**HOD ACTION: ALTERNATE RESOLUTION 212 ADOPTED IN LIEU OF
 RESOLUTIONS 212, 221, 224 AND 225**
*See Policies H 330.888, H-330.932, H-385.905, H 390.838, H 390.849, H-400.972,
 H-400.990, H-400.991, D-165.941, D-390.946, D-390.963 and D-390.988*

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; and be it further

RESOLVED, 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”

221. PROMOTING SUSTAINABILITY IN MEDICARE PHYSICIAN PAYMENTS

Introduced by Texas

Resolution 221 was considered with Resolutions 212, 224 and 225. See Resolution 212.

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

RESOLVED, That our AMA seek annual and full Medicare Economic Index updates for Medicare Part B physician payments; and be it further

RESOLVED, That our AMA seek legislation that provides only for positive performance incentives; 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.

224. IMPROVE PHYSICIAN PAYMENTS

Introduced by Florida

Resolution 224 was considered with Resolutions 212, 221 and 225. See Resolution 212.

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

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

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

D-165.941, “Sequestration Budget Cuts”

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; 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); 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; 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).

225. END BUDGET NEUTRALITY

Introduced by Florida

Resolution 225 was considered with Resolutions 212, 221 and 224. See Resolution 212.

RESOLVED, That our American Medical Association work towards the elimination of budget neutrality requirements under federal law; 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:

H-385.905, “Merit-based Incentive Payment System (MIPS) Update”

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; and be it further

RESOLVED, That our AMA reaffirm Policy 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; and be it further

RESOLVED, That our AMA reaffirm and take action on Policy 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)

226. ADDRESS ADOLESCENT TELEHEALTH CONFIDENTIALITY CONCERNS

Introduced by Michigan

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED

See Policy H-60.965

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

H-60.965, “Confidential Health Services for Adolescents”

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;
- (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.

229. CMS ADMINISTRATIVE REQUIREMENTS**Introduced by New York**

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED
See Policy D-190.970

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); 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; 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; 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.

234. PERMITTING THE DISPENSING OF STOCK MEDICATIONS FOR POST DISCHARGE PATIENT USE AND THE SAFE USE OF MULTI-DOSE MEDICATIONS FOR MULTIPLE PATIENTS
Introduced by Illinois, California, Iowa, Georgia, New Jersey, Pennsylvania, American Academy of Ophthalmology, American Society of Cataract and Refractive Surgery, American Society of Ophthalmic Plastic and Reconstructive Surgery, American Society of Retina Specialists

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy D-120.929

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; and be it further

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, injectables, and topical medications, in accordance with safe handling and dispensing protocols that help ensure patient safety, minimize duplicated patient costs, and reduce medication waste.

240. RANSOMWARE PREVENTION AND RECOVERY
Introduced by Organized Medical Staff Section

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy D-478.959

RESOLVED, That our American Medical Association work with other stakeholders to seek legislation or regulation that supports resources to cover cyberattack prevention and recovery expenses for physician practices, hospitals, and healthcare entities to ensure continuity of optimal patient care; 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.

REFERENCE COMMITTEE C

301. EQUITABLE REPORTING OF USMLE STEP 1 AND COMLEX-USA LEVEL 1 SCORES
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee C.

HOD ACTION: ADOPTED AS FOLLOWS
TITLE CHANGED
See Policy H-275.953

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.

305. INCREASE AWARENESS AMONG RESIDENCY, FELLOWSHIP, AND ACADEMIC PROGRAMS ON THE UNITED STATES-PUERTO RICO RELATIONSHIP STATUS

Reference committee hearing: see report of Reference Committee C.

HOD ACTION: ALTERNATE RESOLUTION 305 ADOPTED
See Policy H-295.854

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; 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.

309. PROTECTING MEDICAL STUDENT ACCESS TO ABORTION EDUCATION AND TRAINING

Reference committee hearing: see report of Reference Committee C.

HOD ACTION: ALTERNATE RESOLUTION 309 ADOPTED
See Policy H-295.923

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, ~~although observation of, attendance at, or any direct or indirect participation in an abortion should not be required.~~

2. ~~Further, the Our~~ AMA supports the ~~opportunity for residents to learn~~ 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.

23. Our AMA encourages the Accreditation Council for Graduate Medical Education to ~~better~~ 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.

REFERENCE COMMITTEE D

408. ENSURING AFFORDABILITY AND EQUITY IN COVID-19 VACCINE BOOSTERS Introduced by New York

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: ADOPTED AS FOLLOWS
See Policies D-440.921 and D-440.981

RESOLVED, That our American Medical Association support the public purchase and cost-free distribution and administration of COVID-19 booster vaccine doses; and be it further

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

**410. AFFIRMATIVELY PROTECTING THE SAFETY AND DIGNITY OF PHYSICIANS
AND TRAINEES AS WORKERS**
Introduced by Resident and Fellow Section

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: ADOPTED AS FOLLOWS
TITLE CHANGED
See Policies H-440.810 and D-515.977

RESOLVED, That our American Medical Association 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 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

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 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~~ the rights of physicians and trainees to participate in public commentary addressing the adequacy of clinical resources and/or health and environmental safety conditions necessary to provide appropriate and safe care of patients and physicians during a pandemic or natural disaster.
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 trainees from violence and unsafe working conditions.

**411. ADDRESSING PUBLIC HEALTH DISINFORMATION DISSEMINATED
BY HEALTH PROFESSIONALS**

Reference committee hearing: see report of Reference Committee D.

**HOD ACTION: ALTERNATE RESOLUTION 411 ADOPTED IN LIEU OF
RESOLUTIONS 411 AND 412**
See Policy D-440.914

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; 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.

412. HEALTH PROFESSIONAL DISINFORMATION DURING A PUBLIC HEALTH CRISIS
Introduced by Young Physicians Section

Resolution 412 was considered with Resolution 411. See Resolution 411.

RESOLVED, That our American Medical Association work with health professional societies to address disinformation that undermines public health initiatives.

**414. ADVOCACY ON THE US DEPARTMENT OF EDUCATION'S SPRING 2022 TITLE IX RULE ON
SEXUAL HARASSMENT AND ASSAULT IN EDUCATION PROGRAMS**
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy D-515.976

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

REFERENCE COMMITTEE E**502. ADVOCATING FOR HEAT EXPOSURE PROTECTIONS FOR ALL WORKERS**
Introduced by Washington

Reference committee hearing: see report of Reference Committee E.

HOD ACTION: ADOPTED AS FOLLOWS
TITLE CHANGED
See Policy D-135.967

RESOLVED, That our American Medical Association (AMA) advocate for all workers to have access to preventive 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; and be it further

RESOLVED, That our AMA advocate for legislation that creates federal standards for protections against heat stress and sun exposure specific to the hazards of the workplace; 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; and be it further

RESOLVED, That our AMA work with the United States Department of Labor, OSHA, and other appropriate federal stakeholders to develop and enforce evidence-based policies, guidelines, and protections against heat injury for workers independent of legal status; 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.

505. REPRESENTATION OF DERMATOLOGICAL PATHOLOGIES IN VARYING SKIN TONES

Reference committee hearing: see report of Reference Committee E.

HOD ACTION: ALTERNATE RESOLUTION 505 ADOPTED
See Policy H-295.853

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.

506. ENHANCING HARM REDUCTION FOR PEOPLE WHO USE DRUGS **Introduced by Medical Student Section**

Reference committee hearing: see report of Reference Committee E.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy D-95.987

RESOLVED, That our American Medical Association amend Policy D-95.987, "Prevention of Opioid Overdose," 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 for harm reduction from drug use, including but not limited to drug contamination testing and injection drug preparation, use and disposal supplies.

REFERENCE COMMITTEE F

601. INFORMAL INTER-MEMBER MENTORING **Introduced by Senior Physicians Section**

Reference committee hearing: see report of Reference Committee F.

HOD ACTION: ADOPTED
TITLE CHANGED
See Policy D-635.980

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.

605. FORMALIZATION OF THE RESOLUTION COMMITTEE AS A STANDING COMMITTEE OF THE AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES **Introduced by Texas**

Reference committee hearing: see report of Reference Committee F.

HOD ACTION: 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; and be it further

RESOLVED, That the membership of the Resolution Committee reflect the diversity of the House of Delegates; 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.

606. INCREASING THE EFFECTIVENESS OF ONLINE REFERENCE COMMITTEE TESTIMONY **Introduced by Texas**

Reference committee hearing: see report of Reference Committee F.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy D-600.956

RESOLVED, That our American Medical Association conduct a trial of two-years during which all reference committees, prior to the in-person reference committee hearing, produce a preliminary reference committee document based on the written online testimony; and be it further

RESOLVED, That the preliminary reference committee document will be used to inform the discussion at the in-person reference committee; and be it further

RESOLVED, That there be an evaluation to determine if this procedure should continue; and be it further

RESOLVED, That AMA pursue any bylaw changes that might be necessary to allow this trial; and be it further

RESOLVED, That the period for online testimony be no longer than 14 days.

614. INSURANCE INDUSTRY BEHAVIORS

Introduced by New Jersey, District of Columbia, Oklahoma, Pennsylvania, South Carolina, Tennessee, California, American Society of Anesthesiologists, New York, Florida, American College of Allergy, Asthma and Immunology

Reference committee hearing: see report of Reference Committee F.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy D-385.949

RESOLVED, That our American Medical Association step up its ongoing review of the proper use of the AMA CPT Codes in medical billing claims payments and its misuse by the US Health Insurance Industry; 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 a search for potential litigation partners across the medical federation; and be it further

RESOLVED, That our AMA communicate with AMA members outcomes in litigating egregious behaviors of the health insurance industry.

615. EMPLOYED PHYSICIANS

Introduced by Oklahoma, Alabama, District of Columbia, Georgia, Mississippi, New Jersey, North Carolina, South Carolina, Tennessee

Reference committee hearing: see report of Reference Committee F.

HOD ACTION: 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; and be it further

RESOLVED, That our AMA study amending Policy G-615.105 to read as follows:

G-615.105, "Employed Physicians and the AMA"

1. Our AMA will 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 assistance, such as information, advice, and legal opinions, 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, medical staff bylaws, sham peer review, economic credentialing, and the denial of due process.
3. Our AMA will also 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.; 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; 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.

REFERENCE COMMITTEE G

701. COVERAGE OF PREGNANCY-ASSOCIATED HEALTHCARE FOR 12 MONTHS POSTPARTUM FOR UNINSURED PATIENTS INELIGIBLE FOR MEDICAID **Introduced by Medical Student Section**

Reference committee hearing: see report of Reference Committee G.

HOD ACTION: ADOPTED AS FOLLOWS
See Policies H-165.828 and D-290.974

RESOLVED, That our American Medical Association amend Policy D-290.974, “Extending Medicaid Coverage for One Year Postpartum,” by addition and deletion 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 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;

and be it further

RESOLVED, That our AMA amend Policy 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.