REFERRAL CHANGES AND OTHER REVISIONS
2024 Interim Meeting

WITHDRAWN RESOLUTIONS

- Res. 926 – Development of Climate Health Education Tools for Physicians

REVISED RESOLUTIONS

- Res. 302 – Strengthening Parental Leave Policies for Medical Trainees and Recent Graduates

REVISED REPORTS

- BOT 18 – Expanding Palliative Care (New title)

RESOLUTIONS WITH ADDITIONAL SPONSORS
(Additional sponsors underlined)

- Res. 210 – Laser Surgery
  (American Academy of Ophthalmology, <u>The American College of Surgeons)</u>

- Res. 211 – Water Bead Injuries
  (American Academy of Ophthalmology, <u>American Academy of Otolaryngology-Head and Neck Surgery</u>)

- Res. 812 – Advocate for Therapy Cap Exception Process
  (Michigan, American Academy of Physical Medicine and Rehabilitation, American Academy of Orthopaedic Surgeons, <u>American College of Rheumatology</u>)

ORDER OF BUSINESS
SECOND SESSION

Saturday, November 9, 2024
12:30 PM

1. **Call to Order by the Speaker – Lisa Bohman Egbert, MD**

2. **Report of the Rules and Credentials Committee – Robert H. Emmick, MD**

3. **Presentation Correction and Adoption of Minutes from the June 2024 Annual Meeting**

4. **Referral Changes and Other Revisions**

5. **Acceptance of Business**

--REPORTS--

Report(s) of the Board of Trustees - Michael Suk, MD, JD, MPH, MBA, Chair

01 Augmented Intelligence Development, Deployment, and Use in Health Care
02 On-Site Physician Requirements for Emergency Departments
03 Stark Law Self-Referral Ban
04 Addressing Work Requirements For J-1 Visa Waiver Physicians
05 Protecting the Health of Incarcerated Patients
06 Health Technology Accessibility for Aging Patients
07 Reevaluation of Scoring Criteria for Rural Communities in the National Health Service Corps Loan Repayment Program
08 Increasing Access to Medical Care for People Seeking Asylum
09 Corporate Practice of Medicine Prohibition
11 Carbon Pricing to Address Climate Change
13 AMA/Specialty Society RVS Update Committee
14 Privacy Protection and Prevention of Further Trauma for Victims of Distribution of Intimate Videos and Images Without Consent
15 Published Metrics for Hospitals and Hospital Systems
16 AMA Reimbursement of Necessary HOD Business Meeting Expenses for Delegates and Alternates
18 Expanding Protections of End-of-Life Care
22* Specialty Society Representation in the House of Delegates - Five-Year Review
23* Advocating for the Informed Consent for Access to Transgender Health Care
24* Physicians Arrested for Non-Violent Crimes While Engaged in Public Protests
25* World Medical Association Observer Status in the House of Delegates

Report(s) of the Council on Constitution and Bylaws - Jerry P. Abraham, MD, MPH, Chair

01 Resolution Deadline Clarification
02 Name Change for Reference Committee
03 Bylaw Amendments to Address Medical Student Leadership

Report(s) of the Council on Ethical and Judicial Affairs - Jeremy A. Lazarus, MD, Chair

01 Expanding Access to Palliative Care
02 Protecting Physicians Who Engage in Contracts to Deliver Health Care Services

Report(s) of the Council on Long Range Planning and Development - Michelle Berger, MD, Chair

01 Academic Physicians Section Five-Year Review

Report(s) of the Council on Medical Education - Krystal Tomei, MD, MPH, Chair

01 Medication Reconciliation Education
02 Updates to Recommendations for Future Directions for Medical Education

Report(s) of the Council on Medical Service - Stephen Epstein, MD, MPP, Chair

01 Nonprofit Hospital Charity Care Policies
02 Unified Financing Health Care System
03 Time-Limited Patient Care
04 Biosimilar Coverage Structures

Report(s) of the Council on Science and Public Health - John T. Carlo, MD, MBA, Chair

01 Cannabis Therapeutic Claims in Marketing and Advertising
02 Drug Shortages: 2024 Update
03 HPV-Associated Cancer Prevention
04 Reducing Sodium Intake to Improve Public Health
05 Teens and Social Media

Report(s) of the HOD Committee on Compensation of the Officers-Claudette Dalton, MD, Chair

01 Report of the House of Delegates Committee on the Compensation of the Officers

Report(s) of the Speakers - Lisa Bohman Egbert, MD, Speaker; John H. Armstrong, MD, Vice Speaker

01 Report of the Election Task Force 2

--EXTRACTION OF INFORMATIONAL REPORTS--

BOT Report(s)

10 AMA Efforts on Medicare Payment Reform
12 Eliminating Eligibility Criteria for Sperm Donors Based on Sexual
17 Environmental Sustainability of AMA National Meetings
19 Update on Climate Change and Health AMA Activities
20 2024 AMA Advocacy Efforts
21 Task Force to Preserve the Patient-Physician Relationship When Evidence-

CEJA Opinion(s)

01 Research Handling of De-Identified Patient Data
02 Amendment to E-2.1.1, “Informed Consent”
03 Amendment to E-3.1.1, “Privacy in Health Care”
04 Amendment to E-3.2.4 “Access to Medical Records by Data Collection
05 Amendment to E-3.3.2, “Confidentiality and Electronic Medical Records”

06 Physicians' Use of Social Media for Product Promotion and Compensation
07 Short-Term Global Health Clinical Encounters

Report(s) of the Speakers

02 Reconciliation Report

--INTRODUCTION OF RESOLUTIONS--

001 Addressing Gender-Based Pricing Disparities
002 Anti-Doxxing Data Privacy Protection
003 On the Ethics of Human Lifespan Prolongation
004 Improving Usability of Electronic Health Records for Transgender and Gender Diverse Patients
005 Updating the AMA Definition of Infertility
006 Opposition to the Deceptive Relocation of Migrants and Asylum Seekers
007 Supporting Diversity in Research
008 Missing and Murdered Black Women and Girls
009 Opposition to Creation or Enforcement of Civil Litigation, Commonly Referred to as Civil Causes of Action
010* Development of Resources for Medical Staffs to Engage in Collective Negotiation with Hospital and Health Systems
011* American Kidney Donation Legislation
201 Boarding Patients in the Emergency Room
202 Illicit Drugs: Calling for a Multifaceted Approach to the "Fentanyl" Crisis
204 Support for Physician-Supervised Community Paramedicine Programs
205 Native American Medical Debt
206 Protect Infant and Young Child Feeding
207 Accountability for G-605.009: Requesting A Task Force to Preserve the Patient-Physician Relationship Task Force Update and Guidance
208 Medicare Part B Enrollment and Penalty Awareness
210 Laser Surgery
211 Water Bead Injuries
212 Addressing the Unregulated Body Brokerage Industry
213 Sustainable Long-term Funding for Child Psychiatry Access Programs
214 Advocating for Evidence-Based Strategies to Improve Rural Obstetric Health Care and Access
215 Advocating for Federal and State Incentives for Recruitment and Retention of Physicians to Practice in Rural Areas
216 Clearing Federal Obstacles for Supervised Injection Sites
217 Expand Access to Skilled Nursing Facility Services for Patients with Opioid Use Disorder
218 Time Sensitive Credentialing of New Providers with an Insurance Carrier
219 Advocate to Continue Reimbursement for Telehealth / Telemedicine Visits Permanently
220 MIPS Reform
221 Medicare Coverage for Non-PAR Physicians

222 Rollback on Physician Performance Measures
223 Mandated Economic Escalators in Insurance Contracts
225 Elimination of Medicare 14-Day Rule
226 Information Blocking Rule
227 Medicare Payment Parity for Telemedicine Services
228* Codification of the Chevron Deference Doctrine
229* Supporting Penalties on Insurers Who Fail to Pay Doctors
230* Addressing and Reducing Patient Boarding in Emergency Departments
302 Strengthening Parental Leave Policies for Medical Trainees and Recent Graduates
304 Payment and Benefit Parity for Fellows
305 Removing Board Certification as a Requirement for Billing for Home Sleep Studies
306 Streamlining Continuing Medical Education Across States and Medical Specialties
601 Expanding AMA Meeting Venue Options
602 Delaying the ETF Endorsement Timeline Revision for Section IOP Revisions
604 Opposing Discrimination and Protecting Free Speech Among Member Organizations of Organized Medical Associations
605 AMA House of Delegates Expenses
606 Protecting Free Speech and Encouraging Respectful Discourse Among Member Organizations of Organized Medical Associations
607 AMA House of Delegates Venues
801 Reimbursement for Managing Portal Messages
802 Address Physician Burnout with Inbox Management Resources and Increased Payment
803 Healthcare Savings Account Reform
804 Improving Public Assistance for People with Disabilities
805 Coverage for Care for Sexual Assault Survivors
807 Expanded Pluralism in Medicaid
808 Requirement to Communicate Covered Alternatives for Denied Medications
809 Minimum Requirements for Medication Formularies
810 Immediate Digital Access to Updated Medication Formulary for Patients and Their Physicians
811 AMA Practice Expense Survey Geographic Analysis
812 Advocate for Therapy Cap Exception Process
813 Insurance Coverage for Pediatric Positioning Chairs
814 Legislation for Physician Payment for Prior Authorization
815 Addressing the Crisis of Pediatric Hospital Closures and Impact on Care
817 ACA Subsidies for Undocumented Immigrants
818 Payment for pre-certified/preauthorized procedures
819 Establishing a New Office-Based Facility Setting to Pay Separately from the Medicare Physician Fee Schedule for the Technical Reimbursement of Physician Services Using High-Cost Supplies

820 State Medicaid Coverage of Home Sleep Testing
821 Patient Access to Asthma Medications
822 Resolution on Medicare Coverage for Non-Emergent Dialysis Transport
823 Reigning in Medicare Advantage - Institutional Special Needs Plans
824 Ophthalmologists Required to Be Available for Level I & II Trauma Centers
825* Transparency of Facility Fees for Hospital Outpatient Department Visits
826* Renewing the Expansion of Premium Tax Credits
901 Heat Alerts and Response Plans
902 Advancing Menopause Research and Care
903 Improving the Identification of Intimate Partner Violence (IPV) in People with Disabilities
904 Regulation of Ionized Radiation Exposure for Healthcare Workers
905 Regulation and Transparency of Contaminants in Menstrual Hygiene Products
907 Call for Study: The Need for Hospital Interior Temperatures to be Thermally Neutral to Humans within Those Hospitals
909 Support of Universal School Meals for School Age Children
910 Food Insecurity Among Patients with Celiac Disease, Food Allergies, and Food Intolerance
911 Adequate Masking and HPV Education for Health Care Workers (including those over age 45)
912 Assuring Representation of Older Age Adults in Clinical Trials
913 Sexually Transmitted Infections are on the Rise in the Senior Population
915 Reducing Barriers in Sports Participation for LGBTQIA+ People
916 Access to Healthcare for Transgender and Gender Diverse People in the Carceral System
917 Mpox Global Health Emergency Recognition and Response
918 Healthcare in Tribal Jails
919 Improving Rural Access to Comprehensive Cancer Care Service
920 Revise FAA Regulations to Include Naloxone (Narcan) in the On-Board Medical Kit for Commercial Airlines flying within the Continental United States
922 Advocating for the Regulation of Pink Peppercorn as a Tree Nut
923 Updated Recommendations for Child Safety Seats
926 Development of Climate Health Education Tools for Physicians
928 Public Safety Agencies Data Collection Enhancement
929 Safety Concerns Regarding Inadequate Labeling of Food Products Upon Ingredient Changes with Known Major Food Allergens
930 Economic Factors to Promote Reliability of Pharmaceutical Supply
931* Mass Deportation as a Public Health Issue

--RESOLUTIONS NOT FOR CONSIDERATION—

203	Alternative Pathways for International Medical Graduates	B
209	Physician Liability for AI and Other Technological Advances in Medicine	B
224	Update the status of Virtual Credit card policy, EFT fees, and lack of Enforcement of Administrative Simplification Requirements by CMS	B
301	Reopening Schools Closed by the Flexner Report	C
303	Transparency and Access to Medical Training Program Unionization Status, Including Creation of a FREIDA Unionization Filter	C
307	Humanism in Anatomical Medical Education	C
603	Study of Grading Systems in AMA Board Reports	F
608*	Direct Election of Resident/Fellow Members of the AMA Board of Trustees and Various AMA Councils	F
806	Study of the Federal Employee Health Benefit Plan (FEHBP)	J
816	Study of CO-OP Insurance as a Vehicle for Public Healthcare Insurance Option	J
906	Call for Study: Should Petroleum-Powered Emergency Medical Services (EMS) Vehicles in Urban Service Areas be Replaced by Renewably-Powered Electric Vehicles?	K
908	Support for Doula Care Programs	K
914	Protecting the Healthcare Supply Chain from the Impacts of Climate Change	K
921	In Support of a National Drug Checking Registry	K
924	Public Health Implications of US Food Subsidies	K
925	Improving Public Awareness of Lung Cancer Screening and CAD in Chronic Smokers	K
927	The Creation of Healthcare Sustainability Lecture Series	K

*Contained in the meeting tote

Report of the AMPAC Board of Directors

Presented by: Brooke M. Buckley, MD
Chair

On behalf of the AMPAC Board of Directors, I am pleased to present this report to the House of Delegates regarding our activities this election cycle. The country continues to face a myriad of challenges in health care, including many that directly impact physician practices and their patients. Issues like the ever-looming cuts to physician Medicare payments, time consuming prior authorizations and sky rocketing prescription drug costs remain as major roadblocks to how physicians provide quality care for their patients.

The continuing challenges faced by the medical community have only strengthened our commitment to our core mission - to provide physicians with opportunities to support candidates for federal office who have demonstrated their support for organized medicine through a willingness to work with physicians to strengthen our ability to care for America's patients. In addition, we continue to help physician advocates grow their abilities through our political education programs, which include intensive training sessions that provide them with all the tools necessary to successfully take the next step and work on campaigns or run for office themselves.

AMPAC Membership Fundraising

Thank you to the House of Delegate members who contributed to AMPAC in 2024, especially those at the Capitol Club levels. AMPAC has shown continued growth this election cycle, with receipts now exceeding $1.69 million—a 6% increase compared to the previous cycle. Notably, AMPAC's hard dollars have risen by 7%. The Capitol Club currently boasts 715 members, and we anticipate further growth in participation during this Interim meeting.

Currently, the HOD State delegation's AMPAC participation is at 62%, which is notably lower than last year's 73%. We need your support. The backing of members within the House of Medicine is crucial as it empowers the AMA's advocacy team to effectively engage with lawmakers and policymakers, ensuring we can advance and protect your profession's interests. If you haven't yet contributed to AMPAC for 2024, or if you're interested in joining or renewing your AMPAC membership for 2025, we encourage you to visit AMPAC's booth in the AMA exhibit area or scan one of the many AMPAC QR codes located throughout the meeting area.

AMPAC is thrilled to introduce a new Capitol Club level for the 2025 membership year: Diamond, with a contribution of $5,000. This new level will bolster AMPAC's efforts and provide additional resources for AMA advocacy. We are also excited to host the Capitol Club luncheon on Monday, November 11 at 12:30 p.m. All current Capitol Club Diamond, Platinum, Gold, and Silver contributors are invited to this ticketed event, so stop by to get your ticket. Our special guest is Nate Silver, a pioneer in data journalism and founder of the acclaimed website FiveThirtyEight. Mr. Silver will share his insights on what pollsters got right and wrong with the election.

As one election cycle ends, a new one begins. Our effectiveness hinges on our unity and collective efforts to strengthen our AMA advocacy initiatives. Your ongoing support as leaders of the AMA House of Delegates is vital, so please consider making an AMPAC investment.

Political Action (as of 11/7/24)

In a deeply polarized electorate and in a highly competitive election cycle, AMPAC made an impactful mark on behalf of medicine investing nearly $2.4 million in the 2024 cycle. Both political parties underwent leadership changes in the House of Representatives in the 118th Congress. Despite a rough period of multiple and unprecedented leadership elections for the majority party in the House of Representatives, AMPAC was able to successfully navigate a path forward with both political parties. Working with state medical society partners and AMA Congressional Affairs, AMPAC provided prime access opportunities to build relationships and help advance medicine's legislative agenda with key decision makers in Congress on both sides of the aisle, strengthening many existing relationships and building new bonds with allies of medicine. Staff and physicians were able to inform members on the Hill and at home on issues of importance including Medicare physician payment reform, scope of practice, and prior authorization.

AMPAC spent more than $1.47 million in direct contributions to support 252 medicine-friendly House and Senate candidates from both political parties. These investments in friends of medicine will continue to ensure that the AMA has a place at the table when important health care policy debates take place. Nearly 30 race outcomes are still unknown as states continue to tabulate votes and report election results. Of those races that have been decided however, 88% of AMPAC-supported candidates won election/reelection.

AMPAC also invested over $915,000 in independent expenditures in support of two physician members of Congress running in two of the most competitive districts in the country this cycle: Rep. Mariannette Miller-Meeks, MD (R-IA) and Rep. Yadira Caraveo, MD (D-CO). AMPAC utilized a multi-media strategy to reach key demographics in each district to persuade voters to support these medicine-friendly candidates. Both of these races remain too close to call but both physicians are currently leading in their respective races and AMPAC remains optimistic that they will return to Congress.

The next Congress will tie or set a record number of physician members of Congress, at least in modern history. Several new physicians have been elected to the House of Representatives: Kelly Morrison, MD (D-MN), Bob Onder, MD (R-MO), Herb Conaway, MD (D-NJ), Maxine Dexter, MD (D-OR), and Mark Kennedy, MD (R-UT); all supported by AMPAC. Once all race results are finalized, the total number of physicians in the 119th Congress will be between 20 and 23.

Political Education Programs:

The 2024 Campaign School took place in-person, July 25 - 28, at the AMA offices in Washington, DC. Interest in the political education programs remains strong with 21 registrants for this year's program. Unfortunately, leading up to the program two participants had to withdraw leaving 19 members who participated. This included: 13 member physicians, two member spouses and four member students. Of these, two had also taken part in the 2024 Candidate Workshop in late March. The Campaign School is renowned for its use of a simulated campaign for the U.S. House of Representatives, complete with demographics, voting statistics and detailed candidate biographies. During the three-day program

participants were placed into campaign teams and with a hands-on approach, our team of bipartisan political experts walked them through a simulated campaign and applied what they learned in real-time exercises on strategy, vote targeting, social media, paid advertising, and public speaking. The program was capped off with a keynote session from former Maryland state delegate Dan Morhaim, MD who spoke about his experiences as a physician legislator. The program once again received high marks with 100% of participants rating the Campaign School as "extremely valuable" in helping them understand the basic elements of a successful political campaign and 100% reporting they "very much agreed" that the AMPAC Campaign School helped them increase their level of experience in building a winning campaign.

Planning is currently underway for the 2025 Candidate Workshop. AMPAC is working with the program's lead trainer to identify dates in the spring and the program will be held in-person again at the AMA offices in Washington, DC. As always, the political education programs remain a member benefit with registration fees heavily discounted for AMA members. Program dates will be announced soon on AMPAConline.org.

Conclusion:

On behalf of the AMPAC Board of Directors, I would like to thank all members of the House of Delegates who support AMPAC and the work we do. Your continued involvement in political and grassroots activities ensures organized medicine a powerful voice in Washington, DC.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Memorial Resolution

Hazle S. Konerding, MD

Introduced by Medical Society of Virginia

Whereas, an extraordinary wife, mother, grandmother, dermatologist, physician leader, advisor, and mentor to many, Hazle S. Konerding, MD, passed away on June 17, 2024; and

Whereas, Dr. Konerding was a Fairbanks, Alaska native, graduating from Choctawhatchee High School and pursuing her undergraduate degree at Northwestern University in Evanston, Illinois before completing her medical degree at the University of Miami School of Medicine, graduating with honors. She interned at the Florida Hospital in Orlando and completed her Dermatology residency at the Medical College of Virginia in Richmond. It was here Dr. Konerding began her career in academia, joining the faculty in the Department of Dermatology. Finally, she established her own private practice in Richmond as a Founding Partner and President of Commonwealth Dermatology until her retirement in 2021; and

Whereas, Hazle's career was distinguished by her active service to the profession for more than four decades. She was a valued member of the Medical Society of Virginia having served as the society's second female president. She later served on the MSV's Board of Directors, Executive Committee, Nominating Committee, MSVIA Board, and the MSV Foundation Board. MSV recognized her with both the Clancy Holland Award for advocacy and the Salute to Service Award for service to the profession. She served her profession regionally as the past president of the Richmond Academy of Medicine, Virginia Dermatological Society, and Richmond Dermatological Society. Additionally, she served on the Board of Directors for Bon Secours Richmond Health System, Access Now, and the Henricus Foundation. Dr. Konerding proudly served Virginia on its AMA Delegation for a decade; and

Whereas, Dr. Konerding became a physician in an era when few women chose to enter medicine, much less seek leadership positions. She was an inspiration and showed her daughters that a woman did not have to choose between motherhood and professional success, nor take a back-row seat when told that girls just didn't belong in leadership. Hazel will remain an inspiration to succeeding generations even in her absence; and

Whereas, Dr. Konerding is survived by her husband of 55 years, Karsten F. Konerding, M.D., her daughters Julia and Linda., her grandchildren Vaden, Anna, Caroline, and Charles, and her brothers-in-law, Erhard, Achim, and Jurgen; therefore be it

RESOLVED, in memoriam, that our American Medical Association recognizes the many contributions made by Dr. Hazle Konerding to the medical profession and the Commonwealth of Virginia and extend our deepest condolences to her colleagues and loved ones.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Supplementary Report of Committee on Rules and Credentials

Presented by: Robert H. Emmick, MD, Chair

Saturday, November 9, 2024

Madam Speaker, Members of the House of Delegates:

The Committee on Rules and Credentials met Friday, November 8, to discuss Late Resolutions. The sponsors of the late resolutions met with the committee and were given the opportunity to present for the committee's consideration the reason the resolution could not be submitted in a timely fashion and the urgency of consideration by the House of Delegates at this meeting.

Recommended for acceptance:

- LATE 1002 – Restoring Annual and Interim Meeting Schedule
- LATE 1003 – National Preparedness for IV Fluid Shortages

Recommended against acceptance:

- LATE 1001 – Establish Pregnancy as a Federal Qualifying Life Event Triggering a Special Enrollment Period

Madam Speaker, this concludes the Supplementary Report of the Committee on Rules and Credentials. I would like to thank Mark Bair, MD, RPh; Kyle P. Edmonds, MD; Christopher Gribbin, MD; Christopher McAdams, MD; Laura Stone McGuire, MD; and Anjlee Panjwani; and on behalf of the committee those who appeared before the committee.

Mark N. Bair, MD, RPh
Utah

Kyle P. Edmonds, MD
California

Robert H. Emmick, MD, Chair
Texas

Christopher Gribbin, MD
New Jersey

Christopher McAdams, MD
Georgia

Laura Stone McGuire, MD
Wisconsin

Anjlee Panjwani
New York

*Alternate Delegate

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: LATE 1001
(I-24)

Introduced by:	American Academy of Family Physicians, American College of Obstetricians and Gynecologists, American College of Physicians, Iowa Medical Society, Washington State Medical Association
Subject:	Establish Pregnancy as a Federal Qualifying Life Event Triggering a Special Enrollment Period
Referred to:	Reference Committee B

Whereas, the current Affordable Care Act (ACA) marketplace qualifying life events triggering a special enrollment period includes the birth of a child, but does not include pregnancy; and

Whereas, our American Medical Association, has existing policy (H-165.828 Health Insurance Affordability) supporting inclusion of pregnancy as qualifying life event for special enrollment period in the health insurance marketplace[1]; and

Whereas, the United States Department of Health and Human Services (HHS) has declined previous requests to establish pregnancy as a qualifying life event triggering a Special Enrollment Period [2]; and

Whereas, this causes a gap in insurance coverage for pregnant women because they earn too much to qualify for Medicaid, are not enrolled or eligible for employer-sponsored plans, and become pregnant outside of the Affordable Care Act (ACA) Marketplace Insurance enrollment period; and

Whereas, according to a 2024 report by the Center for Disease Control and Prevention (CDC), 41.3% of women nationally who gave birth used Medicaid, and 4.1% of women who gave birth were uninsured[3]; and

Whereas, a law passed in Iowa (Senate File 2251)[4] set to take effect in 2025 extends postpartum Medicaid coverage by ten months, funded by raising the income eligibility threshold for postpartum Medicaid coverage from 215% of the federal poverty level (FPL) to 375% of the FPL, causing an estimated 1,200 women and children to lose Medicaid coverage; and

Whereas, as of August 2024, 30 states use the federal marketplace for health insurance, where pregnancy is not recognized as a qualifying life event to obtain coverage[5]; and

Whereas, the United States has the highest maternal mortality rate despite the most healthcare spending. Over 80 percent of these deaths are likely preventable[6]; and

Whereas, women who do not receive prenatal care are three to four times more likely to die from pregnancy-related complications[7]; and

Whereas, infants born to mothers who do not receive prenatal care are three times more likely to have a low birth rate and five times more likely to die in infancy[8]; and

Whereas, severe maternal morbidity costs billions of dollars every year. Many of these costs could be avoided if people remain covered under Medicaid or other insurance and have their conditions addressed before they become severe[9]; therefore be it

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

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

Received: 10/17/2024

REFERENCES

1. https://policysearch.ama-assn.org/policyfinder/detail/H-165.828?uri=%2FAMADoc%2FHOD.xml-0-814.xml
2. Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016 80 Fed. Reg. 10750, 10798 (Feb. 27, 2015) (to be codified at 45 C.F.R. pts. 144, 147, 153-156, 158), https://www.gpo.gov/fdsys/pkg/FR-2015-02-27/pdf/2015-03751.pdf.
3. Osterman MJK, Hamilton BE, Martin JA, Driscoll AK, Valenzuela CP. Births: Final data for 2022. National Vital Statistics Reports; vol 73, no 2. Hyattsville, MD: National Center for Health Statistics. 2024. DOI: https://dx.doi.org/10.15620/cdc:145588.
4. https://www.legis.iowa.gov/legislation/BillBook?ga=90&ba=SF%202251
5. https://www.healthcare.gov/marketplace-in-your-state/#:~:text=California,the%20District%20of%20Columbia's%20website
6. Trost SL, Beauregard J, Njie F, et al. Pregnancy-Related Deaths: Data FFarom Maternal Mortality Review Committees in 36 US States, 2017-2019. Centers for Disease Control and Prevention, US Department of Health and Human Services; 2022
7. Association of Maternal & Child Health Programs, “Opportunities to Optimize Access to Prenatal Care through Health Transformation” (Washington: 2016), available at http://www.amchp.org/Policy-Advocacy/health-reform/resources/Documents/Pregnancy%20Issue%20Brief_Final%202016.pdf.
8. U.S. Department of Health and Human Services Office on Women’s Health, “Prenatal care,” available at https://www.womenshealth.gov/a-z-topics/prenatal-care
9. https://www.acog.org/-/media/project/acog/acogorg/files/advocacy/talkingpoints-extending-medicaid-coverage-for-pregnant-women-beyond-60-days-postpartum.pdf

RELEVANT AMA POLICY

Health Insurance Affordability H-165.828
Our AMA… (8) supports the inclusion of pregnancy as a qualifying life event for special enrollment in the health insurance marketplace. [CMS Rep. 8, I-15; Reaffirmed in lieu of: Res. 121, A-16; Reaffirmation: A-17; Reaffirmed: CMS Rep. 09, A-19; Reaffirmed: CMS Rep. 02, A-19; Reaffirmed in lieu of: Res. 101, A-19; Reaffirmed: CMS Rep. 01, I-20; Reaffirmed: CMS Rep. 2, I-20; Modified: CMS Rep. 3, I-21; Appended: Res. 701, I-21]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: LATE 1002
(I-24)

Introduced by: New York

Subject: Restoring Annual and Interim Meeting Schedule

Referred to: Reference Committee F

Whereas, the Board of Trustees Report 16-I-24 announced that, “the AMA will compress the schedule of both the Annual and Interim Meetings by eliminating one day from each meeting, thereby ending each meeting a day earlier...[to] be implemented at the Annual 2025 meeting of the HOD”; and

Whereas, this board report was posted online after the on-time resolution deadline, and there was no public mention of this decision prior to the release of the report; and

Whereas, the House of Delegates was not consulted in total and was not provided an opportunity vote on this decision directly pertaining to its activities; and

Whereas, effective governance and policy-making require sufficient time for thorough deliberation and consultation among delegates; therefore be it

RESOLVED, that our American Medical Association Board of Trustees restore the length of the Regular Meetings (Annual and Interim) of the House of Delegates to the length that occurred in 2024, and shall do so at the Annual Meeting of the House of Delegates in 2025 and continuing (Directive to Take Action); and be it further

RESOLVED, that any proposed changes to the structure or format of the Regular Meetings of the House of Delegates, including but not limited to duration, composition, or apportionment, be brought before the House for open discussion and approval by vote prior to implementation. (Directive to Take Action).

Fiscal Note: Minimal – less than $1,000

Received: 10/29/2024

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: LATE 1003
(I-24)

Introduced by: Society of Critical Care Medicine (SCCM), American College of Surgeons (ACS), International Medical Graduate (IMG) Section, American College of Chest Physicians (CHEST), American Thoracic Society (ATS), American College of Emergency Physicians (ACEP)

Subject: National Preparedness for IV Fluid Shortages

Referred to: Reference Committee K

Whereas, recent natural disasters, including Hurricanes Helene and Milton, have severely exacerbated existing shortages of intravenous (IV) fluids, leading to canceled surgeries and compromised patient care[1,2]; and

Whereas, IV fluids are essential, life-sustaining medications critical for patient care across all healthcare settings, particularly for vulnerable populations such as critically ill patients, pediatric patients, the elderly, and those with chronic conditions[3-8]; and

Whereas, the concentration of IV fluid production among a limited number of manufacturers creates vulnerability in the supply chain, with a single facility producing up to 60% of the nation's IV fluids[1,2]; and

Whereas, current evidence suggests that many IV fluids can remain safe and effective for several days under controlled conditions, potentially allowing for more flexible use during shortages[9,10]; and

Whereas, the FDA has issued temporary guidance allowing for expanded compounding of certain IV fluids by both outsourcing facilities and pharmacy compounders not registered as outsourcing facilities[11,12]; and

Whereas, the federal government has taken steps to address the current shortage, including invoking the Defense Production Act, expediting regulatory reviews, and allowing temporary importation of IV products[2]; and

Whereas, the Centers for Medicare & Medicaid Services (CMS) continues to enforce Sepsis Bundle (SEP-1) measures during IV fluid shortages, requiring specific fluid volumes and timing despite limited availability of these essential resources; and

Whereas, the current IV fluid shortage has not been declared a public health emergency by the Department of Health and Human Services (HHS), preventing CMS from invoking Section 1135 waivers[13-15] that would provide hospitals the flexibility in meeting quality measures, potentially resulting in financial penalties for hospitals unable to meet quality metrics, such as SEP-1, due to circumstances beyond their control; therefore be it

RESOLVED, that our American Medical Association advocates that the Secretary of Health and Human Services declare a public health emergency during critical medication and supply

shortages, including IV fluids, to enable regulatory flexibility and resource allocation when such shortages significantly impact patient care delivery (Directive to Take Action); and be it further

RESOLVED, that our AMA urges the Centers for Medicare & Medicaid Services to implement policies to temporarily halt financial and other penalties for affected quality metrics during periods of documented medication and IV fluid shortages in order to prevent physicians and hospitals from being penalized for circumstances beyond their control (Directive to Take Action); and be it further

RESOLVED, that our AMA works with relevant stakeholders to prevent and mitigate all critical medications and medical supplies, including designating production facilities as critical infrastructure, supporting health system contingency planning, and developing a national strategic reserve (Directive to Take Action).

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

Received: 11/4/2024

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RELEVANT AMA POLICY

National Drug Shortages (H-100.956)

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

contractually require manufacturers to disclose their quality rating, when available, on product labeling.

16. Our AMA encourages electronic health records (EHR) vendors to make changes to their systems to ease the burden of making drug product changes.
17. Our AMA urges the FDA to evaluate and provide current information regarding the quality of outsourcer compounding facilities.
18. Our AMA urges DHHS and the U.S. Department of Homeland Security (DHS) to examine and consider drug shortages as a national security initiative and include vital drug production sites in the critical infrastructure plan.
19. Our AMA urges the Drug Enforcement Agency and other federal agencies to regularly communicate and consult with the FDA regarding regulatory actions which may impact the manufacturing, sourcing, and distribution of drugs and their ingredients.
20. Our AMA supports innovative approaches for diversifying the generic drug manufacturing base to move away from single-site manufacturing, increasing redundancy, and maintaining a minimum number of manufacturers for essential medicines.
21. Our AMA supports the public availability of FDA facility inspection reports to allow purchasers to better assess supply chain risk.
22. Our AMA opposes the practice of preferring drugs experiencing a shortage on approved pharmacy formularies when other, similarly effective drugs are available in adequate supply but otherwise excluded from formularies or coverage plans.
23. Our AMA shall continue to monitor proposed methodologies for and the implications of a buffer supply model for the purposes of reducing drug shortages and will report its findings as necessary. Most Recent Policy Timeline: Modified: CSAPH Rep. 1, I-23

National Shortages of Lidocaine, Saline Preparation, and Iodinated Contrast Media (D-120.925)
Our American Medical Association will work with national specialty societies and other relevant stakeholders to advocate that the FDA take direct and prompt actions to alleviate current national shortages of lidocaine, normal saline preparations, and iodinated contrast media.
Most Recent Policy Timeline: Res. 223, A-22

Non-Profit or Public Manufacturing of Drugs to Address Generic Drug Shortages (H-100.942)

1. Our American Medical Association supports activities which may lead to the stabilization of the generic drug market by non-profit or public entities. Stabilization of the market may include, but is not limited to, activities such as government-operated manufacturing of generic drugs, the manufacturing or purchasing of the required active pharmaceutical ingredients, or fill-finish. Non-profit or public entities should prioritize instances of generic drugs that are actively, at-risk of, or have a history of being, in shortage, and for which these activities would decrease reliance on a small number of manufacturers outside the United States.
2. Our AMA encourages government entities to stabilize the generic drug supply market by piloting innovative incentive models for private companies which do not create artificial shortages for the purposes of obtaining said incentives.
   Most Recent Policy Timeline: CSAPH Rep. 1, I-23

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (I-24)

Agenda

Reference Committee on Amendments to Constitution and Bylaws

In-Person Hearing

Carlos Latorre, MD, Chair

RECOMMENDED FOR ADOPTION

1. BOT Report 014 – Privacy Protection and Prevention of Further Trauma for Victims of Distribution of Intimate Videos and Images Without Consent
2. CCB Report 01 – Resolution Deadline Clarification
3. CCB Report 02 – Name Change for Reference Committee
4. CEJA Report 01 – Expanding Access to Palliative Care
5. CEJA Report 02 – Protecting Physicians Who Engage in Contracts to Deliver Health Care Services
6. Resolution 003 – On the Ethics of Human Lifespan Prolongation
7. Resolution 004 – Improving Usability of Electronic Health Records for Transgender and Gender Diverse Patients
8. Resolution 006 – Opposition to the Deceptive Relocation of Migrants and Asylum Seekers
9. Resolution 007 – Supporting Diversity in Research
10. Resolution 008 – Missing and Murdered Black Women and Girls

RECOMMENDED FOR ADOPTION AS AMENDED

11. BOT Report 08 – Increasing Access to Medical Care for People Seeking Asylum
12. BOT Report 18 – Expanding Protections at the End-of-Life Care
13. CCB Report 03 – Bylaw Amendments to Address Medical Student Leadership
14. Resolution 001 – Addressing Gender-Based Pricing Disparities
15. Resolution 002 – Anti-Doxxing Data Privacy Protection
16. Resolution 005 – Updating the American Medical Association Definition of Infertility

RECOMMENDED FOR REFERRAL

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

RECOMMENDATION NOT YET DETERMINED

18. BOT Report 22 -Specialty Society Representation in the House of Delegates - Five-Year Review
19. BOT Report 23 - Advocating for the Informed Consent for Access to Transgender Health
20. BOT Report 24 - Physicians Arrested for Non-Violent Crimes While Engaging in Public Protests
21. Resolution 010 - Development of Resources for Medical Staffs to Engage in Collective Negotiation with Hospital and Health Systems
22. Resolution 011 - American Kidney Donation Legislation

Please send amendments and any documentation to:
ama.refcom.ccb@gmail.com

Livestream of Reference Committee Hearing: Zoom Link

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (I-24)

Agenda

Reference Committee B

In-Person Hearing

Dale Mandel, Chair

RECOMMENDED FOR ADOPTION

1. BOT 02 - On-Site Physician Requirements for Emergency Departments
2. BOT 06 - Health Technology Accessibility for Aging Patients
3. BOT 09 - Corporate Practice of Medicine Prohibition
4. 204 - Support for Physician-Supervised Community Paramedicine Programs
5. 205 - Native American Medical Debt
6. 210 – Laser Surgery
7. 211 – Water Bead Injuries
8. 212 - Addressing the Unregulated Body Brokerage Industry
9. 213 - Sustainable Long-term Funding for Child Psychiatry Access Programs
10. 214 - Advocating for Evidence-Based Strategies to Improve Rural Obstetric Health Care and Access

Note: During the reference committee hearing, supplemental material may be sent to RefComB@ama-assn.org. Supplemental material includes items that have been referenced in testimony such as alternative wording, proposed amendments, and supporting documents. This email address is NOT intended as a means to provide testimony, which should only be presented in on the Online Forum or orally to the committee.

When you email your amendment, you will receive a response, indicating that staff has received it. If you do not receive a response, we did NOT receive it and you must resend. Amendments must be formatted correctly with strikethroughs and underlines.

A Zoom webinar link is provided below. Registration is required to view the meeting via Zoom. The link is view-only. Testimony cannot be accepted via Zoom.

https://events.zoom.us/ev/Ar3azOEPBoO0NuZQ4mR79YtN9ipXgJ8L7HiP3rkbB7ixxj9g3bf9~AnRboKCatXyP7h5B6GSoyNXE5ow4VvqHOIimsNUE-MkZfcVWta8lkSmvpw

11. 222 - Rollback on Physician Performance Measures
12. 226 - Information Blocking Rule

RECOMMENDED FOR ADOPTION AS AMENDED

13. BOT 01 – Assessing the Intersection Between AI and Health Care
14. BOT 03 – Reforming Stark Laws Blanket Self-Referral Ban
15. BOT 04 – Addressing Work Requirements For J-1 Visa Waiver Physicians
16. 201 – Boarding Patients in the Emergency Room
17. 202 – Illicit Drugs: Calling for a Multifaceted Approach to the "Fentanyl" Crisis
18. 206 – Protect Infant and Young Child Feeding
19. 207 - Accountability for G-605.009: Requesting A Task Force to Preserve the Patient-Physician Relationship Task Force Update and Guidance
20. 208 - Medicare Part B Enrollment and Penalty Awareness
21. 216 - Clearing Federal Obstacles for Supervised Injection Sites

RECOMMENDED FOR NOT ADOPTION

22. 221 - Medicare Coverage for Non-PAR Physicians

RECOMMENDED FOR REAFFIRMATION IN LIEU OF

23. 215 - Advocating for Federal and State Incentives for Recruitment and Retention of Physicians to Practice in Rural Areas
24. 217 - Expand Access to Skilled Nursing Facility Services for Patients with Opioid Use Disorder
25. 218 - Time Sensitive Credentialing of New Providers with an Insurance Carrier

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26. 219 - Advocate to Continue Reimbursement for Telehealth / Telemedicine Visits Permanently
27. 220 – MIPS Reform
28. 223 - Mandated Economic Escalators in Insurance Contracts
29. 225 - Elimination of Medicare 14-Day Rule
30. 227 - Medicare Payment Parity for Telemedicine Services

RECOMMENDATION NOT YET DETERMINED

31. 228 – Codification of the Chevron Deference Doctrine
32. 229 - Supporting Penalties on Insurers Who Fail to Pay Doctors
33. 230 - Addressing and Reducing Patient Boarding in Emergency Departments
34. *Late Resolution 1001 - Establish Pregnancy as a Federal Qualifying Life Event Triggering a Special Enrollment Period*

RECOMMENDED AGAINST CONSIDERATION

35. *203 - Alternative Pathways for International Medical Graduates*
36. *209 - Physician Liability for AI and Other Technological Advances in Medicine*
37. *224 - Update the status of Virtual Credit card policy, EFT fees, and lack of Enforcement of Administrative Simplification Requirements by CMS*

** Items in italics will be considered based on HOD action at the Second Opening Session.*

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (I-24)

Agenda

Reference Committee C, In-Person Hearing

1:00PM EST in South Hemisphere Salon I, Zoom

Cheryl Gibson Fountain, MD, Chair

RECOMMENDED FOR ADOPTION

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

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

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

RECOMMENDED FOR ADOPTION AS AMENDED

4. Resolution 304 - Payment and Benefit Parity for Fellows

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

RECOMMENDED FOR REFERRAL

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

RECOMMENDATION NOT YET DETERMINED

None

RECOMMENDED AGAINST RECONSIDERATION

7. Resolution 301 - Reopening Schools Closed by the Flexner Report

8. Resolution 303 - Transparency and Access to Medical Training Program Unionization Status, Including Creation of a FREIDA Unionization Filter

9. Resolution 307 - Humanism in Anatomical Medical Education

Notes:

- Amendments and supplemental material for Ref Com C must be sent to meded@ama-assn.org.
- Business items (e.g., Handbook, Meeting Tote)
- Preliminary Report of Ref Com C
- Online Reference Committees
- For technical assistance, email HODMeetingSupport@ama-assn.org or call 800-337-1599.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (I-24)

Agenda
Reference Committee F
In-Person Hearing

Michael B. Simon, MD, MBA, Chair

RECOMMENDED FOR ADOPTION

1. Report of the House of Delegates Committee on the Compensation of the Officers
2. Council on Long Range Planning and Development Report 1 - Academic Physicians Section Five-Year Review

RECOMMENDED FOR ADOPTION AS AMENDED

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

RECOMMENDED FOR ADOPTION IN LIEU OF

4. Board of Trustees Report 16 - AMA Reimbursement of Necessary HOD Business Meeting Expenses for Delegates and Alternates
   Resolution 605 - AMA House of Delegates Expenses

RECOMMENDED FOR NOT ADOPTION

5. Resolution 601 - Expanding AMA Meeting Venue Options
6. Resolution 602 - Delaying the ETF Endorsement Timeline Revision for Section IOP Revisions
7. Resolution 607 - AMA House of Delegates Venues

RECOMMENDED FOR REAFFIRMATION IN LIEU OF

8. Resolution 604 - Opposing Discrimination and Protecting Free Speech Among Member Organizations of Organized Medical Associations
9. Resolution 606 - Protecting Free Speech and Encouraging Respectful Discourse Among Member Organizations of Organized Medical Associations

RECOMMENDATION NOT YET DETERMINED

10. Board of Trustees Report 25 - World Medical Association Observer Status in the House of Delegates
11. Resolution 608 - Direct Election of Resident/Fellow Members of the AMA Board of Trustees and Various AMA Councils
12. *LATE 1002 - Restoring Annual and Interim Meeting Schedule*

RECOMMENDED AGAINST CONSIDERATION

13. *Resolution 603 - Study of Grading Systems in AMA Board Reports*

** Items in italics will be considered based on HOD action at the Second Opening Session.*

Zoom Link:
https://events.zoom.us/ev/Ar3azOEPBoO0NuZQ4mR79YtN9ipXgJ8L7HiP3rkbB7ixxj9g3bf9~AnRboKCatXyP7h5B6GSoyNXE5ow4VvqHOIimsNUE-MkZfcVWta8lkSmvpw

Please email amendment language or additional information to referencecommitteef@gmail.com.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (I-24)

Agenda

Reference Committee J
In-Person Hearing

Dr. Shawn Baca, Chair

RECOMMENDED FOR ADOPTION

1. Board of Trustees Report 05 – Protecting the Health of Incarcerated People
2. Board of Trustees Report 13 – AMA/Specialty Society RVS Update Committee
3. Council on Medical Service Report 2 – Unified Financing Health Care System
4. Council on Medical Service Report 3 – Time-Limited Patient Care
5. Resolution 804 – Improving Public Assistance for People with Disabilities
6. Resolution 808 – Requirement to Communicate Covered Alternatives for Denied Medications
7. Resolution 812 – Advocate for Therapy Cap Exception Process
8. Resolution 813 – Insurance Coverage for Pediatric Positioning Chairs
9. Resolution 824 – Ophthalmologists Required to Be Available for Level I & II Trauma Centers

RECOMMENDED FOR ADOPTION AS AMENDED

10. Board of Trustees Report 15 – Published Metrics for Hospitals and Hospital Systems
11. Council on Medical Service Report 1 – Nonprofit Hospital Charity Care Policies
12. Council on Medical Service Report 4 – Biosimilar Coverage Structures
13. Resolution 805 – Coverage for Sexual Assault Survivors
14. Resolution 810 – Immediate Digital Access to Updated Medication Formulary for Patients
15. Resolution 811 – AMA Practice Expense Survey Geographic Analysis
16. Resolution 815 – Addressing the Crisis of Pediatric Hospital Closures and Impact on Care
17. Resolution 818 – Payment for Pre-Certification/Preauthorization Procedures
18. Resolution 820 – State Medicaid Coverage of Home Sleep Testing
19. Resolution 821 – Patient Access to Asthma Medications
20. Resolution 823 – Reining in Medicare Advantage – Institutional Special Needs Plans

RECOMMENDED FOR REFERRAL

21. Resolution 803 – Healthcare Savings Account Reform
    Resolution 807 – Expanded Pluralism in Medicaid

Amendments and supplemental materials MUST be sent to ReferenceCommitteeJ@gmail.com. Please include the Resolution or Report number in the subject line. Do not send testimony to this email address. This address is only operational for the duration of the Reference Committee J hearing.

Note: Items in *italics* were originally placed on the reaffirmation consent calendar, were late items, or originally listed under the "Do Not Consider" tab. At the beginning of the reference committee hearing, the chair will identify those items that will **not** be discussed in the hearing, and these items will **not** be considered by the reference committee.

A Zoom webinar link is provided below. Registration is required to view the zoom. This link is view-only. Testimony cannot be accepted via Zoom. https://events.zoom.us/ev/Ar3azOEPBoO0NuZQ4mR79YtN9ipXgJ8L7HiP3rkbB7ixxj9g3bf9~AnRboKCatXyP7h5B6GSoyNXE5ow4VvqHOlimsNUE-MkZfcVWta8lkSmvpw

RECOMMENDED FOR REFERRAL FOR DECISION

22. Resolution 814 – Legislation for Physician Payment for Prior Authorization

RECOMMENDED FOR NOT ADOPTION

23. Resolution 809 – Minimum Requirements for Medication Formularies

RECOMMENDED FOR REAFFIRMATION IN LIEU OF

24. Resolution 801 – Reimbursement for Managing Portal Messages
25. Resolution 802 – Address Physician Burnout with Inbox Management Resources and Increased Payment
26. Resolution 817 – ACA Subsidies for Undocumented Immigrants
27. Resolution 819 – Establishing a New Office-Based Facility Setting to Pay Separately from the Medicare Physician Fee Schedule for the Technical Reimbursement of Physician Services Using High-Cost Supplies
28. Resolution 822 – Resolution on Medicare Coverage for Non-Emergent Dialysis Transport

RECOMMENDATION NOT YET DETERMINED

29. Resolution 825 - Transparency of Facility Fees for Hospital Outpatient Department Visits
30. Resolution 826 - Renewing the Expansion of Premium Tax Credits

RECOMMENDED AGAINST CONSIDERATION

31. Resolution 806 - Study of Federal Employee Health Benefit Plan (FEHBP)
32. Resolution 816 - Exploring CO-OP Insurance for Public Healthcare

[AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (I-24)

Agenda

Reference Committee K

In-Person Hearing

Cynthia Romero, MD; Chair

RECOMMENDED FOR ADOPTION

1. BOT 07 - Reevaluation of Scoring Criteria for Rural Communities in the National Health Service Corps Loan Repayment Program
2. BOT 11 - Carbon Pricing to Address Climate Change
3. CSAPH 01 - Cannabis Therapeutic Claims in Marketing and Advertising
4. CSAPH 03 - HPV-Associated Cancer Prevention
5. Resolution 903 - Improving the Identification of Intimate Partner Violence (IPV) in People with Disabilities
6. Resolution 909 - Support of Universal School Meals for School Age Children
7. Resolution 910 - Food Insecurity Among Patients with Celiac Disease, Food Allergies, and Food Intolerance
8. Resolution 915 - Reducing Barriers in Sports Participation for LGBTQIA+ People
9. Resolution 916 - Access to Healthcare for Transgender and Gender Diverse People in the Carceral System
10. Resolution 917 - Mpox Global Health Emergency Recognition and Response
11. Resolution 918 - Healthcare in Tribal Jails
12. Resolution 928 - Public Safety Agencies Data Collection Enhancement
13. Resolution 929 - Safety Concerns Regarding Inadequate Labeling of Food Products Upon Ingredient Changes with Known Major Food Allergens

RECOMMENDED FOR ADOPTION AS AMENDED

14. CSAPH 04 - Reducing Sodium Intake to Improve Public Health
15. CSAPH 05 - Teens and Social Media

Zoom link to hearing (view only webinar)
https://events.zoom.us/ev/Ar3azOEPBoO0NuZQ4mR79YtN9ipXgJ8L7HiP3rkbB7ixxj9g3bf9~AnRboKCatXyP7h5B6GSoyNXE5ow4VvqHOIimsNUE-MkZfcVWta8lkSmvpw

During the reference committee hearing, supplemental material may be sent to RefCommK@gmail.com. Supplemental material includes items that have been referenced in testimony such as alternative wording, proposed amendments, and supporting documents. This email address is NOT intended as a means to provide testimony, which should be only be presented in on the Online Reference Committee or orally to the committee. This address is only operational for the duration of the reference committee hearing.

16. Resolution 901 - Heat Alerts and Response Plans
17. Resolution 902 - Advancing Menopause Research and Care
18. Resolution 904 - Regulation of Ionized Radiation Exposure for Healthcare Workers
19. Resolution 905 - Regulation and Transparency of Contaminants in Menstrual Hygiene Products
20. Resolution 907 - Call for Study: The Need for Hospital Interior Temperatures to be Thermally Neutral to Humans within Those Hospitals
21. Resolution 912 - Assuring Representation of Older Age Adults in Clinical Trials
22. Resolution 913 - Sexually Transmitted Infections are on the Rise in the Senior Population
23. Resolution 919 - Improving Rural Access to Comprehensive Cancer Care Service
24. Resolution 922 - Advocating for the Regulation of Pink Peppercorn as a Tree Nut

RECOMMENDED FOR ADOPTION IN LIEU OF

25. CSAPH 02 - Drug Shortages: 2024 Update
    Resolution 930 - Economic Factors to Promote Reliability of Pharmaceutical Supply
26. Resolution 923 - Updated Recommendations for Child Safety Seats

RECOMMENDED FOR REAFFIRMATION IN LIEU OF

27. Resolution 911 - Adequate Masking and HPV Education for Health Care Workers (including those over age 45)
28. Resolution 920 - Revise FAA Regulations to Include Naloxone (Narcan) in the On-Board Medical Kit for Commercial Airlines flying within the Continental United States

RECOMMENDATION NOT YET DETERMINED

29. Resolution 931 - Mass Deportation as a Public Health Issue

Zoom link to hearing (view only webinar)
https://events.zoom.us/ev/Ar3azOEPBoO0NuZQ4mR79YtN9ipXgJ8L7HiP3rkbB7ixxj9g3bf9~AnRboKCatXyP7h5B6GSoyNXE5ow4VvqHOlimsNUE-MkZfcVWta8lkSmvpw

During the reference committee hearing, supplemental material may be sent to RefCommK@gmail.com. Supplemental material includes items that have been referenced in testimony such as alternative wording, proposed amendments, and supporting documents. This email address is NOT intended as a means to provide testimony, which should be only be presented in on the Online Reference Committee or orally to the committee. This address is only operational for the duration of the reference committee hearing.

30. Late 1003 - National Preparedness for IV Fluid Shortages

RECOMMENDED AGAINST CONSIDERATION

31. Resolution 906 - Call for Study: Should Petroleum-Powered Emergency Medical Services (EMS) Vehicles in Urban Service Areas be Replaced by Renewably-Powered Electric Vehicles?
32. Resolution 908 - Support for Doula Care Programs
33. Resolution 914 - Protecting the Healthcare Supply Chain from the Impacts of Climate Change
34. Resolution 921 - In Support of a National Drug Checking Registry
35. Resolution 924 - Public Health Implications of US Food Subsidies
36. Resolution 925 - Improving Public Awareness of Lung Cancer Screening and CAD in Chronic Smokers
37. Resolution 927 - The Creation of Healthcare Sustainability Lecture Series

** Items in italics will be considered based on HOD action at the Second Opening Session.*

Zoom link to hearing (view only webinar)
https://events.zoom.us/ev/Ar3azOEPBoO0NuZQ4mR79YtN9ipXgJ8L7HiP3rkbB7ixxj9g3bf9~AnRboKCatXyP7h5B6GSoyNXE5ow4VvqHOlimsNUE-MkZfcVWta8lkSmvpw

During the reference committee hearing, supplemental material may be sent to RefCommK@gmail.com. Supplemental material includes items that have been referenced in testimony such as alternative wording, proposed amendments, and supporting documents. This email address is NOT intended as a means to provide testimony, which should be only be presented in on the Online Reference Committee or orally to the committee. This address is only operational for the duration of the reference committee hearing.

Reference Committee on Amendments to Constitution and Bylaws

Report(s) of the Board of Trustees

08 Increasing Access to Medical Care for People Seeking Asylum
14 Privacy Protection and Prevention of Further Trauma for Victims of Distribution of Intimate Videos and Images Without Consent
18 Expanding Protections of End-of-Life Care
22* Specialty Society Representation in the House of Delegates - Five-Year Review
23* Advocating for the Informed Consent for Access to Transgender Health Care
24* Physicians Arrested for Non-Violent Crimes While Engaged in Public Protests

Report(s) of the Council on Constitution and Bylaws

01 Resolution Deadline Clarification
02 Name Change for Reference Committee
03 Bylaw Amendments to Address Medical Student Leadership

Report(s) of the Council on Ethical and Judicial Affairs

01 Expanding Access to Palliative Care
02 Protecting Physicians Who Engage in Contracts to Deliver Health Care Services

Resolutions

001 Addressing Gender-Based Pricing Disparities
002 Anti-Doxxing Data Privacy Protection
003 On the Ethics of Human Lifespan Prolongation
004 Improving Usability of Electronic Health Records for Transgender and Gender Diverse Patients
005 Updating the AMA Definition of Infertility
006 Opposition to the Deceptive Relocation of Migrants and Asylum Seekers
007 Supporting Diversity in Research
008 Missing and Murdered Black Women and Girls
009 Opposition to Creation or Enforcement of Civil Litigation, Commonly Referred to as Civil Causes of Action
010* Development of Resources for Medical Staffs to Engage in Collective Negotiation with Hospital and Health Systems
011* American Kidney Donation Legislation

*Contained in the meeting tote

Reference Committee B

Report(s) of the Board of Trustees

01	Augmented Intelligence Development, Deployment, and Use in Health Care
02	On-Site Physician Requirements for Emergency Departments
03	Stark Law Self-Referral Ban
04	Addressing Work Requirements For J-1 Visa Waiver Physicians
06	Health Technology Accessibility for Aging Patients
09	Corporate Practice of Medicine Prohibition

Resolutions

201	Boarding Patients in the Emergency Room
202	Illicit Drugs: Calling for a Multifaceted Approach to the “Fentanyl” Crisis
204	Support for Physician-Supervised Community Paramedicine Programs
205	Native American Medical Debt
206	Protect Infant and Young Child Feeding
207	Accountability for G-605.009: Requesting A Task Force to Preserve the Patient-Physician Relationship Task Force Update and Guidance
208	Medicare Part B Enrollment and Penalty Awareness
210	Laser Surgery
211	Water Bead Injuries
212	Addressing the Unregulated Body Brokerage Industry
213	Sustainable Long-term Funding for Child Psychiatry Access Programs
214	Advocating for Evidence-Based Strategies to Improve Rural Obstetric Health Care and Access
215	Advocating for Federal and State Incentives for Recruitment and Retention of Physicians to Practice in Rural Areas
216	Clearing Federal Obstacles for Supervised Injection Sites
217	Expand Access to Skilled Nursing Facility Services for Patients with Opioid Use Disorder
218	Time Sensitive Credentialing of New Providers with an Insurance Carrier
219	Advocate to Continue Reimbursement for Telehealth / Telemedicine Visits Permanently
220	MIPS Reform
221	Medicare Coverage for Non-PAR Physicians
222	Rollback on Physician Performance Measures
223	Mandated Economic Escalators in Insurance Contracts
225	Elimination of Medicare 14-Day Rule
226	Information Blocking Rule
227	Medicare Payment Parity for Telemedicine Services
228*	Codification of the Chevron Deference Doctrine
229*	Supporting Penalties on Insurers Who Fail to Pay Doctors
230*	Addressing and Reducing Patient Boarding in Emergency Departments

*Contained in the meeting tote

Reference Committee C

Report(s) of the Council on Medical Education

01 Medication Reconciliation Education
02 Updates to Recommendations for Future Directions for Medical Education

Resolutions

302 Strengthening Parental Leave Policies for Medical Trainees and Recent Graduates
304 Payment and Benefit Parity for Fellows
305 Removing Board Certification as a Requirement for Billing for Home Sleep Studies
306 Streamlining Continuing Medical Education Across States and Medical Specialties

Reference Committee F

Report(s) of the Board of Trustees

16 AMA Reimbursement of Necessary HOD Business Meeting Expenses for Delegates and Alternates

25* World Medical Association Observer Status in the House of Delegates

Report(s) of the Council on Long Range Planning and Development

01 Academic Physicians Section Five-Year Review

Report(s) of the HOD Committee on Compensation of the Officers

01 Report of the House of Delegates Committee on Compensation of the Officers

Report(s) of the Speakers

01 Report of the Election Task Force 2

Resolutions

601 Expanding AMA Meeting Venue Options

602 Delaying the ETF Endorsement Timeline Revision for Section IOP Revisions

604 Opposing Discrimination and Protecting Free Speech Among Member Organizations of Organized Medical Associations

605 AMA House of Delegates Expenses

606 Protecting Free Speech and Encouraging Respectful Discourse Among Member Organizations of Organized Medical Associations

607 AMA House of Delegates Venues

*Contained in the meeting tote

Reference Committee J

Report(s) of the Board of Trustees

05 Protecting the Health of Incarcerated Patients
13 AMA/Specialty Society RVS Update Committee
15 Published Metrics for Hospitals and Hospital Systems

Report(s) of the Council on Medical Service

01 Nonprofit Hospital Charity Care Policies
02 Unified Financing Health Care System
03 Time-Limited Patient Care
04 Biosimilar Coverage Structures

Resolutions

801 Reimbursement for Managing Portal Messages
802 Address Physician Burnout with Inbox Management Resources and Increased Payment
803 Healthcare Savings Account Reform
804 Improving Public Assistance for People with Disabilities
805 Coverage for Care for Sexual Assault Survivors
807 Expanded Pluralism in Medicaid
808 Requirement to Communicate Covered Alternatives for Denied Medications
809 Minimum Requirements for Medication Formularies
810 Immediate Digital Access to Updated Medication Formulary for Patients and Their Physicians
811 AMA Practice Expense Survey Geographic Analysis
812 Advocate for Therapy Cap Exception Process
813 Insurance Coverage for Pediatric Positioning Chairs
814 Legislation for Physician Payment for Prior Authorization
815 Addressing the Crisis of Pediatric Hospital Closures and Impact on Care
817 ACA Subsidies for Undocumented Immigrants
818 Payment for pre-certified/preauthorized procedures
819 Establishing a New Office-Based Facility Setting to Pay Separately from the Medicare Physician Fee Schedule for the Technical Reimbursement of Physician Services Using High-Cost Supplies
820 State Medicaid Coverage of Home Sleep Testing
821 Patient Access to Asthma Medications
822 Resolution on Medicare Coverage for Non-Emergent Dialysis Transport
823 Reigning in Medicare Advantage - Institutional Special Needs Plans
824 Ophthalmologists Required to Be Available for Level I & II Trauma Centers
825* Transparency of Facility Fees for Hospital Outpatient Department Visits
826* Renewing the Expansion of Premium Tax Credits

*Contained in the meeting tote

Reference Committee K

Report(s) of the Board of Trustees

07 Reevaluation of Scoring Criteria for Rural Communities in the National Health Service Corps Loan Repayment Program
11 Carbon Pricing to Address Climate Change

Report(s) of the Council on Science and Public Health

01 Cannabis Therapeutic Claims in Marketing and Advertising
02 Drug Shortages: 2024 Update
03 HPV-Associated Cancer Prevention
04 Reducing Sodium Intake to Improve Public Health
05 Teens and Social Media

Resolutions

901 Heat Alerts and Response Plans
902 Advancing Menopause Research and Care
903 Improving the Identification of Intimate Partner Violence (IPV) in People with Disabilities
904 Regulation of Ionized Radiation Exposure for Healthcare Workers
905 Regulation and Transparency of Contaminants in Menstrual Hygiene Products
907 Call for Study: The Need for Hospital Interior Temperatures to be Thermally Neutral to Humans within Those Hospitals
909 Support of Universal School Meals for School Age Children
910 Food Insecurity Among Patients with Celiac Disease, Food Allergies, and Food Intolerance
911 Adequate Masking and HPV Education for Health Care Workers (including those over age 45)
912 Assuring Representation of Older Age Adults in Clinical Trials
913 Sexually Transmitted Infections are on the Rise in the Senior Population
915 Reducing Barriers in Sports Participation for LGBTQIA+ People
916 Access to Healthcare for Transgender and Gender Diverse People in the Carceral System
917 Mpox Global Health Emergency Recognition and Response
918 Healthcare in Tribal Jails
919 Improving Rural Access to Comprehensive Cancer Care Service
920 Revise FAA Regulations to Include Naloxone (Narcan) in the On-Board Medical Kit for Commercial Airlines flying within the Continental United States
922 Advocating for the Regulation of Pink Peppercorn as a Tree Nut
923 Updated Recommendations for Child Safety Seats
928 Public Safety Agencies Data Collection Enhancement
929 Safety Concerns Regarding Inadequate Labeling of Food Products Upon Ingredient Changes with Known Major Food Allergens
930 Economic Factors to Promote Reliability of Pharmaceutical Supply
931* Mass Deportation as a Public Health Issue

*Contained in meeting tote

REVISED

REPORT OF THE BOARD OF TRUSTEES

B of T Report 18-I-24

Subject: Expanding Palliative Care (Resolution 722-A-23)

Presented by: Michael Suk, MD, JD, MPH, MBA, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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At the 2023 Annual Meeting, the House of Delegates (HOD) referred Resolution 722, "Expanding Protections of End-of-Life Care," authored by the New York Delegation which asks our American Medical Association (AMA):

(1) recognizes that health care, including end of life care like hospice, is a human right,

(2) supports the education of medical students, residents and physicians about the need for physicians who provide end of life health care services,

(3) supports the medical and public health importance of access to safe end of life health care services and the medical, ethical, legal and psychological principles associated with end-of-life care,

(4) supports education of physicians and lay people about the importance of offering medications to treat distressing symptoms associated with end of life including dyspnea, air hunger, and pain,

(5) will work with interested state medical societies and medical specialty societies to vigorously advocate for broad, equitable access to end-of-life care,

(6) supports shared decision-making between patients and their physicians regarding end-of-life health care,

(7) opposes limitations on access to evidence-based end of life care services,

(8) opposes the imposition of criminal and civil penalties or other retaliatory efforts against physicians for receiving, assisting in, referring patients to, or providing end of life health care services.

This report provides relevant background, discussion, and recommendations.

BACKGROUND

The leading causes of death in the United States are associated with chronic illness in which the patient experiences long durations of symptom burden, medical treatments and interventions, and diminished quality of life [1]. As chronic illness progresses to serious and critical illness, death may be anticipated; however, patients and their families are often unprepared for the emotional

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burden of making life-sustaining and/or prolonging medical decisions during treatment of serious and critical illness [2]. As a result, many patients experience physical suffering and receive life-sustaining and/or prolonging medical treatments and interventions that are not in accordance with their preferences, values, and goals [3]. Additionally, patients and their families commonly experience emotional suffering including anxiety and depression [2]. The health care team plays a crucial role in alleviating the burden of physical and existential suffering during serious and critical illness and end-of-life through the delivery of palliative care.

Palliative care is the comprehensive management and coordination of care for pain and other distressing symptoms, including physical, psychological, intellectual, social, psychosocial, spiritual, and existential consequences of a serious illness, which improves the quality of life of patients and their families/caregivers. Additionally, palliative care evaluation and treatments are patient-centered, with a focus on the central role of the family unit in shared decision-making according to the needs, values, beliefs, and culture or cultures of the patient and their family [4]. Importantly, palliative care can be offered in all care settings through a collaborative team approach involving all disciplines (e.g., physicians, nurses, social workers, spiritual care providers, therapists, pharmacists), should be available at any stage of illness from birth to advanced age, and may be offered simultaneously with disease-modifying interventions, including attempts for cure or remission [5, 6]. However, palliative care is especially suited for persons who have incurable, progressive illness and are facing end-of-life. Hospice, which is a part of palliative care, is offered when a patient is eminently dying [7].

Palliative care can be delivered by any physician, in any specialty; however, specialty palliative care can be provided by consultants when the patient and/or their family's needs are more complex [6]. Integration of palliative care into the patient's care plan has many well studied benefits including, improved quality of life, decreased symptom burden, increased goal-concordant care, increased caregiver support, reduced anxiety, decreased hospital mortality, and reductions in unnecessary medical costs [8]. Additionally, early integration of palliative care reduces unnecessary medications and procedures that have the potential to elicit unwanted side effects or complications and, in some cases, lengthens survival while also decreasing suffering [9,10]. Although palliative care is especially suited for persons who have incurable, progressive illness and are facing end-of-life, it is imperative to distinguish the delivery and purpose of palliative care from any action that intentionally causes death, including physician assisted suicide and euthanasia. While palliative care provides pain and symptom management as well as assistance with making difficult medical decisions and emotional support to patients during end-of-life, palliative care interventions never intentionally cause death.

Numerous AMA policies (H-295.875, Palliative Care and End-of-Life Care; H-70.915 Good Palliative Care; D-295.969, Geriatric and Palliative Care Training for Physicians) support the provision of palliative care for patients and the education on palliative care for physicians. The AMA is not alone in its support of palliative care. The World Health Assembly (WHA) declared that providing palliative care should be considered an ethical duty for health organizations [11]. Additionally, the World Health Organization (WHO) declared that palliative care is an ethical duty of health professionals, and, in 2012, the United Nations Office of the High Commissioner for Human Rights recognized that the failure to provide palliative care and end-of-life care to older persons is a human rights violation [11,12]. Furthermore, in 2011, the World Medical Association (WMA) adopted the *Declaration on End-of-life Medical Care* which declared that "The objective of palliative care is to achieve the best possible quality of life through appropriate palliation of pain and other distressing physical symptoms, and attention to the social, psychological and spiritual needs of the patient" and is part of good medical care [13]. Three years later, the WMA further expanded their support of palliative care with the adoption of a resolution that called for the

integration of palliative care in global disease control and health system plans. Additionally, major world religions also endorse palliative care [14].

The AMA recognizes the disparities in access to palliative care services, especially among racial, ethnic, and socioeconomically disadvantaged populations. Ensuring all patients, regardless of background or geography, receive equitable, culturally competent, and appropriate palliative care is essential.

DISCUSSION

Despite a strong evidence basis supporting the benefits of palliative care, and existing AMA and international medical policies supporting palliative care as an ethical and imperative part of high-quality medical care, millions of patients within the United States experience barriers to accessing palliative care due to misconceptions, misinformation, limited resource availability, and inaccurate stigma surrounding the definition of palliative care and its scope [5,11,15,16]. Additionally, due to these same misconceptions and stigma, physicians face barriers to receiving education and providing palliative care at all stages of the disease course [17,18].

While AMA Policy and the *Code of Medical Ethics* (Opinion 5.2: Advance Directives; Opinion 5.3: Withholding or Withdrawing Life-Sustaining Treatment) historically support addressing the palliative needs of patients and assert that clinicians have a duty to provide optimal palliative care to patients, our AMA has not provided specific guidance on the definition, delivery, and scope of high-quality palliative care.

First, although the concept of palliative care is referenced throughout AMA policy, it is often inaccurately labeled as end-of-life care and no specific definition is provided as to what the ethical provision of this care entails or the scope of this practice. Defining palliative care is essential given that palliative care is often misunderstood and misattributed. Second, expanding palliative care education and access is important for ensuring that patients are able to obtain these evidence-based health care interventions during any stage of their serious or critical illness, including end-of-life care. Palliative care should be offered concurrently with disease modifying interventions, including attempts for cure or remission. Thirdly, palliative care, which is an ethical duty, should be distinguished from other practices that are considered ethically questionable or unethical in the practice of medicine by the AMA *Code of Medical Ethics* (e.g., knowingly and intentionally hastening or causing death, physician assisted suicide, and euthanasia). Lastly, advocating for expanding access to palliative care, as well as legal protections for physicians who provide this essential component of high-quality patient care are important.

CONCLUSION

Palliative care is an evidence based, essential component of serious illness, critical illness, and end-of-life care that is often inaccurately defined, misrepresented, and neglected. As a result, patients and their families endure physical and existential suffering that could be mitigated or alleviated with palliative care intervention. Barriers to physicians providing, and patients receiving palliative care may be alleviated through reaffirming existing AMA policy on education and new AMA policy providing guidance on the definition, delivery, and scope of palliative care.

RECOMMENDATIONS

1. The Board of Trustees recommends that policies H-295.825, Palliative Care and End-of-Life Care; H-70.915, Good Palliative Care; D-295.969, Geriatric and Palliative Care Training for Physicians be reaffirmed.

2. The Board of Trustees recommends that alternate Resolution 722, be adopted in lieu of Resolution 722 and the remainder of this report be filed:

Our American Medical Association:

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

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

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

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

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

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

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

(New HOD Policy)

Fiscal Note: Minimal – Less than $500

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REPORT OF THE BOARD OF TRUSTEES

B of T Report 22-I-24

Subject:	Specialty Society Representation in the House of Delegates - Five-Year Review
Presented by:	Michael Suk, MD, JD, MPH, MBA, Chair
Referred to:	Reference Committee on Amendments to Constitution and Bylaws

The Board of Trustees (BOT) has completed its review of the specialty organizations seated in the House of Delegates (HOD) required to submit information and materials for the 2024 American Medical Association (AMA) Interim Meeting in compliance with the five-year review process established by the House of Delegates in Policy G-600.020, "Summary of Guidelines for Admission to the House of Delegates for Specialty Societies," and AMA Bylaw 8.5, "Periodic Review Process."

Organizations are required to demonstrate continuing compliance with the guidelines established for representation in the HOD. Compliance with the five responsibilities of professional interest medical associations and national medical specialty organizations is also required as set out in AMA Bylaw 8.2, "Responsibilities of National Medical Specialty Societies and Professional Interest Medical Associations."

The following organizations were reviewed for the 2024 Interim Meeting:

American College of Cardiology
American College of Chest Physicians
American College of Emergency Physicians
American College of Gastroenterology
American College of Nuclear Medicine
American Medical Group Association
International Society for the Advancement of Spine Surgery
National Association of Medical Examiners

The American Academy of Allergy, Asthma & Immunology was also reviewed at this time because it failed to meet the requirements in November 2023 and was granted a one-year grace period.

Each organization was required to submit materials demonstrating compliance with the guidelines and requirements along with appropriate membership information. A summary of each group's membership data is attached to this report (Exhibit A). A summary of the guidelines for specialty society representation in the AMA HOD (Exhibit B), the five responsibilities of national medical specialty organizations and professional medical interest associations represented in the HOD (Exhibit C), and the AMA Bylaws pertaining to the five-year review process (Exhibit D) are also attached.

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The materials submitted indicate that: American College of Cardiology, American College of Chest Physicians, American College of Emergency Physicians, American College of Gastroenterology, American College of Nuclear Medicine, American Medical Group Association, International Society for the Advancement of Spine Surgery, and National Association of Medical Examiners meet all guidelines and are in compliance with the five-year review requirements of specialty organizations represented in the HOD.

The materials submitted also indicate that the American Academy of Allergy, Asthma & Immunology met all guidelines and is in compliance with the five-year review requirements of specialty organizations represented in the HOD.

RECOMMENDATIONS

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

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

Fiscal Note: Less than $500

APPENDIX

Exhibit A - Summary Membership Information

Organization	**AMA Membership of Organization's Total Eligible Membership**
American Academy of Allergy, Asthma & Immunology*	306 of 1,550 (20%)
American College of Cardiology*	7,932 of 36,839 (22%)
American College of Chest Physicians*	1,660 of 10,233 (16%)
American College of Emergency Physicians*	8,252 of 32,468 (25%)
American College of Gastroenterology*	2,660 of 12,664 (21%)
American College of Nuclear Medicine*	46 of 173 (27%)
American Medical Group Association*	3,692 of 24,734 (15%)
International Society for the Advancement of Spine Surgery	105 of 268 (39%)
National Association of Medical Examiners*	193 of 968 (20%)

* *Represented in the House of Delegates at the 1990 Annual Meeting*

Exhibit B - Summary of Guidelines for Admission to the House of Delegates for Specialty Societies (Policy G-600.020)

Policy G-600.020

1. The organization must not be in conflict with the Constitution and Bylaws of the American Medical Association with regard to discrimination in membership.

2. The organization must:

   (a) represent a field of medicine that has recognized scientific validity;
   (b) not have board certification as its primary focus; and
   (c) not require membership in the specialty organization as a requisite for board certification.

3. The organization must meet one of the following criteria:

   (a) a specialty organization must demonstrate that it has 1,000 or more AMA members; or
   (b) a specialty organization must demonstrate that it has a minimum of 100 AMA members and that twenty percent (20%) of its physician members who are eligible for AMA membership are members of the AMA; or
   (c) a specialty organization must demonstrate that it was represented in the House of Delegates at the 1990 Annual Meeting and that twenty percent (20%) of its physician members who are eligible for AMA membership are members of the AMA.

4. The organization must be established and stable; therefore, it must have been in existence for at least five years prior to submitting its application.

5. Physicians should comprise the majority of the voting membership of the organization.

6. The organization must have a voluntary membership and must report as members only those physician members who are current in payment of applicable dues, and eligible to serve on committees or the governing body.

7. The organization must be active within its field of medicine and hold at least one meeting of its members per year.

8. The organization must be national in scope. It must not restrict its membership geographically and must have members from a majority of the states.

9. The organization must submit a resolution or other official statement to show that the request is approved by the governing body of the organization.

10. If international, the organization must have a US branch or chapter, and this chapter must be reviewed in terms of all of the above guidelines.

Exhibit C

8.2 Responsibilities of National Medical Specialty Societies and Professional Interest Medical Associations. Each national medical specialty society and professional interest medical association represented in the House of Delegates shall have the following responsibilities:

8.2.1 To cooperate with the AMA in increasing its AMA membership.

8.2.2 To keep its delegate(s) to the House of Delegates fully informed on the policy positions of the society or association so that the delegates can properly represent the society or association in the House of Delegates.

8.2.3 To require its delegate(s) to report to the society on the actions taken by the House of Delegates at each meeting.

8.2.4 To disseminate to its membership information as to the actions taken by the House of Delegates at each meeting.

8.2.5 To provide information and data to the AMA when requested.

Exhibit D – AMA Bylaws on Specialty Society Periodic Review

8 - Representation of National Medical Specialty Societies and Professional Interest Medical Associations in the House of Delegates

8.5 **Periodic Review Process.** Each specialty society and professional interest medical association represented in the House of Delegates must reconfirm its qualifications for representation by demonstrating every 5 years that it continues to meet the current guidelines required for granting representation in the House of Delegates, and that it has complied with the responsibilities imposed under Bylaw 8.2. The SSS may determine and recommend that societies currently classified as specialty societies be reclassified as professional interest medical associations. Each specialty society and professional interest medical association represented in the House of Delegates must submit the information and data required by the SSS to conduct the review process. This information and data shall include a description of how the specialty society, or the professional interest medical association has discharged the responsibilities required under Bylaw 8.2.

8.5.1 If a specialty society or a professional interest medical association fails or refuses to provide the information and data requested by the SSS for the review process, so that the SSS is unable to conduct the review process, the SSS shall so report to the House of Delegates through the Board of Trustees. In response to such report, the House of Delegates may terminate the representation of the specialty society or the professional interest medical association in the House of Delegates by majority vote of delegates present and voting or may take such other action as it deems appropriate.

8.5.2 If the SSS report of the review process finds the specialty society or the professional interest medical association to be in noncompliance with the current guidelines for representation in the House of Delegates or the responsibilities under Bylaw 8.2, the specialty society or the professional interest medical association will have a grace period of one year to bring itself into compliance.

8.5.3 Another review of the specialty society's or the professional interest medical association's compliance with the current guidelines for representation in the House of Delegates and the responsibilities under Bylaw 8.2 will then be conducted, and the SSS will submit a report to the House of Delegates through the Board of Trustees at the end of the one-year grace period.

8.5.3.1 If the specialty society or the professional interest medical association is then found to be in compliance with the current guidelines for representation in the House of Delegates and the responsibilities under Bylaw 8.2, the specialty society or the professional interest medical association will continue to be represented in the House of Delegates and the current review process is completed.

8.5.3.2 If the specialty society or the professional interest medical association is then found to be in noncompliance with the current guidelines for representation in the House of Delegates, or the responsibilities under Bylaw 8.2, the House may take one of the following actions:

8.5.3.2.1 The House of Delegates may continue the representation of the specialty society or the professional interest medical association in the House of Delegates, in which case the result will be the same as in Bylaw 8.5.3.1.

8.5.3.2.2 The House of Delegates may terminate the representation of the specialty society or the professional interest medical association in the House of Delegates. The specialty society or the professional interest medical association shall remain a member of the SSS, pursuant to the provisions of the Standing Rules of the SSS. The specialty society or the professional interest medical association may apply for reinstatement in the House of Delegates, through the SSS, when it believes it can comply with all of the current guidelines for representation in the House of Delegates.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 23-I-24

Subject: Advocating for the Informed Consent for Access to Transgender Health Care

Presented by: Michael Suk, MD, JD, MPH, MBA, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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At the 2022 Interim Meeting, the House of Delegates (HOD) referred Resolution 011-I-22, "Advocating for the Informed Consent for Access to Transgender Health Care," introduced by the Washington Delegation, which asked:

> That our American Medical Association advocate and encourage the adoption of an informed consent model when determining coverage for transgender health care service.

This report, therefore, provides background, discussion, and recommendations.

BACKGROUND

Gender-affirming care (GAC) refers to interventions that minimize the incongruence between a transgender person's gender identity and their sex assigned at birth. GAC can encompass a wide range of social, psychological, behavioral, and medical interventions designed to support and affirm an individual's gender goals and gender identity.[1] Supportive, non-medical interventions may include choosing a name, pronouns, and appearance that align with gender identity. Medical interventions generally include feminizing or masculinizing hormone therapy or surgeries that enable the patient to better align with their gender identity. GAC may be provided during or before adolescence; however, recognizing that providing GAC for children is fundamentally different than for adults due to differences in biology, psychology, and autonomy, the scope of this report is limited to gender-affirming medical interventions provided to adults.

GAC is associated with improved quality of life and mental health among transgender and gender diverse individuals, and while not all trans people seek GAC the majority do.[2] GAC is a deliberate, multi-stage process in which the patient and a multidisciplinary care team work together in order to give the patient time to live with each stage and determine whether or how they want to proceed with the next stage as they seek to affirm their gender identity.

Many, but not all, transgender people experience gender dysphoria, a medical condition defined by the American Psychiatric Association in the DSM-5 as a "marked incongruence between one's experienced/expressed gender and natal gender of at least 6 months in duration […] associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning."[3] Transgender patients may also be diagnosed with gender incongruence. "Gender incongruence of adolescence or adulthood" is characterized by ICD-11 as "a marked and persistent incongruence between an individual´s experienced gender and the assigned sex, which often leads to a desire to 'transition', in order to live and be accepted as a person of the experienced gender, through hormonal treatment, surgery or other health care services to make the individual´s body align, as much as desired and to the extent possible, with the experienced gender."[4] Importantly for this discussion, ICD-11

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categorizes gender incongruence as a condition related to sexual health, whereas gender dysphoria is a mental disorder in the DSM-5.

Models of care

Currently in the United States, many health insurers limit coverage of GAC to patients who have been diagnosed with gender dysphoria, a practice that effectively conditions receipt of GAC on prior mental health evaluation and posits GAC as a mental health treatment. This practice is often referred to as the "Standards of Care Model." The Standards of Care Model is derived from clinical guidelines and recommendations from professional organizations such as the World Professional Association for Transgender Health's (WPATH) Standards of Care for the Health of Transgender and Gender Diverse People and The Endocrine Society's Clinical Practice Guidelines on Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons, both of which emphasize the importance of mental health care before, during, and sometimes after GAC.[5]

The Endocrine Society guidelines rely on a diagnosis of gender dysphoria or gender incongruence and state that, "adults seeking gender-affirming hormone treatment and surgery should satisfy certain criteria before proceeding" including a diagnosis of gender dysphoria or gender incongruence.[6] The guidelines emphasize mental health care and state that only trained mental health professionals who, among other criteria, "are able to do a psychosocial assessment of the patient's understanding, mental health, and social conditions that can impact gender-affirming hormone therapy" should make such diagnoses.[7]

An earlier version of WPATH's standards recommended mental health screening and/or assessment as a prerequisite to referral to hormonal and surgical treatments for gender dysphoria.[8] However, in 2022, WPATH published an updated Standards of Care for the Health of Transgender and Gender Diverse People, Version 8, which eliminated the recommendation for psychological evaluation prior to the initiation of medical treatment. Current WPATH standards acknowledge that, "no single assessment process will fit every person or every situation" and that their guidance is intended to be flexible to best meet the needs of local settings around the world.[9] In recommendation 5.1.b, of the WPATH standards, WPATH writes that health professionals should use the latest edition of the World Health Organization's (WHO) International Classification of Disease (ICD) for diagnosis in countries that require a diagnosis for care but does not state that diagnosis should be a prerequisite to treatment.[10] WPATH's updated position recognizes that the importance of patient autonomy must be balanced with the reality that in some cases there may exist a need for psychological evaluations prior to treatment.

Requiring a mental health evaluation prior to the provision of GAC has been criticized by some who argue that the requirement of a gender dysphoria diagnosis conflates a social identity with a mental disorder and can be stigmatizing, inappropriately pathologizes diverse gender identities, and can be used by insurers as a barrier to coverage for treatment. Those opposed to the Standards of Care Model have proposed an alternative model to direct the provision of GAC: the Informed Consent Model. The Informed Consent Model for gender-affirming care situates treatment decisions between patient and physician and does not require a psychological evaluation or diagnosis as a prerequisite to treatment. It is important to note, however, that both models of care support informed consent by patients and collaborative care with their physician and members of their care team.

AMA policy

HOD policy H-185.927, "Clarification of Medical Necessity for Treatment of Gender Dysphoria," states that our AMA "recognizes that medical and surgical treatments for gender dysphoria and gender incongruence, as determined by shared decision making between the patient and physician, are medically necessary as outlined by generally-accepted standards of medical and surgical practice" and that our AMA

also "oppose[s] laws and policies that criminalize, prohibit or otherwise impede the provision of evidence-based, gender-affirming care." HOD Policy H-185.927 further advocates "for equitable, evidence-based coverage of gender-affirming care by health insurance providers, including public and private insurers."

This is consistent with HOD policy H-140.824, "Healthcare Equity Through Informed Consent and a Collaborative Healthcare Model for the Gender Diverse Population," which states that our AMA supports "treatment models for gender diverse people that promotes informed consent, personal autonomy, increased access for gender affirming treatments and eliminates unnecessary third party involvement outside of the physician-patient relationship in the decision making process."

Furthermore, HOD policy H-185.950, "Removing Financial Barriers to Care for Transgender Patients," states, "Our AMA supports public and private health insurance coverage for treatment of gender dysphoria as recommended by the patient's physician." These policies build on HOD policy H-180.980, "Sexual Orientation and/or Gender Identity as Health Insurance Criteria," which states, "The AMA opposes the denial of health insurance on the basis of sexual orientation or gender identity."

Lastly, policy adopted at the 2023 AMA Interim Meeting directed the AMA to "identify issues with physician payment and reimbursement for gender-affirming care and recommend solutions to address these barriers to care." In accordance with this policy, the AMA Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care Is Banned or Restricted (established by HOD policy G-605.009) has undertaken a study of payment issues impeding the provision of gender-affirming care with the objective of recommending further actions to address barriers to care. The Task Force is comprised of representatives from the AMA Councils on Legislation, Medical Service, Medical Education, Science and Public Health, and Ethics and Judicial Affairs, and representatives from Federation organizations, as directed in G-605.009.

DISCUSSION

Our AMA unambiguously supports access to and insurance coverage of medically necessary GAC but does not identify a preferred model of care for determining medical necessity. The Board of Trustees does not wish to depart from this approach and endorse one particular model of care over another. Rather, the AMA vigorously advocates for equitable payment policies while relying on the evidence-based professional guidelines and recommendations set by professional medical associations, as well as individual physician clinical judgment, on questions of appropriate clinical criteria.

The Board of Trustees has found that current AMA policies are comprehensive and address the concerns raised by Resolution 011-I-22. However, in recognition that not all transgender individuals experience gender dysphoria, the Board of Trustees recommends that policy H-185.950, "Removing Financial Barriers to Care for Transgender Patients," be amended to be more inclusive and acknowledge that not all transgender individuals experience gender dysphoria. Finally, the Board of Trustees acknowledges that the insurance coverage concerns raised by Resolution 011-I-22 are being further addressed by the Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care Is Banned or Restricted.

RECOMMENDATIONS

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

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

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

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

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

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

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

Fiscal Note: Minimal – less than $500

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[2] Arjee J. Restar, *Gender-Affirming Care is Preventative Care*, 24 LANCET REG HEALTH AM 100544 (Aug. 2023).
[3] AMERICAN PSYCHIATRIC ASSOCIATION, "gender dysphoria", DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS, (5th ed., text revision 2022).
[4] WORLD HEALTH ORGANIZATION, *Gender incongruence of adolescence or adulthood*, INTERNATIONAL CLASSIFICATION OF DISEASES (11th ed. 2021).
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[6] *Id*.
[7] *Id*.
[8] Eli Coleman, Walter Bockting, Marsha Botzer, et al., *Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People, Version 7*, 13 INT'L J TRANSGENDERISM 4, 165-232 (Aug. 2012).
[9] WPATH, *supra* note 1.
[10] *Id*.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 24-I-24

Subject:	Physicians Arrested for Non-Violent Crimes While Engaged in Public Protests
Presented by:	Michael Suk, MD, JD, MPH, MBA, Chair
Referred to:	Reference Committee on Amendments to Constitution and Bylaws

INTRODUCTION

At the 2023 Interim meeting the House of Delegates (HOD) referred 009-I-23 (Res 009) from the Academic Physicians Section which asked: "our AMA advocate to appropriate credentialing organizations and payers – including the Federation of State Medical Boards, state and territorial licensing boards, hospital and hospital system accrediting boards, and organizations that compensate physicians for provision of healthcare goods and services – that *misdemeanor or felony arrests* of physicians as a result of exercising their First Amendment rights of protest and through nonviolent civil disobedience should not be deemed germane to the ability to safely and effectively practice medicine. (Directive to Take Action)" (Emphasis added).

BACKGROUND

Recent years have seen a rise in political civil disobedience in American society, often in the context of protests promoting civil rights, e.g. the Black Lives Matter movement, the AIDS movement, and the protests condemning the Supreme Court's repeal of abortion rights after their overturning of *Roe v. Wade* [1,2]. The subject matter of these protests often have an impact on public health and thus are connected to a physician's duty to advocate for social changes promoting the betterment of public health. The right to assemble and engage in peaceful protest is protected by the First Amendment of the United States Constitution. Despite constitutional protection, some physicians involved in non-violent protests have been arrested for civil disobedience. Arrests that do not result in charges and subsequent conviction occur largely in the context of political protests due to the use of controversial techniques, such as "kettling", where police use mass arrests without the broader goal to prosecute as a form of crowd control [3]. Arrests without conviction for engaging in civil disobedience during non-violent protests have the potential to negatively affect physician's careers and medical licenses when reported to state medical boards, which make determinations for fitness to practice medicine. Indeed, the professional and psychological toll on sanctioned physicians is enormous and includes reputational harm, discrimination, stigma, and the burden to defend oneself before a state medical board. Additionally, arrests for non-violent public protests are different from other types of criminal arrests, as arrests for non-violent protests are not equivalent to arrests for other types of crimes (e.g., violent crimes) that do have relevant impact on a physician's ability to practice. Hence, it is important to distinguish between arrests stemming from non-violent protests (which are low-risk in nature, not associated with fitness to practice, and are associated with exercising constitutional rights) from other crimes, especially when medical boards may not make such a distinction and conflate all arrests as deserving of equal scrutiny. Resolution 009-I-23 seeks protection for physicians who are arrested, but not subsequently charged or convicted for engaging in an act of civil disobedience during a non-violent protest.

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AMA POLICY

Our AMA has several policies relevant to the issues and concerns described in Resolution 009-I-23.

House Policy

- D-295.949 - Criminal Background Checks for Medical Students states that the "AMA opposes the imposition of criminal and civil penalties or other retaliatory efforts, including adverse medical licensing actions and the termination of medical liability coverage or clinical privileges against patients, patient advocates, physicians, other healthcare workers, and health systems for receiving, assisting in, referring patients to, or providing reproductive health services." (Emphasis added)

- H-355.979 – National Practitioner Data Bank states that the "AMA supports requiring felony convictions of physicians to be reported to state licensing boards."

- H-373.995 – Government Interference in Patient Counseling states that the AMA "opposes state and/or federal efforts to interfere in the content of communication in clinical care delivery between clinicians and patients" and that the AMA supports blocking state or federal legislation that "violate[s] the First Amendment rights of physicians in their practice of the art and science of medicine."

Ethics Policy

- Opinion 1.2.10, "Political Action by Physicians" recognizes the rights of physicians to participate in the political process. The opinion states that "physicians enjoy the right to advocate for change in law and policy, in the public arena, and within their institutions. Indeed, physicians have an ethical *responsibility to seek change* when they believe the requirements of law or policy are contrary to the best interests of patients." (Emphasis added)

- Opinion 1.1.7, "Physician Exercise of Conscience" recognizes that "physicians are moral agents in their own right" and are "informed by and committed to diverse cultural, religious, and philosophical traditions and beliefs". This dictate to conscience allows "physicians to act (or to refrain from acting) in accordance with the dictates of conscience in their professional practice is important for preserving the integrity of the medical profession as well as the integrity of the individual physician"

- Opinion 2.3.4, "Political Communications" explains that "[p]hysicians enjoy the rights and privileges of free speech shared by all Americans" and that physicians should "work towards and advocate for the reform and proper administration of laws related to health care.

- Opinion 9.4.3, "Discipline & Medicine" provides guidance about reporting physician misconduct. The opinion says that "medical societies have a civic and professional obligation to [r]eport to the appropriate governmental body or state board of medical examiners credible evidence that may come to their attention involving the alleged *criminal conduct* of any physician relating to the practice of medicine." (Emphasis added)

- Preamble of the Code of Medical Ethics explains that "[t]he relationship between ethics and law is complex. Ethical values and legal principles are usually closely related, but *ethical responsibilities usually exceed legal duties*" (Emphasis added) Then, the preamble notes that "[i]n some cases, the law mandates conduct that is ethically unacceptable. When physicians believe a law violates ethical values or is unjust they should work to change the law. In exceptional circumstances of unjust laws, *ethical responsibilities should supersede legal duties*." (Emphasis added).

DISCUSSION

Civil Disobedience

Civil disobedience is principally defined by John Rawls as "public, non-violent and conscientious breach of law undertaken with the aim of bringing about a change in laws or government policies [4]." While the civil and/or criminal law will be broken during civil disobedience, key is that actions undertaken are non-violent and are meant to call about public attention on an issue to produce political change. Non-violent acts of civil disobedience may often be in the form of protests like those made famous in the civil rights movement in the 1960's and the more recent racial justice protests and include activities such as illegally blocking traffic, boycotts, and sit-ins. Hence, the intent behind such non-violent protests is noble and in pursuit of changing unjust laws or social policy and are thus fundamentally different from arrests associated with other types of criminal behavior that may be relevant to medical practice, e.g. violent crimes or criminal negligence.

Also, while arrests from non-violent civil disobedience are not germane to the fitness to practice medicine, such arrests are additionally problematic in that they result in inequities. Certain groups of people, including physicians of color and women, face a higher likelihood of arrest for low-level offenses [5] and protests [6] leading to more severe charges during protests, resulting in unjust disparities.

Arrests vs. Criminal Charges and Conviction

Reference Committee testimony for Res 009 notes that the resolution limits its scope to "arrests" and does not include charges or convictions. Some testimony reflected the concern that making a distinction between arrest and conviction is sometimes arbitrary, in that it is not inherent that conduct resulting in a conviction is necessarily "worse" or more "unethical" than conduct that results in no criminal conviction. This is not a cogent point because the presumption of innocence until proven guilty is recognized as a due process right under the Fifth Amendment - meaning that one is considered innocent even after arrest up until they are convicted. Furthermore, the evidentiary standard of proof required for an arrest is lower than the threshold required for a conviction. Therefore, expanding the scope of recommended policy beyond "arrests" is problematic as the distinction between arrests and convictions has practical significance in that an arrest is not necessarily indicative of guilt whereas a conviction is indicative of guilt in the eyes of the law.

Additionally, most states' law define "unprofessional conduct" to include "conviction of a felony" which is then reportable to state medical boards, which can then make a decision about a physician's licensure and fitness to practice [7]. While there is some debate about whether or not a criminal conviction unrelated to a physician's medical practice should be considered in determining fitness to practice, the linkage exists in our public policy [8]. State medical boards find a "connection between 'moral turpitude' outside the practice of medicine and the ability to practice

medicine safety has been accepted as social policy".[8] Hence, a criminal conviction (whether connected to the practice of medicine or not) is relevant and will be used by licensing board to assess fitness.

Misdemeanor vs. Felony

In American criminal law, there are broadly three categories of crimes: infractions, misdemeanors and felonies. Infractions are the least serious crimes, misdemeanors are slightly more serious, while felonies are the most serious category of crimes [9]. When describing arrests, Res 009 uses the language "misdemeanor or felony arrests" without providing a definition or reason for highlighting a distinction between the legal classifications. Additionally, Res 009 makes no reference to arrests for infractions. In the context of Res 009 and the arrests for non-violent protests and civil disobedience the resolution envisions, many such arrests would likely be for infractions and misdemeanors. Depending on the facts and jurisdictions, some arrests may be felony arrests. Keeping the focus of our AMA policy only on *arrests* will cover all scenarios and legal variances across jurisdictions.

CONCLUSION

Res 009-I-23 raises an important issue that physicians should not be unduly punished for engaging in civil disobedience during non-violent protests which result in an arrest without a charge or conviction. However, this resolution should be modified to remove "misdemeanor and felony" as this distinction is not relevant in the context of an arrest only and may lead to confusion about arrests that lead to formal charges or a conviction of a misdemeanor or felony.

RECOMMENDATION

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

> That our AMA advocate to appropriate credentialing organizations and payers – including the Federation of State Medical Boards, state and territorial licensing boards, hospital and hospital system accrediting boards, and organizations that compensate physicians for provision of healthcare goods and services – that ~~misdemeanor or felony~~ arrests of physicians <u>for nonviolent civil disobedience occurring while</u> ~~as a result of~~ exercising their First Amendment rights of protest ~~through nonviolent civil disobedience~~ should not be deemed germane to the ability to safely and effectively practice medicine. (Directive to Take Action)

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

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REPORT OF THE BOARD OF TRUSTEES

B of T Report 25-I-24

Subject: World Medical Association Observer Status in the House of Delegates

Presented by: Michael Suk, MD, JD, MPH, MBA, Chair

Referred to: Reference Committee F

The Board of Trustees has received a request from the World Medical Association (WMA) to be considered for Official Observer status in the House of Delegates (HOD) of the American Medical Association (AMA). The WMA's request has been thoroughly considered using the criteria below (Policy G-600.025, "Official Observers in Our AMA House"):

1. The organization and the AMA should already have established an informal relationship and have worked together for the mutual benefit of both;
2. The organization should be national in scope and have similar goals and concerns about health care issues;
3. The organization is expected to add a unique perspective or bring expertise to the deliberations of the HOD; and
4. The organization does not represent narrow religious, social, cultural, economic, or regional interests so that formal ties with the AMA would be welcomed universally by AMA members.

The Board has discussed the WMA's request and presents the following report.

DISCUSSION

As part of its request, WMA submitted information on how it has met the criteria for Official Observer status, which is summarized below.

Criterion 1. The organization and the AMA should already have established an informal relationship and have worked together for the mutual benefit of both.

As specified in the guidelines, the AMA and WMA have a longstanding relationship. The WMA was established in 1947. The AMA is a founding member. The WMA Secretary General has attended the Annual HOD meeting for over 15 years. At each meeting he briefs the Board of Trustees. Many international guests, most of whom are WMA members, also attend the Annual meeting each year. They are recognized during the open session of the HOD.

Criterion 2. The organization should be national in scope and have similar goals and concerns about health care issues.

Although the WMA is international in scope it has a broad mission and interests that align with the AMA. The organization was created to ensure the independence of physicians and to work for the highest possible standards of ethical behavior and care by physicians. The purpose of the WMA is

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to serve humanity by endeavoring to achieve the highest international standards in medical education, medical science, medical art and ethics, and health care for all people in the world. Besides ethics and science, core activities focus on physician advocacy, representation, and service and outreach.

The WMA is the internationally recognized voice of physicians. It is the only international organization for national medical associations (NMA) and individual physician members. There are now 114 NMA members of the WMA from all regions of the globe.

Criterion 3. The organization is expected to add a unique perspective or bring expertise to the deliberations of the HOD.

AMA policy recognizes the AMA's commitment to the WMA which is reflected by AMA's involvement in the WMA including participation of AMA presidents as members of the delegation that represents the AMA at WMA meetings. AMA officers have frequently held leadership positions in the organization and play critical roles in leading policy development through working groups and by introducing new policy.

Criterion 4. The organization does not represent narrow religious, social, cultural, economic, or regional interests so that formal ties with the AMA would be welcomed universally by AMA members.

The WMA does not represent narrow religious, social, cultural, economic, or regional interests and has already been welcomed to participate in previous AMA activities.

The Board of Trustees appreciates the long-standing relationship with the WMA. Allowing the WMA to be an Official Observer in the HOD will acknowledge this longstanding and important relationship and further assist in promoting the highest physician ethical standards and policies, both in the US and globally.

RECOMMENDATION

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

Fiscal Note: Under $500

Appendix - Official Observers to the House of Delegates

Organization	Year Admitted
Accreditation Association for Ambulatory Health Care	1993
Alliance for Continuing Medical Education	1999
Alliance for Regenerative Medicine	2014
Ambulatory Surgery Center Association	2005
American Academy of Physician Assistants	1994
American Association of Medical Assistants	1994
American Board of Medical Specialties	2014
American Dental Association	1982
American Health Quality Association	1987
American Hospital Association	1992
American Nurses Association	1998
American Public Health Association	1990
American Podiatric Medical Association	2019
Association of periOperative Registered Nurses	2000
Association of State and Territorial Health Officials	1990
Commission on Graduates of Foreign Nursing Schools	1999
Council of Medical Specialty Societies	2008
Educational Commission for Foreign Medical Graduates	2011
Federation of State Medical Boards	2000
Federation of State Physician Health Programs	2006
Medical Group Management Association	1988
National Association of County and City Health Officials	1990
National Commission on Correctional Health Care	2000
National Council of State Boards of Nursing	2000
National Indian Health Board	2013
PIAA	2013
Society for Academic Continuing Medical Education	2003
United States Professional Association for Transgender Health	2024
US Pharmacopeia	1998

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 010
(I-24)

Introduced by: Organized Medical Staff Section

Subject: Development of Resources for Medical Staffs to Engage in Collective Negotiation with Hospital and Health Systems

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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Whereas, the ability of medical staffs to negotiate collectively with hospital systems is essential for ensuring fair working conditions, adequate staffing, and the highest quality of patient care; and

Whereas, collective negotiation can lead to improved communication and collaboration between medical staffs and hospital and health system administration, fostering a more supportive and effective healthcare environment; and

Whereas, many medical staffs currently lack the resources and materials necessary to effectively engage in collective negotiation; and

Whereas, the American Medical Association is committed to supporting physicians and medical staffs in their professional endeavors and advocating for policies that enhance the practice of medicine; and

Whereas, New York state case law, such as *City of New York v. New York State Nurses Association* (2017), supports the rights of medical staffs to engage in collective negotiation and obtain necessary information for representation[1]; and

Whereas, the National Labor Relations Board (NLRB) has determined that medical staff at Bellevue Hospital have the right to negotiate collectively, as evidenced by their ruling that the hospital violated the National Labor Relations Act (NLRA) by threatening employed physicians with cutbacks and layoffs for engaging in concerted activities[2]; therefore be it

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

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

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

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

Received: 11/8/2024

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 011
(I-24)

Introduced by: Organized Medical Staff Section

Subject: American Kidney Donation Legislation

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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Whereas, over 90,000 Americans with End-Stage Kidney Disease (ESKD) are awaiting a kidney transplant[1]; and

Whereas, over 8,000 Americans waiting for a kidney die or become too sick to transplant each year for lack of an available kidney[1]; and

Whereas, living kidney donation in America, including anonymous (volunteer) donation to wait-listed ESKD patients has not grown for two decades[1]; and

Whereas, our AMA Code of Medical Ethics states that it is "appropriate to carry out pilot studies among limited populations to investigate the effects of such financial incentives for the purpose of examining and possibly revising current policies in the light of scientific evidence"[2]; and

Whereas, United States House of Representatives bill H.R. 4343 states that "experts are arriving at a consensus that trials are necessary to find new methods of promoting additional organ donation which will save lives and reduce organ trafficking"[3]; and

Whereas, several innovative pieces of federal legislation, including H.R. 9275 which creates a pilot study (trial) offering a delayed tax credit to living donors giving a kidney to Americans on the waiting list, as well as other bills, are or may soon come before the United States Congress[4,5]; therefore be it

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

Fiscal Note: Minimal – less than $1,000

Received: 11/8/2024

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 228
(I-24)

Introduced by: Medical Student Section

Subject: Codification of the Chevron Deference Doctrine

Referred to: Reference Committee B

Whereas, due to the highly partisan and bureaucratic nature of Congress, legislators often pass laws that outline broad provisions, but defer technical details of implementation to federal agencies staffed by subject-matter experts with doctoral and master's degrees, which is especially crucial for medical, scientific, technological, and public health regulations[1-3]; and

Whereas, for 40 years, federal courts have followed the "Chevron deference doctrine," under which courts defer to agency interpretation of *ambiguous* legislation[3]; and

Whereas, *Chevron* deference does not apply to unambiguous, clearly-written legislation passed by Congress, and the legislative process remains a pathway that can always be taken to lobby for clear legislation that directs and overrides agency interpretation if desired[3]; and

Whereas, healthcare and public health agencies depend heavily on Chevron deference to allow subject matter expert staff with scientific, technical, and implementational expertise to run the myriad daily core government operations upon which our society depends, filling in the gaps and compensating for the lack of direction Congress cannot or will not provide[4]; and

Whereas, 70 SCOTUS cases and over 17,000 lower court cases that pertain to multiple regulatory domains affecting vast swathes of American life explicitly rely on *Chevron*, and Congress has not seen fit to reverse these decisions through legislative action[5]; and

Whereas, healthcare, public health, scientific, and technological regulations are best left to subject-matter and technical experts to interpret, not partisan legislators and courts ill-equipped to critically evaluate statistical evidence informing complex implementational questions[3,6]; and

Whereas, in June 2024, the Supreme Court overturned *Chevron v. NRDC*, making the courts the final arbiter of all federal agency implementation of legislation[13–15]; and

Whereas, while Congress has the power to clarify an ambiguous law in response to a court overturning an agency rule, gridlock makes this impractical and infeasible for the thousands of federal rules on which healthcare and public health depend, and the loss of Chevron deference has functionally shifted power from subject matter experts to unelected court judges[18-20]; and

Whereas, the most appropriate "hierarchy" of decision-making should first allow agencies composed of subject matter experts with key operational expertise to interpret ambiguous directives, and allow Congress to clarify their own unclear laws, rather than the courts[19,20]; and

Whereas, many scenarios such as pandemics and natural disasters require rapid mobilization within hours or days, which would be significantly impaired without *Chevron*; and

Whereas, in June 2024, the Supreme Court also greatly expanded the statute of limitations for suing federal agencies, leaving nearly all existing federal rules vulnerable to hostile litigation and

threatening to massively increase caseloads for already overburdened court systems[21,22]; and

Whereas, legal challenges against federal regulations on LGBTQ+ discrimination in healthcare, abortion referrals, and banning non-competes are mounting, and more are expected[24,25]; and

Whereas, since the demise of *Chevron*, courts have ruled in favor of federal agencies only 4 times out of 26 lawsuits against the Department of Health and Human Services (HHS), Federal Trade Commission, and Environmental Protection Agency, and other agencies[39-41]; and

Whereas, the demise of *Chevron* removes the ability to standardize federal rulemaking using a set of pre-established regulatory standards, potentially leading to inconsistent rulings across 94 federal district courts and 13 courts of appeals and creating a chaotic regulatory landscape that will greatly increase confusion and costs for all healthcare stakeholders[6,13,26]; and

Whereas, the demise of *Chevron* sets a dangerous precedent for the gradual erosion of regulations governing environmental policy, healthcare, public health, and civil rights, threatens our AMA's advocacy on myriad healthcare and public health priorities, and imperils our mission to "promote the art and science of medicine and the betterment of public health"[7-9, 15-17, 23]; and

Whereas, the American Academy of Pediatrics (AAP), American Thoracic Society, American Cancer Society, American Heart Association, American Lung Association, and 11 other healthcare organizations filed an amicus brief in support of Chevron deference, stating: "Like any other stakeholders in a federal program, Amici do not always agree with how the Secretary and CMS exercise their authority. But Amici all concur that it is constitutionally permissible and vastly preferable for such authority to lie with a centralized agency, staffed with subject matter experts and accountable to the President, Congress, and the courts, rather than expect that Congress or the courts would be willing or able to assume such a role"[28]; and

Whereas, *Chevron* was not overturned because it was deemed unconstitutional, but on legislative grounds under the Administrative Procedure Act, meaning that Congress can codify the Chevron doctrine and presenting an urgent opportunity for AMA advocacy[13,29,30]; and

Whereas, other constitutional checks by Congress and the courts on federal rules already exist and will still be in place if *Chevron* is reinstated, including the Congressional Review Act and the "arbitrary and capricious" rule[2,31-33]; and

Whereas, multiple bills to explicitly specify the scope of agency deference have been introduced in both the House and Senate, including the Stop Corporate Capture Act, which proposes language to codify "reasonable" agency deference as given under *Chevron* [34–36, 43,44]; and

Whereas, most states use *Chevron* to defer to state agencies, but at least twelve states have weakened or eliminated it, presenting an opportunity for the AMA to support state medical societies pursuing related advocacy[37,38]; therefore be it

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

a. generally leave reasonable interpretation of ambiguous regulatory statutes to the purview of the executive branch, including agencies comprised of scientific and medical experts evaluating robust evidence; and
b. generally prioritize legislative oversight and modification of ambiguous regulatory statutes and agency rules, instead of deferring to the judicial branch for this function.

(New HOD Policy)

Fiscal Note: Minimal – less than $1000

Received: 11/8/2024

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 229
(I-24)

Introduced by: Private Practice Physicians Section

Subject: Supporting Penalties on Insurers Who Fail to Pay Doctors

Referred to: Reference Committee B

Whereas, in 2020, Congress passed the No Surprises Act (NSA), which took patients out of the middle of payment disputes between health insurers and out of network providers; and

Whereas, the NSA created a baseball style arbitration process for resolving such payment disputes called an Independent Dispute Resolution (IDR) process; and

Whereas, if doctors prevailed at the IDR, insurers were, by law, required to pay the doctors within 30 days; and

Whereas, there have been numerous problems with implementation of the IDR provision, including specifically that insurers have been refusing to pay doctors within 30 days when doctors win at the IDR; and

Whereas, there have been no penalties for insurers for flaunting the laws of the NSA; and

Whereas, a bill has been put forth in Congress, the No Surprises Enforcement Act, that would impose penalties on insurers that failed to pay doctors within 30 days when doctors win at IDR; and

Whereas, the imposition of real penalties would hopefully pressure insurers to pay doctors the amounts they are owed for their medical services; therefore be it

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

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

Received: 11/8/2024

RELEVANT AMA POLICY

Addressing the Failed Implementation of the No Surprises Act Independent Dispute Resolution Process D-285.957

Our American Medical Association will advocate for the federal departments to immediately and correctly implement the fair and timely Independent Dispute Resolution (IDR) process as stipulated by the No Suprises Act including advocating specifically for the following:

a. Specific requirements for insurers: Insurers must be required to make IDR loss payments directly to physicians, clarify IDR eligibility on explanation of benefit forms, and be prohibited from falsely claiming ineligibility due to network status or incorrect venue claims.
b. Operational improvements in the IDR process: IDR entities must not close claims based on unverified insurer claims, an adequate number of IDR entities must be certified, and a structured timeline must be set for IDR entity selection and payment process.

Citation: Res. 253, A-24

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 230
(I-24)

Introduced by: Organized Medical Staff Section

Subject: Addressing and Reducing Patient Boarding in Emergency Departments

Referred to: Reference Committee B

Whereas, patient boarding, defined as the practice of holding patients in the emergency department (ED) after they have been admitted to the hospital due to lack of inpatient beds, has become a widespread and persistent problem in healthcare facilities across the United States; and

Whereas, in a new ACEP poll of 2,164 U.S. adults, 44 percent said they or a loved one experienced long waits in emergency departments with 16 percent waiting 13 or more hours before being admitted or transferred; and

Whereas, prolonged ED boarding is associated with poorer patient outcomes, increased length of stay, higher mortality rates, and decreased patient satisfaction; and

Whereas, ED boarding contributes to ED overcrowding, leading to increased wait times, delayed care for incoming patients, and potential compromises in patient safety; and

Whereas, boarding places additional stress on ED staff, contributing to burnout among physicians, nurses, and other healthcare workers; and

Whereas, the practice of boarding disrupts the primary mission of the ED to provide timely emergency care and hampers the ED's ability to respond effectively to surges in patient volume; and

Whereas, addressing ED boarding requires a system-wide approach involving hospital administration, inpatient services, and community healthcare resources; therefore be it

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

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

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

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

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

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

Received: 11/8/2024

REVISED

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 302
(I-24)

Introduced by: Resident and Fellow Section, LGBTQ+ Section, Minority Affairs Section

Subject: Strengthening Parental Leave Policies for Medical Trainees and Recent Graduates

Referred to: Reference Committee

Whereas, supporting trainees with adequate parental leave is associated with improved resident wellness and productivity, as well as long-term maternal and child health outcomes;[1-3] and

Whereas, as of October 2020, all federal employees including members of the military are eligible for 12 weeks of paid parental leave for the birth or adoption of a child;[4] and

Whereas, both the American Academy of Pediatrics (AAP) and the American Academy of Family Physicians (AAFP) recommend that up to 12 weeks of paid parental leave should be available during residency training;[8] and

Whereas, a study of top-ranked hospitals and cancer centers found that the mean paid maternity and parental leave is 7.8 and 3.6 weeks, respectively, well below the 12-week paid family leave recommendation of the American Academy of Pediatrics and the mean of 18.6 weeks afforded by other Organization for Economic Co-operation and Development countries;[5] and

Whereas, the Family and Medical Leave Act of 1993 gives “eligible” employees of large employers and all government agencies regardless of size to take unpaid leave if it has been earned (defined as after 12 months of work) for a period of up to 12 weeks in any 12 month period;[6] and

Whereas, there are state-based parental leave laws that also require employees to have worked at least 12 months, which poses a burden for new graduates from residency and fellowship;[7] and

Whereas, in survey responses many residents do not feel supported in taking parental leave due to perceived or actual lack of support from faculty/peers, strain on residency program, and lack of flexibility of programs;[8] and

Whereas, in one survey, ⅔ of medical trainees who were parents felt that childcare contributed to their burnout especially when compounded by short parental leave and the difficulties of a relatively low trainee salary;[9] and

Whereas, in one survey of trainees in an institution and state offering only unpaid parental leave, the leading factor influencing length of parental leave time was financial;[10] and

Whereas, in one survey, nearly 40% of surgical trainees reported considering leaving residency during or after pregnancy for reasons including dissatisfaction with leave options;[11] and

Whereas, many women physicians delay childbearing until after training which often overlaps with periods of peak fertility such that approximately ¼ of women physicians report infertility, up to double the rate of the general US population;[12-14] and

Whereas, even if residencies and fellowships support paid leave, there is limited flexibility to support residents finishing residency on time, including limited board licensing exam dates; therefore be it

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

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

Fiscal Note: Minimal – less than $1000

Received: 9/24/2024

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RELEVANT AMA POLICY:

Increasing Practice Viability For Physicians Through Increased Employer And Employee Awareness Of Protected Leave Policies H-405.960
Our American Medical Association adopts as policy the following guidelines for, and encourages the implementation of, Parental, Family and Medical Necessity Leave for Medical Students and Physicians:

1. Our AMA urges residency training programs, medical specialty boards, the Accreditation Council for Graduate Medical Education, and medical group practices to incorporate and/or encourage development of leave policies, including parental, family, and medical leave policies, as part of the physician's standard benefit agreement.
2. Recommended components of parental leave policies for physicians include:
    a. duration of leave allowed before and after delivery;
    b. category of leave credited;
    c. whether leave is paid or unpaid;
    d. whether provision is made for continuation of insurance benefits during leave, and who pays the premium;
    e. whether sick leave and vacation time may be accrued from year to year or used in advance;
    f. how much time must be made up in order to be considered board eligible;
    g. whether make-up time will be paid;
    h. whether schedule accommodations are allowed; and
    i. leave policy for adoption.
3. Our AMA policy is expanded to include physicians in practice, reading as follows:
    a. residency program directors and group practice administrators should review federal law concerning maternity leave for guidance in developing policies to assure that pregnant physicians are allowed the same sick leave or disability benefits as those physicians who are ill or disabled;
    b. staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in other physicians' workloads, particularly in residency programs; and
    c. physicians should be able to return to their practices or training programs after taking parental leave without the loss of status.
4. Our AMA recommends that medical practices, departments, and training programs strive to provide 12 weeks of paid parental, family, and medical necessity leave in a 12-month period for their attending and trainee physicians as needed, with the understanding that no parent be required to take a minimum leave.
5. Residency program directors should review federal and state law for guidance in developing policies for parental, family, and medical leave.
6. Medical students and physicians who are unable to work because of pregnancy, childbirth, abortion or stillbirth, and other related medical conditions should be entitled to such leave and other benefits on the same basis as other physicians who are temporarily unable to work for other medical reasons.
7. Residency programs should develop written policies on leave for physicians. Such written policies should include the following elements:
    a. leave policy for birth or adoption;
    b. duration of leave allowed before and after delivery;
    c. duration of leave allowed after abortion or stillbirth;
    d. category of leave credited (e.g., sick, vacation, parental, unpaid leave, short term disability);
    e. whether leave is paid or unpaid;
    f. whether provision is made for continuation of insurance benefits during leave and who pays for premiums; (g) whether sick leave and vacation time may be accrued from year to year or used in advance;
    g. extended leave for resident physicians with extraordinary and long-term personal or family medical tragedies for periods of up to one year, without loss of previously accepted residency positions, for devastating conditions such as terminal illness, permanent disability, or complications of pregnancy that threaten maternal or fetal life;
    h. how time can be made up in order for a resident physician to be considered board eligible;
    i. what period of leave would result in a resident physician being required to complete an extra or delayed year of training;
    j. whether time spent in making up a leave will be paid; and
    k. whether schedule accommodations are allowed, such as reduced hours, no night call, modified rotation schedules, and permanent part-time scheduling.
8. Medical schools should develop written policies on parental leave, family leave, and medical leave for medical students. Such written policies should include the following elements:
    a. leave policy for birth or adoption;
    b. duration of leave allowed before and after delivery;

   c. extended leave for medical students with extraordinary and long-term personal or family medical tragedies, without loss of previously accepted medical school seats, for devastating conditions such as terminal illness, permanent disability, or complications of pregnancy that threaten maternal or fetal life;
   d. how time can be made up in order for a medical students to be eligible for graduation with minimal or no delays;
   e. what period of leave would result in a medical student being required to complete an extra or delayed year of training; and
   f. whether schedule accommodations are allowed, such as modified rotation schedules, no night duties, and flexibility with academic testing schedules.

9. Our AMA endorses the concept of equal parental leave for birth and adoption as a benefit for resident physicians, medical students, and physicians in practice regardless of gender or gender identity.
10. Staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in the workloads of other physicians, particularly those in residency programs.
11. Physicians should be able to return to their practices or training programs after taking parental leave, family leave, or medical leave without the loss of status.
12. Residency program directors must assist residents in identifying their specific requirements (for example, the number of months to be made up) because of leave for eligibility for board certification and must notify residents on leave if they are in danger of falling below minimal requirements for board eligibility. Program directors must give these residents a complete list of requirements to be completed in order to retain board eligibility.
13. Our AMA encourages flexibility in residency programs and medical schools incorporating parental leave and alternative schedules for pregnant trainees.
14. In order to accommodate leave protected by the federal Family and Medical Leave Act, our AMA encourages all specialties within the American Board of Medical Specialties (ABMS) to allow graduating residents to extend training after the traditional residency completion date while still maintaining board eligibility, in the event of leave beyond six weeks. Our AMA encourages specialty boards to develop flexible policies for board certification for those physicians who take leave beyond the minimum of six weeks of family or medical leave (per ABMS policy) and whose residency programs are able to certify that residents meet appropriate competencies for program completion.
15. Our AMA will work with appropriate stakeholders to encourage that residency programs annually publish and share with FREIDA and other appropriate stakeholders, self-identified and other demographic data, including but not limited to the composition of their program over the last 5 years by age; historically marginalized, minoritized, or excluded status; sexual orientation and gender identity.
16. Our AMA will encourage the Accreditation Council for Graduate Medical Education and other relevant stakeholders to annually collect data on childbirth and parenthood from all accredited US residency programs and publish this data with disaggregation by gender identity and specialty.
17. These policies as above should be freely available online through FREIDA and in writing to all current trainees and applicants to medical school, residency or fellowship.
18. Medical schools are encouraged to develop clear, equitable parental leave policies and determine how a 12-week parental, family, or medical leave may be incorporated with alternative, timely means of completing missed curriculum while still meeting competency requirements necessary to complete a medical degree.
19. Our AMA opposes any discrimination related to physicians taking protected leave during training and/or medical practice for medical, religious, and/or family reasons.
20. Our AMA will encourage relevant stakeholders to survey physicians and medical students who have taken family leave, in an effort to learn about the experiences of various demographic groups and identify potential disparities in career progression trends. [CCB/CLRPD Rep. 4, A-13; Modified: Res. 305, A-14; Modified: Res. 904, I-14; Modified: Res. 307, A-22; Modified: Res. 302, I-22; Modified: Res. 312, I-22; Modified: CME Rep. 01 and Res. 306, I-23]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 608
(I-24)

Introduced by: Resident and Fellow Section

Subject: Direct Election of Resident/Fellow Members of the AMA Board of Trustees and Various AMA Councils

Referred to: Reference Committee F

Whereas, one position on our AMA Board of Trustees and one position on each of our AMA Councils are allocated to be held by a resident/fellow physician; and

Whereas, the resident/fellow physician member of our AMA Board of Trustees as well as the resident/fellow physician member of our AMA Council on Constitution and Bylaws (CCB), our AMA Council on Medical Education (CME), our AMA Council on Medical Service (CMS), and our AMA Council on Science and Public Health (CSAPH) are elected by our AMA House of Delegates; and

Whereas, per AMA Bylaw 3.5.6, the medical student member of our AMA Board of Trustees is directly elected by the AMA Medical Student Section (MSS); and

Whereas, per AMA Bylaw 6.8.2, the medical student members of CCB, CME, CMS, and CSAPH are selected by the Governing Council of the MSS with the concurrence of our AMA Board of Trustees; and

Whereas, per current AMA Resident and Fellow Section (RFS) Internal Operating Procedures (IOP), candidates seeking the RFS endorsement for the resident/fellow physician position on our AMA Board of Trustees and aforementioned Councils must run for this endorsement at the Interim meeting prior to the election in our AMA House of Delegates at the subsequent Annual meeting; and

Whereas, for the past several years, the vast majority of races for these resident/fellow physician positions on our AMA Board of Trustees and elected Councils have been uncontested, with the only candidate choosing to run being the candidate who secured the endorsement of the RFS; and

Whereas, pursuant to recent updates to AMA endorsement procedures, resident/fellow physicians running for these positions beginning at A-26 would have to secure the RFS endorsement at least one year prior to the Annual meeting of our AMA House of Delegates; and

Whereas, the resident/fellow physicians on our AMA Board of Trustees and aforementioned Councils serve two-year terms; and

Whereas, residency training for many specialties—such as Internal Medicine, Family Medicine, and Pediatrics—is only three years in duration, and many residents choose not to pursue fellowship; and

Whereas, a lead time to secure the RFS endorsement of at least one year or more prior to election is therefore overly burdensome or incompatible with the time limitations of medical training for many medical trainees; and

Whereas, our RFS has already convened an ad hoc Committee on IOP Revisions dedicated to updating RFS procedures around elections and endorsements; therefore be it

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

Fiscal Note: Minimal - less than $1,000

Received: 11/8/2024

RELEVANT AMA POLICY

AMA Bylaws 3.5.6
3.5.6 Medical Student Trustee. The Medical Student Section shall elect the medical student trustee annually. The medical student trustee shall have all of the rights of a trustee to participate fully in meetings of the Board, including the right to make motions and to vote on policy issues, intra-Board elections or other elections, appointments or nominations conducted by the Board of Trustees. 3.5.6.1 Term. The medical student trustee shall be elected at the Business Meeting of the Medical Student Section prior to the Interim Meeting for a term of one year beginning at the close of the next Annual Meeting and concluding at the close of the second Annual Meeting following the meeting at which the trustee was elected. **3.5.6.2 Re-election**. The medical student trustee shall be eligible for re-election as long as the trustee remains eligible for medical student membership in AMA. Bylaws of the American Medical Association July 2024 **3.5.6.3 Cessation of Enrollment**. The term of the medical student trustee shall terminate and the position shall be declared vacant if the medical student trustee should cease to be eligible for medical student membership in the AMA by virtue of the termination of the trustee's enrollment in an educational program. If the medical student trustee graduates from an educational program within 90 days prior to an Annual Meeting, the trustee shall be permitted to continue to serve on the Board of Trustees until completion of the Annual Meeting.

AMA Bylaws 6.8.2
6.8.2 Medical Student Member. Medical student members of these Councils shall be appointed by the Governing Council of the Medical Student Section with the concurrence of the Board of Trustees.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 825
(I-24)

Introduced by: Organized Medical Staff Section

Subject: Transparency of Facility Fees for Hospital Outpatient Department Visits

Referred to: Reference Committee J

Whereas, transparency in healthcare costs is essential for empowering patients to make informed decisions regarding their medical care; and

Whereas, many patients are often unaware of the additional costs associated with services rendered at hospital outpatient department designated clinics, particularly regarding facility fees that can significantly impact their overall financial responsibility; and

Whereas, the lack of clarity around facility fees and professional service charges contributes to surprise billing and financial hardship for consumers, undermining trust in the healthcare system; and

Whereas, the current lack of transparency causes a burden on hospital employed physicians who are then asked to justify to their patients the higher cost of care; and

Whereas, the American Medical Association has a long-standing commitment to advocating for fair and transparent healthcare practices that prioritize patient welfare; therefore be it

RESOLVED, that our American Medical Association advocate for legislation or regulation that mandates the proactive transparency of the added costs to the consumer for health care services rendered at hospital outpatient department designated clinics (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate the additional costs of facility fees over professional services be stated upon scheduling of such services, noting the two are separate and additive charges, as well as prominently displayed at the point of service. (Directive to Take Action)

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

Received: 11/8/2024

RELEVANT AMA POLICY

Price Transparency D-155.987

1. Our American Medical Association encourages physicians to communicate information about the cost of their professional services to individual patients, taking into consideration the insurance status (e.g., self-pay, in-network insured, out-of-network insured) of the patient or other relevant information where possible.

2. Our AMA advocates that health plans provide plan enrollees or their designees with complete information regarding plan benefits and real time cost-sharing information associated with both in-network and out-of-network provider services or other plan designs that may affect patient out-of-pocket costs.

3. Our AMA will actively engage with health plans, public and private entities, and other stakeholder groups in their efforts to facilitate price and quality transparency for patients and physicians, and help ensure that entities promoting price transparency tools have processes in place to ensure the accuracy and relevance of the information they provide.

4. Our AMA will work with states and the federal government to support and strengthen the development of all-payer claims databases.

5. Our AMA encourages electronic health records vendors to include features that assist in facilitating price transparency for physicians and patients.

6. Our AMA encourages efforts to educate patients in health economics literacy, including the development of resources that help patients understand the complexities of health care pricing and encourage them to seek information regarding the cost of health care services they receive or anticipate receiving.

7. Our AMA will request that the Centers for Medicare and Medicaid Services expand its Medicare Physician Fee Schedule Look-up Tool to include hospital outpatient payments.

Citation: CMS Rep. 4, A-15; Reaffirmed in lieu of: Res. 121, A-16; Reaffirmed in lieu of: Res 213, I-17; Reaffirmed: BOT Rep. 14, A-18; Reaffirmed in lieu of: Res. 112, A-19

Addressing Financial Incentives to Shop for Lower-Cost Health Care H-185.920

1. Our AMA supports the following continuity of care principles for any financial incentive program (FIP):
a. Collaborate with the physician community in the development and implementation of patient incentives.
b. Collaborate with the physician community to identify high-value referral options based on both quality and cost of care.
c. Provide treating physicians with access to patients' FIP benefits information in real-time during patient consultations, allowing patients and physicians to work together to select appropriate referral options.
d. Inform referring and/or primary care physicians when their patients have selected an FIP service prior to the provision of that service.
e. Provide referring and/or primary care physicians with the full record of the service encounter.
f. Never interfere with a patient-physician relationship (eg, by proactively suggesting health care items or services that may or may not become part of a future care plan).
g. Inform patients that only treating physicians can determine whether a lower-cost care option is medically appropriate in their case and encourage patients to consult with their physicians prior to making changes to established care plans.

2. Our AMA supports the following quality and cost principles for any FIP:
a. Remind patients that they can receive care from the physician or facility of their choice consistent with their health plan benefits.
b. Provide publicly available information regarding the metrics used to identify, and quality scores associated with, lower and higher-cost health care items, services, physicians and facilities.
c. Provide patients and physicians with the quality scores associated with both lower and higher-cost physicians and facilities, as well as information regarding the methods used to determine quality scores. Differences in cost due to specialty or sub-specialty focus should be explicitly stated and clearly explained if data is made public.
d. Respond within a reasonable timeframe to inquiries of whether the physician is among the preferred lower-cost physicians; the physician's quality scores and those of lower-cost physicians; and directions for how to appeal exclusion from lists of preferred lower-cost physicians.
e. Provide a process through which patients and physicians can report unsatisfactory care experiences when referred to lower-cost physicians or facilities. The reporting process should be easily accessible by patients and physicians participating in the program.

f. Provide meaningful transparency of prices and vendors.
g. Inform patients of the health plan cost-sharing and any financial incentives associated with receiving care from FIP-preferred, other in-network, and out-of-network physicians and facilities.
h. Inform patients that pursuing lower-cost and/or incentivized care, including FIP incentives, may require them to undertake some burden, such as traveling to a lower-cost site of service or complying with a more complex dosing regimen for lower-cost prescription drugs.
i. Methods of cost attribution to a physician or facility must be transparent, and the assumptions underlying cost attributions must be publicly available if cost is a factor used to stratify physicians or facilities.

3. Our AMA supports requiring health insurers to indemnify patients for any additional medical expenses resulting from needed services following inadequate FIP-recommended services.

4. Our AMA opposes FIPs that effectively limit patient choice by making alternatives other than the FIP-preferred choice so expensive, onerous and inconvenient that patients effectively must choose the FIP choice.

5. Our AMA encourages state medical associations and national medical specialty societies to apply these principles in seeking opportunities to collaborate in the design and implementation of FIPs, with the goal of empowering physicians and patients to make high-value referral choices.

6. Our AMA encourages objective studies of the impact of FIPs that include data collection on dimensions such as:
a. Patient outcomes/the quality of care provided with shopped services;
b. Patient utilization of shopped services;
c. Patient satisfaction with care for shopped services;
d. Patient choice of health care provider;
e. Impact on physician administrative burden; and
f. Overall/systemic impact on health care costs and care fragmentation.
Citation: CMS Rep. 2, I-19

Private Health Insurance Formulary Transparency H-125.979

1. Our American Medical Association will work with pharmacy benefit managers, health insurers, and pharmacists to enable physicians to receive accurate, real-time formulary data at the point of prescribing.
2. Our AMA supports legislation or regulation that ensures that private health insurance carriers declare which medications are available on their formularies by October 1 of the preceding year, that formulary information be specific as to generic versus trade name and include copay responsibilities, and that drugs may not be removed from the formulary nor moved to a higher cost tier within the policy term.
3. Our AMA will develop model legislation:
    a. requiring insurance companies to declare which drugs on their formulary will be covered under trade names versus generic.
    b. requiring insurance carriers to make this information available to consumers by October 1 of each year.
    c. forbidding insurance carriers from making formulary deletions within the policy term.
4. Our AMA will promote the following insurer-pharmacy benefits manager - pharmacy (IPBMP) to physician procedural policy: In the event that a specific drug is not or is no longer on the formulary when the prescription is presented, the IPBMP shall provide notice of covered formulary alternatives to the prescriber promptly so that appropriate medication can be provided to the patient within 72 hours.

5. Drugs requiring prior authorization, shall be adjudicated by the IPBMP within 72 hours of receipt of the prescription.
6. Our AMA
    a. promotes the value of online access to up-to-date and accurate prescription drug formulary plans from all insurance providers nationwide.
    b. supports state medical societies in advocating for state legislation to ensure online access to up-to-date and accurate prescription drug formularies for all insurance plans.
7. Our AMA will continue its efforts with the National Association of Insurance Commissioners addressing the development and management of pharmacy benefits.
8. Our AMA will develop model state legislation on the development and management of pharmacy benefits.

Citation: Sub. Res. 724, A-14; Appended: Res. 701, A-16; Appended: Alt. Res. 806, I-17; Reaffirmed: CMS Rep. 07, A-18; Reaffirmed: BOT Rep. 20, A-19; Reaffirmed: CMS Rep. 05, A-19; Reaffirmed: CMS Rep. 2, A-21; Reaffirmed: CMS Rep. 06, A-24

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 826
(I-24)

Introduced by: Resident and Fellow Section

Subject: Renewing the Expansion of Premium Tax Credits

Referred to: Reference Committee J

Whereas, premium tax credits have been a central part of the Affordable Care Act (ACA) and improving health insurance affordability[1-3]; and

Whereas, these tax credits were expanded for 2021 and 2022 as part of the American Rescue Plan Act, and these expanded credits were continued through 2025 by the Inflation Reduction Act[2]; and

Whereas, after years of almost no change in enrollment on the ACA exchanges, enrollment nearly doubled from 11.3 million before the expansion to 21.4 million after the expansion[2]; and

Whereas, nine of the ten states with the highest percentage of residents covered by the ACA marketplace had the largest recent increases in ACA exchange enrollment, which occurred in West Virginia, Louisiana, Ohio, Indiana, and Tennessee[4-5]; and

Whereas, about three in four adults report being “very” or “somewhat worried” about being able to afford unexpected medical bills or the cost of health care[6]; and

Whereas, these enhanced subsidies have cut premium payments by an estimated 44% ($705 annually) for enrollees receiving premium tax credits[2]; and

Whereas, increased subsidies have been particularly important for Black and Latino enrollees, with increases from 2021-23 by over 80%[1]; and

Whereas, if subsidies are not extended nearly all 21 million Marketplace enrollees will see their premiums rise and, particularly devastatingly, nearly 4 million people will lose their insurance coverage;[1-3,7] and

Whereas, though enhanced subsidies expire at the end of 2025, they must be extended by Spring of 2025, lest consumers with subsidized plans face two-fold or larger premium increases, on average, when purchasing plans in Fall of 2025; therefore be it

RESOLVED, that our American Medical Association reaffirm that expanding coverage and protecting access to care is a top AMA priority (New HOD Policy); and be it further

RESOLVED, that our AMA will monitor and oppose efforts to rollback affordable and quality health insurance coverage at the federal level (Directive to Take Action); and be it further

RESOLVED, that our AMA will immediately initiate or substantially invest in a focused grassroots campaign to support extending Affordable Care Act tax credit enhancement from the American Rescue Plan Act and the Inflation Reduction Act. (Directive to Take Action)

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

Received: 11/8/2024

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RELEVANT AMA POLICY

H-165.824: Improving Affordability in the Health Insurance Exchanges

1. Our American Medical Association will:
    a. support adequate funding for and expansion of outreach efforts to increase public awareness of advance premium tax credits.
    b. support expanding eligibility for premium tax credits up to 500 percent of the federal poverty level.
    c. support providing young adults with enhanced premium tax credits while maintaining the current premium tax credit structure which is inversely related to income.
    d. encourage state innovation, including considering state-level individual mandates, auto-enrollment and/or reinsurance, to maximize the number of individuals covered and stabilize health insurance premiums without undercutting any existing patient protections.
2. Our AMA supports:
    a. eliminating the subsidy "cliff", thereby expanding eligibility for premium tax credits beyond 400 percent of the federal poverty level (FPL).
    b. increasing the generosity of premium tax credits.
    c. expanding eligibility for cost-sharing reductions.
    d. increasing the size of cost-sharing reductions.

[CMS Rep. 02, A-18; Appended: CMS Rep. 02, A-19; Reaffirmed: CMS Rep. 3, I-21]

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

1. That our American Medical Association advocates for a pluralistic health care system, which may include a public option, that focuses on increasing equity and access, is cost-conscious, and reduces burden on physicians.
2. Our AMA will advocate that any public option to expand health insurance coverage must meet the following standards:
    a. The primary goals of establishing a public option are to maximize patient choice of health plan and maximize health plan marketplace competition.
    b. Eligibility for premium tax credit and cost-sharing assistance to purchase the public option is restricted to individuals without access to affordable employer-sponsored coverage that meets standards for minimum value of benefits.
    c. Physician payments under the public option are established through meaningful negotiations and contracts. Physician payments under the public option must be higher than prevailing Medicare rates and at rates sufficient to sustain the costs of medical practice.

d. Physicians have the freedom to choose whether to participate in the public option. Public option proposals should not require provider participation and/or tie physician participation in Medicare, Medicaid and/or any commercial product to participation in the public option.
e. The public option is financially self-sustaining and has uniform solvency requirements.
f. The public option does not receive advantageous government subsidies in comparison to those provided to other health plans.
g. The public option shall be made available to uninsured individuals who fall into the "coverage gap" in states that do not expand Medicaid – having incomes above Medicaid eligibility limits but below the federal poverty level, which is the lower limit for premium tax credits – at no or nominal cost.

3. Our AMA supports states and/or the federal government pursuing auto-enrollment in health insurance coverage that meets the following standards:
    a. Individuals must provide consent to the applicable state and/or federal entities to share their health insurance status and tax data with the entity with the authority to make coverage determinations.
    b. Individuals should only be auto-enrolled in health insurance coverage if they are eligible for coverage options that would be of no cost to them after the application of any subsidies. Candidates for auto-enrollment would, therefore, include individuals eligible for Medicaid/Children's Health Insurance Program (CHIP) or zero-premium marketplace coverage.
    c. Individuals should have the opportunity to opt out from health insurance coverage into which they are auto-enrolled.
    d. Individuals should not be penalized if they are auto-enrolled into coverage for which they are not eligible or remain uninsured despite believing they were enrolled in health insurance coverage via auto-enrollment.
    e. Individuals eligible for zero-premium marketplace coverage should be randomly assigned among the zero-premium plans with the highest actuarial values.
    f. Health plans should be incentivized to offer pre-deductible coverage including physician services in their bronze and silver plans, to maximize the value of zero-premium plans to plan enrollees.
    g. Individuals enrolled in a zero-premium bronze plan who are eligible for cost-sharing reductions should be notified of the cost-sharing advantages of enrolling in silver plans.
    h. There should be targeted outreach and streamlined enrollment mechanisms promoting health insurance enrollment, which could include raising awareness of the availability of premium tax credits and cost-sharing reductions, and establishing a special enrollment period.
4. Our AMA:
    a. will advocate that any federal approach to cover uninsured individuals who fall into the "coverage gap" in states that do not expand Medicaid--having incomes above Medicaid eligibility limits but below the federal poverty level, which is the lower limit for premium tax credit eligibility--make health insurance coverage available to uninsured individuals who fall into the coverage gap at no or nominal cost, with significant cost-sharing protections.
    b. will advocate that any federal approach to cover uninsured individuals who fall into the coverage gap provide states that have already implemented Medicaid expansions with additional incentives to maintain their expansions.
    c. supports extending eligibility to purchase Affordable Care Act (ACA) marketplace coverage to undocumented immigrants and Deferred Action for Childhood Arrivals (DACA) recipients, with the guarantee that health plans and ACA marketplaces will not collect and/or report data regarding enrollee immigration status.
    d. recognizes the potential for state and local initiatives to provide coverage to immigrants without regard to immigration status.

[CMS Rep. 1, I-20; Appended: CMS Rep. 3, I-21; Reaffirmation: A-22; Reaffirmed: CMS Rep. 3, A-22; Reaffirmed: Res. 122, A-22; Modified: Res. 813, I-22; Reaffirmed: CMS Rep. 5, I-23]

H-165.828 Health Insurance Affordability

1. Our American Medical Association supports modifying the eligibility criteria for premium credits and cost-sharing subsidies for those offered employer-sponsored coverage by lowering the

threshold that determines whether an employee's premium contribution is affordable to the level at which premiums are capped for individuals with the highest incomes eligible for subsidized coverage in Affordable Care Act (ACA) marketplaces.

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

[CMS Rep. 8, I-15; Reaffirmed in lieu of: Res. 121, A-16; Reaffirmation: A-17; Reaffirmed: CMS Rep. 09, A-19; Reaffirmed: CMS Rep. 02, A-19; Reaffirmed in lieu of: Res. 101, A-19; Reaffirmed: CMS Rep. 01, I-20; Reaffirmed: CMS Rep. 2, I-20; Modified: CMS Rep. 3, I-21; Appended: Res. 701, I-21]

H-165.865 Principles for Structuring a Health Insurance Tax Credit

(1) AMA support for replacement of the present exclusion from employees' taxable income of employer-provided health insurance coverage with tax credits will be guided by the following principles: (a) Tax credits should be contingent on the purchase of health insurance, so that if insurance is not purchased the credit is not provided. (b) Tax credits should be refundable. (c) The size of tax credits should be inversely related to income. (d) The size of tax credits should be large enough to ensure that health insurance is affordable for most people. (e) The size of tax credits should be capped in any given year. (f) Tax credits should be fixed-dollar amounts for a given income and family structure. (g) The size of tax credits should vary with family size to mirror the pricing structure of insurance premiums. (h) Tax credits for families should be contingent on each member of the family having health insurance. (i)Tax credits should be applicable only for the purchase of health insurance, including all components of a qualified Health Savings Account, and not for out-of-pocket health expenditures. (j) Tax credits should be advanceable for low-income persons who could not afford the monthly out-of-pocket premium costs.
(2) It is the policy of our AMA that in order to qualify for a tax credit for the purchase of individual health insurance, the health insurance purchased must provide coverage for hospital care, surgical and medical care, and catastrophic coverage of medical expenses as defined by Title 26 Section 9832 of the United States Code.
(3) Our AMA will support the use of tax credits, vouchers, premium subsidies or direct dollar subsidies, when designed in a manner consistent with AMA principles for structuring tax credits and when designed to enable individuals to purchase individually owned health insurance.
[CMS Rep. 4, A-00; CMS Rep. 5, A-00; Reaffirmation I-00; Reaffirmation A-02; Reaffirmation I-03; CMS Rep. 2, A-04; Consolidated: CMS Rep. 7, I-05; Reaffirmation A-07; Modified: CMS Rep. 8, A-08; Reaffirmed in lieu of Res. 813, I-08; Reaffirmation A-10; Reaffirmed: CMS Rep. 9, A-11; Reaffirmation A-11; Reaffirmed: Res. 239, A-12; Reaffirmed: CMS Rep. 9, A-14; Reaffirmed: CMS Rep. 01, A-24]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 931
(I-24)

Introduced by: Resident and Fellow Section

Subject: Mass Deportation as a Public Health Issue

Referred to: Reference Committee K

Whereas, our American Medical Association has proudly declared medicine's social contract with humanity, admonishing our profession to "refrain from supporting or committing crimes against humanity and condemn any such acts" with solemn resolve[1]; and

Whereas, the Rome Statute of the International Criminal Court–the main arbiter of "the most serious crimes of international concern" defines crimes against humanity as inclusive of "deportation or forcible transfer of population…when committed as part of a widespread or systematic attack directed against any civilian population, with knowledge of the attack"[2]; and

Whereas, a key immigration advisor helping to shape plans for Federal mass deportation operations in 2025 discussed the necessity of "large-scale staging grounds" near the border that would likely serve as internment camps for detained individuals[3]; and

Whereas, Project 2025 estimates US Immigration and Customs Enforcement (ICE) bed capacity would need to increase to over 100,000 and advocates "civil arrest, detention, and removal of immigration violators anywhere in the United States, without warrant where appropriate"[3]; and

Whereas, the American Civil Liberties Union (ACLU) and other organizations intend to address the possibility of mass deportation and attendant raids and internment camps with a strategy in advance and with lawsuits, as necessary[4]; and

Whereas, US immigration policy in the 1930s—a period that does not bear repeating—led to the deportation of 1 million Mexican migrants, 60% of whom were American citizens, in spite of the American Constitution[5]; and

Whereas, "Operation Wetback," the largest deportation operation in American history, was a shameful enterprise characterized by the wrongful removal of American citizens, brutal mistreatment of targeted immigrants on the basis of racist stereotypes[5]; and

Whereas, as part of "Operation Wetback," Border Patrol employed military tactics, threatened employers, and promised indiscriminate sweeps of workplaces and the construction of holding facilities for detained individuals[5]; and

Whereas, our AMA has recognized historical harm wrought by its own historical discriminatory policy and has made substantial and meaningful efforts to rectify and inform the public and members in relation to such, including the adoption of policy declaring racism a threat to public health (H-65.952)[6]; and

Whereas, historical precedent ranging from the last decade to the last century, as noted above, strongly suggest that, as regards to mass immigrant deportation and detention efforts, major rights violations contrary to AMA values, the spirit of AMA policy, and medical ethics are the norm[7]; therefore be it

RESOLVED, that our American Medical Association recognizes mass deportation of immigrants, asylum seekers, and refugees as a public health issue, and recognizes the long-term mental and physical health implications of deportation on individuals, families, and communities (New HOD Policy); and be it further

RESOLVED, that our AMA oppose deportation of health care workers solely based on their documentation status (New HOD Policy); and be it further

RESOLVED, that our AMA oppose the large-scale internment of individuals targeted for deportation efforts. (New HOD Policy)

Fiscal Note: Minimal – less than $1000

Received: 11/8/2024

REFERENCES

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3. Kollmann, A. (2024, May 3). *Trump proposes mass deportations and detention camps for migrants*. The Guardian. https://www.theguardian.com/us-news/article/2024/may/03/trump-mass-deportations-detention-camps-military-migrants
4. American Civil Liberties Union. (2024, September 10). *Project 2025 offers dystopian view of America*. American Civil Liberties Union. https://www.aclu.org/news/civil-liberties/project-2025-offers-dystopian-view-of-america
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7. Human Rights Watch. (2020, April 30). *U.S.: New report shines spotlight on abuses and growth in immigrant detention under Trump*. Human Rights Watch. https://www.hrw.org/news/2020/04/30/us-new-report-shines-spotlight-abuses-and-growth-immigrant-detention-under-trump

Relevant AMA Policy:

Racism as a Public Health Threat H-65.952

1. Our American Medical Association acknowledges that, although the primary drivers of racial health inequity are systemic and structural racism, racism and unconscious bias within medical research and health care delivery have caused and continue to cause harm to marginalized communities and society as a whole.
2. Our AMA recognizes racism, in its systemic, cultural, interpersonal, and other forms, as a serious threat to public health, to the advancement of health equity, and a barrier to appropriate medical care.
3. Our AMA encourages the development, implementation, and evaluation of undergraduate, graduate, and continuing medical education programs and curricula that engender greater understanding of:
    a. The causes, influences, and effects of systemic, cultural, institutional, and interpersonal racism.
    b. How to prevent and ameliorate the health effects of racism.
4. Our AMA:
    a. supports the development of policy to combat racism and its effects.
    b. encourages governmental agencies and nongovernmental organizations to increase funding for research into the epidemiology of risks and damages related to racism and how to prevent or repair them.
5. 5. Our AMA will work to prevent and combat the influences of racism and bias in innovative health technologies.

[Res. 5, I-20; Reaffirmed: Res. 013, A-22; Modified: Speakers Rep., A-22; Reaffirmed: Res. 320, A-24]

Support of Human Rights and Freedom H-65.965

1. Our American Medical Association continues to support the dignity of the individual, human rights and the sanctity of human life,
2. Our AMA reaffirms its long-standing policy that there is no basis for the denial to any human being of equal rights, privileges and responsibilities commensurate with his or her individual

capabilities and ethical character because of an individual's sex, sexual orientation, gender, gender identity or transgender status, race, religion, disability, ethnic origin, national origin or age.

3. Our AMA opposes any discrimination based on an individual's sex, sexual orientation, gender identity, race, appearance, religion, disability, ethnic origin, national origin or age and any other such reprehensible policies.
4. Our AMA recognizes that hate crimes pose a significant threat to the public health and social welfare of the citizens of the United States, urges expedient passage for appropriate hate crimes prevention legislation in accordance with our AMA's policy through letters to members of Congress; and registers support for hate crimes prevention legislation, via letter, to the President of the United States.

[CCB/CLRPD Rep. 3, A-14; Reaffirmed in lieu of: Res. 001, I-16; Reaffirmation: A-17; Modified: Res. 013, A-22; Reaffirmed: BOT Rep. 5, I-22]

A Declaration of Professional Responsibility H-140.900

Our American Medical Association adopts the Declaration of Professional Responsibility
DECLARATION OF PROFESSIONAL RESPONSIBILITY: MEDICINE'S SOCIAL CONTRACT WITH HUMANITY
Preamble:
Never in the history **of** human civilization has the well being **of** each individual been so inextricably linked to that **of** every other. Plagues and pandemics respect no national borders in **a** world **of** global commerce and travel. Wars and acts **of** terrorism enlist innocents as combatants and mark civilians as targets. Advances in medical science and genetics, while promising to do great good, may also be harnessed as agents **of** evil. The unprecedented scope and immediacy **of** these universal challenges demand concerted action and response by all.
As physicians, we are bound in our response by **a** common heritage **of** caring for the sick and the suffering. Through the centuries, individual physicians have fulfilled this obligation by applying their skills and knowledge competently, selflessly and at times heroically. Today, our profession must reaffirm its historical commitment to combat natural and man-made assaults on the health and well being **of** humankind. Only by acting together across geographic and ideological divides can we overcome such powerful threats. Humanity is our patient.
Declaration:
We, the members **of** the world community **of** physicians, solemnly commit ourselves to:

1. Respect human life and the dignity **of** every individual.
2. Refrain from supporting or committing crimes against humanity and condemn any such acts.
3. Treat the sick and injured with competence and compassion and without prejudice.
4. Apply our knowledge and skills when needed, though doing so may put us at risk.
5. Protect the privacy and confidentiality **of** those for whom we care and breach that confidence only when keeping it would seriously threaten their health and safety or that **of** others.
6. Work freely with colleagues to discover, develop, and promote advances in medicine and public health that ameliorate suffering and contribute to human well-being.
7. Educate the public and polity about present and future threats to the health **of** humanity.
8. Advocate for social, economic, educational, and political changes that ameliorate suffering and contribute to human well-being.
9. Teach and mentor those who follow us for they are the future **of** our caring profession.

We make these promises solemnly, freely, and upon our personal and professional honor.
[CEJA Rep. 5, I-01; Reaffirmation A-07; Reaffirmed: CEJA Rep. 04, A-17; Reaffirmed: Res. 215, A-23]

Consideration of the Health and Welfare of U.S. Minor Children in Deportation Proceedings Against Their Undocumented Parents D-60.966

Our AMA: (1) supports that the mental health, physical well-being, and welfare of U.S. citizen minors should be taken into consideration in determining whether undocumented parents of U.S. citizen minors may be detained or deported; and (2) will work with local and state medical societies and other relevant stakeholders to address the importance of considering the health and welfare of U.S. citizen minors in cases where the parents of those minors are in danger of detention or deportation. [Res. 016, A-17]

Care of Women and Children in Family Immigration Detention H-350.955

1. Our American Medical Association recognizes the negative health consequences of the detention of families seeking safe haven.
2. Due to the negative health consequences of detention, our AMA opposes the expansion of family

immigration detention in the United States.
3. Our AMA opposes the separation of parents from their children who are detained while seeking safe haven.
4. Our AMA will advocate for access to health care for women and children in immigration detention.
5. Our AMA will advocate for the preferential use of alternatives to detention programs that respect the human dignity of immigrants, migrants, and asylum seekers who are in the custody of federal agencies. [Res. 002, A-17; Appended: Res. 218, A-21; Reaffirmed: Res. 234, A-22]

Immigration Status is a Public Health Issue D-350.975

1. Our American Medical Association declares that immigration status is a public health issue that requires a comprehensive public health response and solution.
2. Our AMA recognizes interpersonal, institutional, structural, and systemic factors that negatively affect immigrants' health.
3. Our AMA will promote the development and implementation of educational resources for healthcare professionals to better understand health and healthcare challenges specific for the immigrant population.
4. Our AMA will support the development and implementation of public health policies and programs that aim to improve access to healthcare and minimize systemic health barriers for immigrant communities.

[Res. 904, I-22; Reaffirmed: Res. 210, A-23]

Opposing the Detention of Migrant Children H-60.906

1. Our American Medical Association opposes the separation of migrant children from their families and any effort to end or weaken the Flores Settlement that requires the United States Government to release undocumented children "without unnecessary delay" when detention is not required for the protection or safety of that child and that those children that remain in custody must be placed in the "least restrictive setting" possible, such as emergency foster care.
2. Our AMA supports the humane treatment of all undocumented children, whether with families or not, by advocating for regular, unannounced, auditing of the medical conditions and services provided at all detention facilities by a non-governmental, third party with medical expertise in the care of vulnerable children.
3. Our AMA urges continuity of care for migrant children released from detention facilities.

[Res. 004, I-18; Reaffirmed: Res. 234, A-22]

Resolutions not for Consideration

Resolutions

203	Alternative Pathways for International Medical Graduates
209	Physician Liability for AI and Other Technological Advances in Medicine
224	Update the status of Virtual Credit card policy, EFT fees, and lack of Enforcement of Administrative Simplification Requirements by CMS
301	Reopening Schools Closed by the Flexner Report
303	Transparency and Access to Medical Training Program Unionization Status, Including Creation of a FREIDA Unionization Filter
307	Humanism in Anatomical Medical Education
603	Study of Grading Systems in AMA Board Reports
608	Direct Election of Resident/Fellow Members of the AMA Board of Trustees and Various AMA Councils
806	Study of the Federal Employee Health Benefit Plan (FEHBP)
816	Study of CO-OP Insurance as a Vehicle for Public Healthcare Insurance Option
906	Call for Study: Should Petroleum-Powered Emergency Medical Services (EMS) Vehicles in Urban Service Areas be Replaced by Renewably-Powered Electric Vehicles?
908	Support for Doula Care Programs
914	Protecting the Healthcare Supply Chain from the Impacts of Climate Change
921	In Support of a National Drug Checking Registry
924	Public Health Implications of US Food Subsidies
925	Improving Public Awareness of Lung Cancer Screening and CAD in Chronic Smokers
927	The Creation of Healthcare Sustainability Lecture Series

Summary of Fiscal Notes (I-24)

Report(s) of the Board of Trustees

01	Augmented Intelligence Development, Deployment, and Use in Health Care	Minimal
02	On-Site Physician Requirements for Emergency Departments	Minimal
03	Stark Law Self-Referral Ban	Minimal
04	Addressing Work Requirements For J-1 Visa Waiver Physicians	Minimal
05	Protecting the Health of Incarcerated Patients	Minimal
06	Health Technology Accessibility for Aging Patients	Minimal
07	Reevaluation of Scoring Criteria for Rural Communities in the National Health Service Corps Loan Repayment Program	Minimal
08	Increasing Access to Medical Care for People Seeking Asylum	Minimal
09	Corporate Practice of Medicine Prohibition	Minimal
10	AMA Efforts on Medicare Payment Reform	Info. Report
11	Carbon Pricing to Address Climate Change	Minimal
12	Eliminating Eligibility Criteria for Sperm Donors Based on Sexual	Info. Report
13	AMA/Specialty Society RVS Update Committee	Minimal
14	Privacy Protection and Prevention of Further Trauma for Victims of Distribution of Intimate Videos and Images Without Consent	Minimal
15	Published Metrics for Hospitals and Hospital Systems	Minimal
16	AMA Reimbursement of Necessary HOD Business Meeting Expenses for Delegates and Alternates	$2 million
17	Environmental Sustainability of AMA National Meetings	Info. Report
18	Expanding Protections of End-of-Life Care	Minimal
19	Update on Climate Change and Health AMA Activities (BOT Report 03-I-23)	Info. Report
20	2024 AMA Advocacy Efforts	Info. Report
21	Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care is Banned or Restricted	Info. Report
22	Specialty Society Representation in the House of Delegates - Five-Year Review	Minimal
23	Advocating for the Informed Consent for Access to Transgender Health Care	Minimal
24	Physicians Arrested for Non-Violent Crimes While Engaged in Public Protests	Moderate
25	World Medical Association Observer Status in the House of Delegates	Minimal

Report(s) of the Council on Constitution and Bylaws

01	Resolution Deadline Clarification	Minimal
02	Name Change for Reference Committee	Minimal
03	Bylaw Amendments to Address Medical Student Leadership	Minimal

Report(s) of the Council on Ethical and Judicial Affairs

01	Expanding Access to Palliative Care	Minimal
02	Protecting Physicians Who Engage in Contracts to Deliver Health Care Services	Minimal

Summary of Fiscal Notes (I-24)

Opinion(s) of the Council on Ethical and Judicial Affairs

01	Research Handling of De-Identified Patient Data	Info. Report
02	Amendment to E-2.1.1, "Informed Consent"	Info. Report
03	Amendment to E-3.1.1, "Privacy in Health Care"	Info. Report
04	Amendment to E-3.2.4 "Access to Medical Records by Data Collection	Info. Report
05	Amendment to E-3.3.2, "Confidentiality and Electronic Medical Records"	Info. Report
06	Physicians' Use of Social Media for Product Promotion and Compensation	Info. Report
07	Short-Term Global Health Clinical Encounters	Info. Report

Report(s) of the Council on Long Range Planning and Development

01	Academic Physicians Section Five-Year Review	Within Current Budget

Report(s) of the Council on Medical Education

01	Medication Reconciliation Education	Minimal
02	Updates to Recommendations for Future Directions for Medical Education	Moderate

Report(s) of the Council on Medical Service

01	Nonprofit Hospital Charity Care Policies	Minimal
02	Unified Financing Health Care System	Minimal
03	Time-Limited Patient Care	Modest
04	Biosimilar Coverage Structures	Modest

Report(s) of the Council on Science and Public Health

01	Cannabis Therapeutic Claims in Marketing and Advertising	Minimal
02	Drug Shortages: 2024 Update	Minimal
03	HPV-Associated Cancer Prevention	Moderate
04	Reducing Sodium Intake to Improve Public Health	Minimal
05	Teens and Social Media	Moderate

Report(s) of the HOD Committee on Compensation of the Officers

01	Report of the House of Delegates Committee on Compensation of the Officers	Estimated annual cost of Recommendations 2, 3 and 4 is $185,175 based on data for July 1, 2023 - June 30, 2024

Report(s) of the Speakers

01	Report of the Election Task Force 2	Minimal
02	Reconciliation Report	Info. Report

Resolutions

001	Addressing Gender-Based Pricing Disparities	Minimal
002	Anti-Doxxing Data Privacy Protection	Modest
003	On the Ethics of Human Lifespan Prolongation	Modest
004	Improving Usability of Electronic Health Records for Transgender and Gender Diverse Patients	Minimal
005	Updating the AMA Definition of Infertility	Moderate
006	Opposition to the Deceptive Relocation of Migrants and Asylum Seekers	Minimal
007	Supporting Diversity in Research	Modest
008	Missing and Murdered Black Women and Girls	Modest

Summary of Fiscal Notes (I-24)

009	Opposition to Creation or Enforcement of Civil Litigation, Commonly Referred to as Civil Causes of Action	Minimal
010	Development of Resources for Medical Staffs to Engage in Collective Negotiation with Hospital and Health Systems	Moderate
011	American Kidney Donation Legislation	Minimal
201	Boarding Patients in the Emergency Room	Modest
202	Illicit Drugs: Calling for a Multifaceted Approach to the "Fentanyl" Crisis	Moderate
204	Support for Physician-Supervised Community Paramedicine Programs	Minimal
205	Native American Medical Debt	Minimal
206	Protect Infant and Young Child Feeding	Modest
207	Accountability for G-605.009: Requesting A Task Force to Preserve the Patient-Physician Relationship Task Force Update and Guidance	$1.25M ($250k per year for five years)
208	Medicare Part B Enrollment and Penalty Awareness	Moderate
210	Laser Surgery	Minimal
211	Water Bead Injuries	Modest
212	Addressing the Unregulated Body Brokerage Industry	Moderate
213	Sustainable Long-term Funding for Child Psychiatry Access Programs	Modest
214	Advocating for Evidence-Based Strategies to Improve Rural Obstetric Health Care and Access	Minimal
215	Advocating for Federal and State Incentives for Recruitment and Retention of Physicians to Practice in Rural Areas	Modest
216	Clearing Federal Obstacles for Supervised Injection Sites	Modest
217	Expand Access to Skilled Nursing Facility Services for Patients with Opioid Use Disorder	Modest
218	Time Sensitive Credentialing of New Providers with an Insurance Carrier	Modest
219	Advocate to Continue Reimbursement for Telehealth / Telemedicine Visits Permanently	Modest
220	MIPS Reform	Modest
221	Medicare Coverage for Non-PAR Physicians	Modest
222	Rollback on Physician Performance Measures	Moderate
223	Mandated Economic Escalators in Insurance Contracts	Modest
225	Elimination of Medicare 14-Day Rule	Modest
226	Information Blocking Rule	Modest
227	Medicare Payment Parity for Telemedicine Services	Modest
228	Codification of the Chevron Deference Doctrine	Minimal
229	Supporting Penalties on Insurers Who Fail to Pay Doctors	Modest
230	Addressing and Reducing Patient Boarding in Emergency Departments	Moderate
302	Strengthening Parental Leave Policies for Medical Trainees and Recent Graduates	Minimal
304	Payment and Benefit Parity for Fellows	Minimal
305	Removing Board Certification as a Requirement for Billing for Home Sleep Studies	Modest
306	Streamlining Continuing Medical Education Across States and Medical Specialties	Modest
601	Expanding AMA Meeting Venue Options	Minimal

Summary of Fiscal Notes (I-24)

602	Delaying the ETF Endorsement Timeline Revision for Section IOP Revisions	Minimal
604	Opposing Discrimination and Protecting Free Speech Among Member Organizations of Organized Medical Associations	Minimal
605	AMA House of Delegates Expenses	$2.82 million annually based on current delegate count. Would increase if delegate count increases.
606	Protecting Free Speech and Encouraging Respectful Discourse Among Member Organizations of Organized Medical Associations	Minimal
607	AMA House of Delegates Venues	Minimal
801	Reimbursement for Managing Portal Messages	Modest
802	Address Physician Burnout with Inbox Management Resources and Increased Payment	Modest
803	Healthcare Savings Account Reform	Modest
804	Improving Public Assistance for People with Disabilities	Minimal
805	Coverage for Care for Sexual Assault Survivors	Modest
807	Expanded Pluralism in Medicaid	Moderate
808	Requirement to Communicate Covered Alternatives for Denied Medications	Modest
809	Minimum Requirements for Medication Formularies	Modest
810	Immediate Digital Access to Updated Medication Formulary for Patients and Their Physicians	Modest
811	AMA Practice Expense Survey Geographic Analysis	Moderate
812	Advocate for Therapy Cap Exception Process	Modest
813	Insurance Coverage for Pediatric Positioning Chairs	Modest
814	Legislation for Physician Payment for Prior Authorization	Modest
815	Addressing the Crisis of Pediatric Hospital Closures and Impact on Care	Moderate
817	ACA Subsidies for Undocumented Immigrants	Minimal
818	Payment for pre-certified/preauthorized procedures	Modest
819	Establishing a New Office-Based Facility Setting to Pay Separately from the Medicare Physician Fee Schedule for the Technical Reimbursement of Physician Services Using High-Cost Supplies	Moderate
820	State Medicaid Coverage of Home Sleep Testing	Minimal
821	Patient Access to Asthma Medications	Minimal
822	Resolution on Medicare Coverage for Non-Emergent Dialysis Transport	Modest
823	Reigning in Medicare Advantage - Institutional Special Needs Plans	Modest
824	Ophthalmologists Required to Be Available for Level I & II Trauma Centers	Modest
825	Transparency of Facility Fees for Hospital Outpatient Department Visits	Modest
826	Renewing the Expansion of Premium Tax Credits	Modest
901	Heat Alerts and Response Plans	Minimal
902	Advancing Menopause Research and Care	Modest
903	Improving the Identification of Intimate Partner Violence (IPV) in People with Disabilities	Modest
904	Regulation of Ionized Radiation Exposure for Healthcare Workers	Minimal
905	Regulation and Transparency of Contaminants in Menstrual Hygiene Products	Minimal

Summary of Fiscal Notes (I-24)

907	Call for Study: The Need for Hospital Interior Temperatures to be Thermally Neutral to Humans within Those Hospitals	Modest
909	Support of Universal School Meals for School Age Children	Modest
910	Food Insecurity Among Patients with Celiac Disease, Food Allergies, and Food Intolerance	Minimal
911	Adequate Masking and HPV Education for Health Care Workers (including those over age 45)	Modest
912	Assuring Representation of Older Age Adults in Clinical Trials	Moderate
913	Sexually Transmitted Infections are on the Rise in the Senior Population	$80,454 Contract with third parties to develop educational content for physicians
915	Reducing Barriers in Sports Participation for LGBTQIA+ People	$80,067 Contract with third parties to develop educational content for physicians
916	Access to Healthcare for Transgender and Gender Diverse People in the Carceral System	Modest
917	Mpox Global Health Emergency Recognition and Response	Moderate
918	Healthcare in Tribal Jails	Modest
919	Improving Rural Access to Comprehensive Cancer Care Service	Modest
920	Revise FAA Regulations to Include Naloxone (Narcan) in the On-Board Medical Kit for Commercial Airlines flying within the Continental United States	Modest
922	Advocating for the Regulation of Pink Peppercorn as a Tree Nut	Minimal
923	Updated Recommendations for Child Safety Seats	Minimal
928	Public Safety Agencies Data Collection Enhancement	Moderate
929	Safety Concerns Regarding Inadequate Labeling of Food Products Upon Ingredient Changes with Known Major Food Allergens	Minimal
930	Economic Factors to Promote Reliability of Pharmaceutical Supply	Minimal
931	Mass Deportation as a Public Health Issue	Minimal

Not for Consideration

203	Alternative Pathways for International Medical Graduates	Moderate
209	Physician Liability for AI and Other Technological Advances in Medicine	Minimal
224	Update the status of Virtual Credit card policy, EFT fees, and lack of Enforcement of Administrative Simplification Requirements by CMS	Modest
301	Reopening Schools Closed by the Flexner Report	Moderate
303	Transparency and Access to Medical Training Program Unionization Status, Including Creation of a FREIDA Unionization Filter	Minimal
307	Humanism in Anatomical Medical Education	Minimal
603	Study of Grading Systems in AMA Board Reports	Modest
608	Direct Election of Resident/Fellow Members of the AMA Board of Trustees and Various AMA Councils	Minimal
806	Study of the Federal Employee Health Benefit Plan (FEHBP)	Modest
816	Study of CO-OP Insurance as a Vehicle for Public Healthcare Insurance Option	Moderate

Summary of Fiscal Notes (I-24)

906	Call for Study: Should Petroleum-Powered Emergency Medical Services (EMS) Vehicles in Urban Service Areas be Replaced by Renewably-Powered Electric Vehicles?	Modest
908	Support for Doula Care Programs	Minimal
914	Protecting the Healthcare Supply Chain from the Impacts of Climate Change	Minimal
921	In Support of a National Drug Checking Registry	Minimal
924	Public Health Implications of US Food Subsidies	Modest
925	Improving Public Awareness of Lung Cancer Screening and CAD in Chronic Smokers	$43,166 Initiating a public health campaign
927	The Creation of Healthcare Sustainability Lecture Series	$261,553 Contract with third-parties to develop educational content; development of a taskforce