

October 21, 2016

Memo to: Delegates, Alternate Delegates
Executive Directors
State Medical Associations, National Medical Specialty Societies, Professional
Interest Medical Associations, Other Societies, Sections and Special Groups

Subject: 2016 Interim Meeting Handbook Addendum

We are pleased to provide the following items received in addition to those included in the advance Delegate's Handbook.

Reports

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

Resolutions Recommended for Consideration

- 005 No Compromise on AMA's Anti-Female Genital Mutilation Policy
- 006 Effective Peer Review
- 007 Fair Process for Employed Physicians
- 216 Ending Medicare Advantage Auto-Enrollment
- 217 The Rights of Patients, Providers and Facilities to Contract for Non-Covered Services
- 218 Support for Prescription Drug Monitoring Programs
- 219 Protect Individualized Compounding in Physicians' Offices as Practice of Medicine
- 312 Eliminating the Tax Liability for Payment of Student Loans
- 604 Oppose Physician Gun Gag Rule Policy by Taking our AMA Business Elsewhere
- 814 Addressing Discriminatory Health Plan Exclusions or Problematic Benefit Substitutions for Essential Health Benefits Under the Affordable Care Act
- 815 Preservation of Physician-Patient Relationships and Promotion of Continuity of Patient Care
- 816 Support for Seamless Physician Continuity of Patient Care
- 925 Graphic Warning Label on all Cigarette Packages

Resolutions Not for Consideration

- 605 Study of Models of Childcare Provided at Healthcare Institutions

Finally, your Speakers wish to inform you that the charts listing actions taken in follow-up to resolutions and report recommendations from the 2015 Interim and 2016 Annual Meetings will be posted on the Interim Meeting website (www.ama-assn.org/go/interim2016).

Sincerely,



Susan R. Bailey, MD
Speaker, House of Delegates



Bruce A. Scott, MD
Vice Speaker, House of Delegates

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 005
(I-16)

Introduced by: M. Zuhdi Jasser, MD, Delegate

Subject: No Compromise on Anti-Female Genital Mutilation Policy

Referred to: Reference Committee on Amendments to Constitution and Bylaws
(John P. Abenstein, MD, Chair)

- 1 Whereas, Female genital mutilation (FGM) is the forcible mutilation of the clitoris and external
2 genitalia of women and girls for non-medical reasons affecting not only women in Southern
3 Asia, the Middle East and Africa, but also remains within the immigrant communities in the U.S.
4 and Europe; and
5
6 Whereas, FGM practiced on girls typically between 4 and 12 years of age (but can range from
7 birth to prior to marriage) is responsible for the torture, maiming, and mutilation of millions upon
8 millions of women and girls worldwide; and
9
10 Whereas, FGM in any form is a violation of basic human rights and bodily autonomy. It denies
11 the victim physical integrity, a normal sexual life, freedom from violence and subjugation, and
12 most extreme cases, causes death; and
13
14 Whereas, The forcible mutilation of a girl's genitalia in any way sets the stage for male-dominant
15 psychological torture, control, and dehumanization of that girl and woman will suffer in her family
16 forever and can lead to a lifetime of depression, anxiety and trauma; and
17
18 Whereas, Existing AMA Policy H-525.980 explicitly condemns the practice of female genital
19 mutilation (FGM); and
20
21 Whereas, In the U.S. an estimated 513,000 women and girls are at risk of undergoing the
22 procedure back in their home country or the country of their parents and annual International
23 Day of Zero Tolerance to FGM found that 70 million more women and girls have undergone the
24 procedure than previously thought; and
25
26 Whereas, There has recently been significant media coverage in 2016 about recent attempts by
27 some academics and physicians in the American medical community to redefine FGM and
28 promote a type of FGM in the form of a genital 'nick' or 'alteration' as a "compromise" position; and
29
30 Whereas, Our AMA must remain clear in its stance on FGM and reject any type of patriarchal
31 'nicking' procedure as an unethical surrender to the barbaric underpinnings of the FGM culture; and
32
33 Whereas, Any compromise procedure is still FGM and entirely violates existing AMA policy
34 H-525.980 last modified A-12; and
35
36 Whereas, Survivors and advocates against FGM like Khadija Gbla, Leyla Hussein (also a
37 psychotherapist) as well as organizations like No FGM Australia and Amref Health Africa (led by
38 Dr. Githinji Gitahi, a gynecologist) wholly rejected the compromise on FGM; and

1 Whereas, Our AMA, in the spirit of our existing Policy H-525.980, should listen to the victims,
2 advocate on their behalf in the ethical practice of medicine, and update our policy to make it
3 clear in 2016 that our AMA rejects any compromise procedures and that we uncompromisingly
4 stand with individuals and organizations who have experienced FGM and who are surrounded
5 by the horrors of FGM in all its incarnations; and
6

7 Whereas, AMA Policy H-525.980 needs to be updated to reflect not only its condemnation of
8 FGM but its condemnation of any compromise procedures; therefore be it
9

10 RESOLVED, That our American Medical Association reaffirm its policy against female genital
11 mutilation (FGM) (Reaffirm HOD Policy); and be it further
12

13 RESOLVED, That, due to the public debate in 2016 over whether the medical community
14 sanctions a proposed 'nicking procedure,' our AMA must further clarify its current position on
15 FGM to explicitly state that our AMA condemns any and all ritual procedures including, but not
16 limited to, 'nicking' or 'genital alteration' procedures done to the genitals of women and girls
17 (New HOD Policy); and be it further
18

19 RESOLVED, That our AMA, on behalf of the medical community, actively advocate against the
20 practice of FGM in all its forms (including the recently proposed 'nicking' and 'alteration'
21 procedures) and effectively add the voice of America's physicians to the voices of many anti-
22 FGM human rights activists and their organizations which advocate for the survivors and victims
23 of FGM (Directive to Take Action); and be it further
24

25 RESOLVED, That our AMA partner in this public advocacy with reputable anti-FGM activists
26 and survivors including, but not limited to, Jaha Dukureh of the Tahirih Justice Center, Waris
27 Dirie of Desert Flower Foundation, Layla Hussein of the Maya Center and the Dahlia Project,
28 and Nimco Ali of the Daughters of Eve or Safe Hands for Girls to name a few (Directive to Take
29 Action); and be it further
30

31 RESOLVED, That our AMA educate its membership and the American public about the harm of
32 FGM prominently through its website and provide resources about the ethics and medical harm
33 of any and all forms of FGM. (Directive to Take Action)

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

Received: 10/11/16

RELEVANT AMA POLICY

Expansion of AMA Policy on Female Genital Mutilation H-525.980

Our AMA: (1) condemns the practice of female genital mutilation (FGM); (2) considers FGM a form of child abuse; (3) supports legislation to eliminate the performance of female genital mutilation in the United States and to protect young girls and women at risk of undergoing the procedure; (4) supports that physicians who are requested to perform genital mutilation on a patient provide culturally sensitive counseling to educate the patient and her family members about the negative health consequences of the procedure, and discourage them from having the procedure performed. Where possible, physicians should refer the patient to social support groups that can help them cope with societal mores; (5) will work to ensure that medical students, residents, and practicing physicians are made aware of the continued practice and existence of FGM in the United States, its physical effects on patients, and any requirements for reporting FGM; and (6) is in opposition to the practice of female genital mutilation by any physician or licensed practitioner in the United States. CSA Rep. 5, I-94 Res. 513, A-96 Reaffirmed: CSAPH Rep. 3, A-06 Modified: Res. 9, A-12

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 006
(I-16)

Introduced by: Washington

Subject: Effective Peer Review

Referred to: Reference Committee on Amendments to Constitution and Bylaws
(John P. Abenstein, MD, Chair)

- 1 Whereas, The Health Care Quality Improvement Act of 1986 (HCQIA) intended to protect the
2 public from incompetent physicians by allowing those physicians on peer review committees to
3 communicate in an open and honest environment and thus weed out incompetent physicians,
4 without the specter of a retaliatory lawsuit by the reviewed physician; and
5
6 Whereas, Most states have passed statutes that broaden the protections afforded by the HCQIA
7 in order to further promote peer review while severely limiting whistleblower protections to very
8 limited specific situations; and
9
10 Whereas, A number of states have specific whistleblower protections; however, California's
11 Health and Safety Code 1278.5(b)(1)(A) states that no health care facility shall discriminate or
12 retaliate against any person who has "presented a grievance, complaint or report to the facility";
13 and
14
15 Whereas; Common law protections are usually limited to situations where the offensive action
16 violates a clearly articulated public policy; and
17
18 Whereas; Many, if not most, physicians are now either employed or controlled by hospital
19 conglomerates; therefore, the threat of a retaliatory lawsuit is far less threatening than
20 termination of employment or elimination of hospital privileges; and
21
22 Whereas; Our AMA policy does not seem to reflect the dramatic recent change in workplace
23 arrangements nor protect employed physicians from retaliation as a result of effective peer
24 review; therefore be it
25
26 RESOLVED, That our American Medical Association study the current environment for effective
27 peer review, on both a federal and state basis, in order to update its current policy to include
28 strategies for promoting effective peer review by employed physicians as well as consider a
29 national strategy for protecting all physicians from retaliation as a result from participating in
30 effective peer review. (Directive to Take Action)

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

Received: 10/13/16

RELEVANT AMA POLICY

Principles for Incident-Based Peer Review and Disciplining at Health Care Organizations H-375.965

AMA policy is that:

(1) Summary suspension of clinical privileges is an extraordinary remedy which should be used only when the physician's continued practice presents an "imminent danger to the health of any individual." The decision to summarily suspend a member's medical staff membership or clinical privileges should be made by the chief of staff, chair or vice-chair of the member's clinical department, or medical executive committee. The medical executive committee (MEC) must meet as soon as possible, but in no event more than 14 days after the summary suspension is imposed, or before the time in which a report would be required to the state licensing agency if applicable, whichever is shorter, to review and consider the summary suspension. The MEC shall then promptly modify, continue or terminate the summary suspension. The suspended physician must be invited to attend and make a statement concerning the issues under investigation, but the meeting with the MEC shall not constitute the physician's fair hearing. If the MEC sustains the suspension, said action will trigger the fair hearing procedures contained in these policies.

(2) At the request of a medical staff department or of a member under review, or at its own initiative if needed for adequate and unbiased review, the medical executive committee may arrange, through the state or local medical society, the relevant specialty society or other appropriate source, for an external hearing panel to hear the case in order to assure professional and impartial clinical assessment.

(3) Prior to any disciplinary hearing, the physician should be provided with a clear, and if applicable, clinically supported basis for the proposed professional review action. A hearing panel of a health care organization should be guided by generally accepted clinical guidelines and established standards in its review actions.

(4) Physician health and impairment issues should be identified and managed by a medical staff committee, which should operate separately from the disciplinary process.

(5) Summary suspension reports that do not adhere to these principles should not be circulated or posted without confirmation by a state medical board or other appropriate authority allowing due process.

(6) Summary suspension reports should be immediately retracted or removed from posting if reversed or where a physician is exonerated.

(7) Physicians who are the subject of a summary suspension report should be afforded the right to add a statement or notice of dispute to the report that is of reasonable length.

BOT Action in response to referred for decision BOT Rep. 23, A-05; BOT Action in response to referred for decision Res. 220, I-08

<http://www.ama-assn.org/meetings/public/annual05/bot23a05.doc>

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 007
(I-16)

Introduced by: Washington

Subject: Fair Process for Employed Physicians

Referred to: Reference Committee on Amendments to Constitution and Bylaws
(John P. Abenstein, MD, Chair)

- 1 Whereas, Employed physicians face unique challenges in that they are held accountable but
2 sometimes not given enough resources or authority; and
3
4 Whereas, Employed physicians sometimes face moral dilemmas within the workplace regarding
5 processes beyond their control, creating increased stress and even depression; often
6 contributing to physician burnout; and
7
8 Whereas, Fear of retaliation and the stigma associated with being a “troublemaker” or not being
9 a team player contributes to underreporting of problems in health care; and
10
11 Whereas, The more responsibility the physician has, the greater the exposure to serious events;
12 and
13
14 Whereas, Physicians find themselves facing a dilemma if their employer will not correct the
15 problem/situation; therefore be it
16
17 RESOLVED, That our American Medical Association support whistleblower protections for
18 health care providers and parties who raise questions of quality, safety, and efficacy of health
19 care and are adversely treated by any health care organization or entity (New HOD Policy); and
20 be it further
21
22 RESOLVED, That our AMA advocate for protection in medical staff bylaws to minimize negative
23 repercussions for physicians who report problems within their workplace. (New HOD Policy)

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

Received: 10/13/16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 216
(I-16)

Introduced by: Florida

Subject: Ending Medicare Advantage "Auto-Enrollment"

Referred to: Reference Committee B
(Ann R. Stroink, MD, Chair)

- 1 Whereas, The Centers for Medicare and Medicaid Services now allows commercial healthcare
2 insurers to “auto-enroll” their insured into that carrier’s Medicare Advantage Plan with a single
3 letter of notification during that insured’s pre-Medicare enrollment period; and
4
5 Whereas, During the pre-Medicare enrollment period each individual will receive dozens of
6 communications from multiple healthcare insurers regarding a wide variety of Medicare
7 insurance products that many Medicare-eligible individuals find confusing; and
8
9 Whereas, The insured receiving notification by their healthcare carrier of “auto-enrollment” in
10 that carrier’s Medicare Advantage Plan must actively “opt-out” of that plan within 60 days or lose
11 their ability to enroll in traditional Medicare for a year; therefore be it
12
13 RESOLVED, The our American Medical Association work with the Centers for Medicare and
14 Medicaid Services and/or Congress to end the procedure of “auto-enrollment” of individuals into
15 Medicare Advantage Plans. (Directive to Take Action)

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

Received: 10/05/16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 217
(I-16)

Introduced by: American Society of Ophthalmic Plastic and Reconstructive Surgery
American Academy of Ophthalmology
American Academy of Facial Plastic and Reconstructive Surgery
American Society for Aesthetic Plastic Surgery
American Society of Cataract and Refractive Surgery
American Society of Retinal Specialists
American Society of Plastic Surgeons

Subject: The Rights of Patients, Providers and Facilities to Contract for Non-Covered Services

Referred to: Reference Committee B
(Ann R. Stroink, MD, Chair)

- 1 Whereas, Blepharoplasty and blepharoptosis repair are distinct surgical procedures directed at
2 correcting different pathology of the upper eyelids; and
3
4 Whereas, Each may be performed for medically necessary (functional) or aesthetic indications;
5 and
6
7 Whereas, These distinctions are dictated by coverage rules of third party payers regarding
8 medical necessity; and
9
10 Whereas, In 2009, NCCI bundled payments for blepharoplasty and ptosis repair and the
11 bundling applied to procedures that met medical necessity criteria but aesthetic procedures
12 would be performed per agreement between patients, surgeons and facilities in accordance with
13 current practice and regulations; and
14
15 Whereas, In May, 2016, CMS issued a guidance that interpreted the bundles to include all
16 ptosis procedures and all functional and aesthetic aspects of blepharoplasty (CMS MLN Matters
17 Number M9658); and
18
19 Whereas, This guidance makes it a violation of policy for aesthetic surgery to be done on the
20 same eyelid, at the same time as functional surgery or at any time by the initial surgeon or by a
21 second surgeon at the same time or at any future time; and
22
23 Whereas, This prohibits the rights of a patient to contract with a surgeon to obtain aesthetic
24 surgery involving an eyelid once any functional surgery has been performed on that lid at the
25 time of the functional surgery or at any time in the future by the same or any surgeon; and
26
27 Whereas, Medical third party payers are not obligated to pay for procedures that do not meet
28 their medical necessity criteria but DO NOT have authority to regulate choices made by patients
29 and providers regarding procedures that do not meet their criteria for medical necessity and
30 decisions regarding non-covered benefits are to be made by agreement between patients,
31 providers and facilities (AMA Policy D-380.997); and

1 Whereas, CMS Matter Number MM9658 violates the rights of patients, facilities and providers to
2 privately contract for non-covered services; and
3

4 Whereas, This regulation sets a bad precedent for future CMS guidance that could affect private
5 contracting between patients and providers in any area of medicine; therefore be it
6

7 RESOLVED, That our American Medical Association reaffirm Policy D-380.997 and any other
8 applicable policies (Reaffirm HOD Policy); and be it further
9

10 RESOLVED, That our AMA engage in efforts to convince the CMS to rescind the CMS guidance
11 that bundled all blepharoptosis procedures with all functional and aesthetic aspects of
12 blepharoplasty and to abstain from bundling other situations in which functional and aesthetic
13 considerations should be able to be considered separately (Directive to Take Action); and be it
14 further
15

16 RESOLVED, That our AMA actively oppose further regulations that would interfere with the
17 rights of patients, providers, and facilities to privately contract for non-covered services. (New
18 HOD Policy)

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

Received: 10/13/16

RELEVANT AMA POLICY

Private Contracting by Medicare Patients D-380.997

1. It is the policy of the AMA: (a) that any patient, regardless of age or health care insurance coverage, has both the right to privately contract with a physician for wanted or needed health services and to personally pay for those services; (b) to pursue appropriate legislative and legal means to permanently preserve that patient's basic right to privately contract with physicians for wanted or needed health care services; (c) to continue to expeditiously pursue regulatory or legislative changes that will allow physicians to treat Medicare patients outside current regulatory constraints that threaten the physician/patient relationship; and (d) to seek immediately suitable cases to reverse the limitations on patient and physician rights to contract privately that have been imposed by CMS or the private health insurance industry.

2. Our AMA strongly urge CMS to clarify the technical and statutory ambiguities of the private contracting language contained in Section 4507 of the Balanced Budget Act of 1997.

3. Our AMA reaffirms its position in favor of a pluralistic health care delivery system to include fee-for-service medicine, and will lobby for the elimination of any restrictions and physician penalties for provision of fee-for-service medicine by a physician to a consenting patient, including patients covered under Medicare.

CMS Rep. 6, A-99 Reaffirmation A-04 Reaffirmation A-08 Reaffirmation I-13 Modified: CMS Rep. 1, A-15

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 218
(I-16)

Introduced by: American Academy of Orthopaedic Surgeons, North American Spine Society, American Association for Hand Surgery, American Orthopaedic Foot and Ankle Society, American Congress of Obstetricians and Gynecologists, American Association of Hip and Knee Surgeons, Kansas

Subject: Support for Prescription Drug Monitoring Programs

Referred to: Reference Committee B
(Ann R. Stroink, MD, Chair)

1 Whereas, State prescription drug monitoring programs (PDMPs) have been established to
2 collect and monitor prescribing and dispensing data of controlled substances; and
3
4 Whereas, PDMPs are currently established in 49 states, the District of Columbia, and Guam;
5 and
6
7 Whereas, Data from PDMPs help physicians to assess risks of abuse or diversion of controlled
8 substances; and
9
10 Whereas, Patients may acquire controlled substances from health care providers and/or
11 pharmacies in more than one state; and
12
13 Whereas, State-based PDMPs currently are not interactive across state lines, limiting the data
14 to which physicians have access, thereby limiting their ability to determine individual patients'
15 risks for addiction or diversion; and
16
17 Whereas, The National All Schedules Prescription Electronic Reporting Act (NASPER) was first
18 passed by Congress in 2005 and last re-authorized in the Comprehensive Addiction and
19 Recovery Act of 2016; and
20
21 Whereas, NASPER contains the initial mandate that PDMPs be interactive between states; and
22
23 Whereas, NASPER does not remain fully funded; and
24
25 Whereas, Our AMA has been supportive of full appropriations for NASPER; therefore be it
26
27 RESOLVED, That our American Medical Association continue to encourage Congress to assure
28 that the National All Schedules Prescription Electronic Reporting Act (NASPER) and/or similar
29 programs be fully funded to allow state prescription drug monitoring programs (PDMPs) to
30 remain viable and active (New HOD Policy); and be it further
31
32 RESOLVED, That our AMA work to assure that interstate operability of PDMPs in a manner that
33 allows data to be easily accessed by physicians and does not place an onerous burden on their
34 practices. (Directive to Take Action)

¹ <http://www.pdmpassist.org/content/prescription-drug-monitoring-frequently-asked-questions-faq>
² <https://www.govtrack.us/congress/bills/109/hr1132/summary>

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

Received: 10/11/16

RELEVANT AMA POLICY

Prescription Drug Monitoring Program Confidentiality H-95.946

Our AMA will: (1) advocate for the placement and management of state-based prescription drug monitoring programs with a state agency whose primary purpose and mission is health care quality and safety rather than a state agency whose primary purpose is law enforcement or prosecutorial; (2) encourage all state agencies responsible for maintaining and managing a prescription drug monitoring program (PDMP) to do so in a manner that treats PDMP data as health information that is protected from release outside of the health care system; and (3) advocate for strong confidentiality safeguards and protections of state databases by limiting database access by non-health care individuals to only those instances in which probable cause exists that an unlawful act or breach of the standard of care may have occurred.

Res. 221, A-12 Reaffirmed: BOT Rep. 12, A-15 Reaffirmed: BOT Rep. 5, I-15

Development and Promotion of Single National Prescription Drug Monitoring Program H-95.939

Our American Medical Association (1) supports the voluntary use of state-based prescription drug monitoring programs (PDMP) when clinically appropriate; (2) encourages states to implement modernized PDMPs that are seamlessly integrated into the physician's normal workflow, and provide clinically relevant, reliable information at the point of care; (3) supports the ability of physicians to designate a delegate to perform a check of the PDMP, where allowed by state law; (4) encourage states to foster increased PDMP use through a seamless registration process; (5) encourages all states to determine how to use a PDMP to enhance treatment for substance use disorder and pain management; (6) encourages states to share access to PDMP data across state lines, within the safeguards applicable to protected health information; and (7) encourages state PDMPs to adopt uniform data standards to facilitate the sharing of information across state lines.

BOT Rep. 12, A-15 Reaffirmed: BOT Rep. 5, I-15 Reaffirmation A-16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 219
(I-16)

Introduced by: American Academy of Allergy, Asthma and Immunology

Subject: Protect Individualized Compounding in Physicians' Offices
as Practice of Medicine

Referred to: Reference Committee B
(Ann R. Stroink, MD, Chair)

1 Whereas, The AMA has adopted policy that encourages the United States Pharmacopeia (USP)
2 to retain special rules for compounding in physician offices for allergen immunotherapy and
3 potentially other kinds of small-volume physician office-based compounding, including engaging
4 with the U.S. Congress and the Food and Drug Administration (FDA); that the AMA shall form a
5 coalition of specialties impacted by rules related to physician in-office compounding; that
6 regulation of physician in-office compounding should be regulated by state medical boards
7 rather than state pharmacy boards; and that the AMA supports current 2008 USP General
8 Chapter <797> sterile compounding rules as pertaining to allergen extracts; and
9

10 Whereas, AMA Washington office staff have recently convened medical specialties affected by
11 recent proposed actions by the USP and FDA as they relate to physician office compounding
12 and are initiating a survey of the potential impact of proposed requirements on each specialty,
13 as well as assisting with outreach regarding broad concerns on this issue; and
14

15 Whereas, The USP's revisions to Chapter <797> are not anticipated until at least 2018; and
16

17 Whereas, In August 2016, the FDA issued a draft guidance entitled "Insanitary Conditions at
18 Compounding Facilities" that effectively circumvents the USP Chapter <797> revision process
19 by indicating that states should enforce a set of standards for compounding facilities, including
20 considering to be insanitary any compounded material not mixed under those standards, and
21 specifically including physician in-office compounding in its definition of "compounding facilities";
22 and
23

24 Whereas, The draft guidance specifically cites the 60 tragic deaths and 750 fungal meningitis
25 infections in 2012 resulting from contaminated products produced by a compounding pharmacy
26 and indicates that other adverse events have resulted from contaminated drug products
27 produced in commercial compounding facilities, but as yet the FDA has not provided evidence
28 or indication of any adverse events resulting from individually compounded medications
29 produced in physician offices; and specifically the FDA has not produced any data that allergen
30 extract compounding in physician offices has resulted in any infectious complications in
31 patients; and
32

33 Whereas, Any physician in the practice of Allergy/Immunology would have to consider
34 immediately halting treatment already underway for patients on allergen immunotherapy,
35 including those in treatment for allergies with a significant risk of life threatening anaphylaxis,
36 under threat of potential recourse by states implementing these standards as soon as a finalized
37 guidance might be issued, thereby putting these patients at serious risk of physical harm; and

1 Whereas, Allergen immunotherapy, which has been provided in the U.S. for more than 100
2 years with no known documented adverse infectious events, requires the allergist to compound
3 not only initial individualized treatment sets, but sometimes also to make modifications to a
4 patients' allergen extract over the course of this highly personalized treatment; and this
5 generally would not be possible under the standards suggested in the draft guidance, therefore
6 creating a significant barrier to the physician's ability to practice evidence based medicine; and
7

8 Whereas, The FDA's draft guidance, if made final, would thus have significant detrimental
9 impact on patients' access to optimal individualized care by limiting their physicians' ability to
10 practice medicine; and
11

12 Whereas, There is no known evidence that this effort by the FDA to expand compounding
13 pharmacy-level precautionary measures is indicated or necessary for small-volume physician in-
14 office compounding, and if FDA has such evidence that has not been shared then it is acting
15 without sufficient transparency for such an extraordinary regulatory over-reach; therefore be it
16

17 RESOLVED, That our American Medical Association strongly request that the US Food and
18 Drug Administration (FDA) withdraw its draft guidance "Insanitary Conditions at Compounding
19 Facilities" and that no further action be taken by the agency until revisions to the USP Chapter
20 <797> on Sterile Compounding, have been finalized (Directive to Take Action); and be it further
21

22 RESOLVED, That our AMA work with the US Congress to adopt legislation that would preserve
23 physician office-based compounding as the practice of medicine and codify in law that
24 physicians compounding medications in their offices for immediate or subsequent use in the
25 management of their patients are not compounding facilities under the jurisdiction of the FDA.
26 (Directive to Take Action)

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

Received: 10/13/16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 312
(I-16)

Introduced by: Maryland

Subject: Eliminating the Tax Liability for Payment of Student Loans

Referred to: Reference Committee C
(Martin J. Trichtinger, MD, Chair)

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- 1 Whereas, It may be difficult to recruit physicians to underserved areas where there are
2 physician shortages; and
3
4 Whereas, Private employers offering student loan repayment to physicians that agree to work in
5 underserved areas could help to alleviate physician shortages in these areas; and
6
7 Whereas, The current tax code requires funds given by the private employers to physicians to
8 repay student loans to be considered ordinary income and a tax liability; and
9
10 Whereas, The private employers would need to provide additional funds to the physicians to
11 cover the tax liability which significantly increases the cost of repayment of student loans;
12 therefore be it
13
14 RESOLVED, That our American Medical Association work with the Internal Revenue Service to
15 eliminate the tax liability when private employers provide the funds to repay student loans for
16 physicians who agree to work in an underserved area. (Directive to Take Action)

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

Received: 10/11/16

RELEVANT AMA POLICY

Effectiveness of Strategies to Promote Physician Practice in Underserved Areas D-200.980

1. Our AMA, in collaboration with relevant medical specialty societies, will continue to advocate for the following: (a) Continued federal and state support for scholarship and loan repayment programs, including the National Health Service Corps, designed to encourage physician practice in underserved areas and with underserved populations. (b) Permanent reauthorization and expansion of the Conrad State 30 J-1 visa waiver program. (c) Adequate funding (up to at least FY 2005 levels) for programs under Title VII of the Health Professions Education Assistance Act that support educational experiences for medical students and resident physicians in underserved areas.
 2. Our AMA encourages medical schools and their associated teaching hospitals, as well as state medical societies and other private sector groups, to develop or enhance loan repayment or scholarship programs for medical students or physicians who agree to practice in underserved areas or with underserved populations.
 3. Our AMA will advocate to states in support of the introduction or expansion of tax credits and other practice-related financial incentive programs aimed at encouraging physician practice in underserved areas.
 4. Our AMA will advocate for the creation of a national repository of innovations and experiments, both successful and unsuccessful, in improving access to and distribution of physician services to government-insured patients (National Access Toolbox).
- CME Rep. 1, I-08 Modified: CME Rep. 4, A-10 Reaffirmation I-11 Appended: Res. 110, A-12 Reaffirmation A-13 Reaffirmation A-14

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 604
(I-16)

Introduced by: American Thoracic Society

Subject: Oppose Physician Gun Gag Rule Policy by Taking our AMA Business Elsewhere

Referred to: Reference Committee F
(Gary R. Katz, MD, Chair)

- 1 Whereas, Our AMA encourages our members to reduce firearm morbidity and mortality by
2 asking their patients about household firearms and educating their patients about the dangers
3 such firearms may pose. The AMA opposes laws that restrict physicians from discussing
4 firearms safety with their patients; and
5
6 Whereas, The state of Florida enacted the Firearms Owner's Privacy Law (FOPL), which
7 prohibits health care providers from;
8 (i) intentionally recording information concerning firearm ownership in a patient's medical record
9 if the information is not relevant to the patient's medical care or safety or the safety of others;
10 (ii) asking a patient whether he or she owns a firearm unless the information is relevant to the
11 patient's medical care or safety or the safety of others:
12 (iii) discriminating against a patient based solely on firearms ownership; and
13 (iv) unnecessarily harassing a patient about firearm ownership. Violation of the law constitutes
14 grounds for discipline under the Florida licensure statutes; and
15
16 Whereas, Our sister organizations, American Academy of Pediatrics, the American Academy of
17 Family Physicians, and the American College of Physicians have challenged the Florida
18 Firearms Owners Privacy law in court; and
19
20 Whereas, Our AMA has filed an amicus brief in support of our sister organizations seeking to
21 overturn the Firearms Owner Privacy Law; and
22
23 Whereas, Our AMA is holding our 2016 Interim House of Delegates meeting in Orlando, Florida;
24 and
25
26 Whereas, Orlando, Florida joins a long list of U.S. cities who have suffered directly from mass
27 shootings; therefore be it
28
29 RESOLVED, That our American Medical Association adopt policy that bars our AMA from
30 holding House of Delegates meetings in states that enact physician gun gag rule laws (New
31 HOD Policy); and be it further
32
33 RESOLVED, That our AMA contact governors and convention bureaus of states that have
34 enacted physician gun gag rules and inform them that our AMA will no longer hold House of
35 Delegates meetings in their state, until the restrictive physician gun gag rule is repealed or
36 struck down by the courts. (Directive to Take Action)

Fiscal Note: Minimal - less than \$1,000.
Received: 10/11/16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 605
(I-16)

Introduced by: American Medical Women's Association

Subject: Study of Models of Childcare Provided at Healthcare Institutions

Referred to: Reference Committee F
(Gary R. Katz, MD, Chair)

- 1 Whereas, Physicians with pre-school age children face significant difficulties finding childcare
2 that is easily accessible to their work place, is affordable, and accommodates the unpredictable
3 work hours faced by physicians; and
4
5 Whereas, This lack of childcare can place additional stress on already stressful careers,
6 especially for younger physicians; and
7
8 Whereas, Some businesses are starting to provide childcare services, utilizing a variety of
9 funding models; and
10
11 Whereas, Some healthcare institutions are also starting to provide these services; and
12
13 Whereas, Provision of these services could help with retention of physicians, especially those
14 earlier in their careers; and
15
16 Whereas, The number and size of institutions offering this and the models that they use to do so
17 are unknown; therefore be it
18
19 RESOLVED, That our American Medical Association study which healthcare institutions
20 currently provide accessible, affordable childcare services, the size of the institutions (in terms
21 of number of physicians) providing these services, the impact of these services on residents and
22 faculty (especially in terms of decreasing stress and increasing retention), and the various
23 funding models used for these (Directive to Take Action); and be it further
24
25 RESOLVED, That our AMA report back to the House of Delegates with this information at the
26 Annual Meeting in 2017. (Directive to Take Action)

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

Received: 11/12/16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 814
(I-16)

Introduced by: Connecticut, Maine, Massachusetts, New Hampshire,
Rhode Island, Vermont

Subject: Addressing Discriminatory Health Plan Exclusions or
Problematic Benefit Substitutions for Essential Health
Benefits Under the Affordable Care Act

Referred to: Reference Committee J
(Candace E. Keller, MD, Chair)

-
- 1 Whereas, Improving patient outcomes is an American Medical Association goal; and
2
3 Whereas, The Affordable Care Act requires that benefits are provided without discrimination
4 based on health condition, race, color, national origin, age, disability, sex, sexual orientation or
5 gender identity; and
6
7 Whereas, Covered benefits in states still vary widely, including gaps in coverage, arbitrary limits,
8 discriminatory benefit designs and/or cost-sharing on the basis of age, sex, gender, degree of
9 medical dependency, gender identity, disability, and quality of life; and
10
11 Whereas, Gaps in women’s health coverage persist because insurers often exclude health
12 services women are likely to need, leaving women vulnerable to higher costs and denied claims
13 that threaten economic security and physical health; and
14
15 Whereas, Six categories of services are frequently excluded from insurance coverage that
16 disproportionately affect women such as treatment of conditions resulting from non-covered
17 services, (e.g. (e.g. Treatment of an infection after a non-covered prophylactic mastectomy)
18 maternity care, gender transition, maintenance therapy, genetic testing, self-inflicted conditions,
19 fetal surgeries, and preventive services; and
20
21 Whereas, Parity violations persist for a number of critical services, including, but not limited to
22 mental health and substance abuse disorders, and gaps persist in coverage for pediatric
23 services, including dental and vision services, habilitative services and prescription drugs; and
24
25 Whereas, Service exclusions and benefit substitutions are often described in health plan
26 materials in language that is difficult to fully comprehend; therefore be it

- 1 RESOLVED, That our American Medical Association work with state medical societies and their
2 state regulators to facilitate the following:
- 3 1. Prohibit health plans from imposing arbitrary limits that are unreasonable or potentially
4 discriminatory for coverage of the Essential Health Benefits.
 - 5 2. Require any insurer, whose plans contain exclusions that are not in the state Essential
6 Health Benefits benchmark plan, demonstrate that its benefits are substantially similar and
7 actuarially equivalent to the benchmark, in compliance with federal regulations.
 - 8 3. Define the state habilitative Essential Health Benefits definition that goes beyond the federal
9 minimum definition.³
 - 10 4. Review current plans for discriminatory exclusions and require insurers to revise these plans
11 if discriminatory exclusions present;
 - 12 5. Review consumer complaints for incidents of discriminatory benefit and formulary design,
13 cost-sharing, problematic Essential Health Benefits substitutions or exclusions.
 - 14 6. Prohibit insurer benefit substitutions in the Essential Health Benefits (Directive to Take
15 Action); and be it further
16
- 17 RESOLVED, That our AMA work with federal regulators to:
- 18 1. Improve the Essential Health Benefits benchmark plan selection process to ensure arbitrary
19 limits and exclusions do not impede access to healthcare and coverage.
 - 20 2. Develop policy to prohibit Essential Health Benefits substitutions that do not exist in a state's
21 benchmark plan or selective use of exclusions or arbitrary limits to prevent high-cost claims
22 or that encourage high-cost enrollees to drop coverage.
 - 23 3. Review current plans for discriminatory exclusions and submit any specific incidents of
24 discrimination through an administrative complaint to Office for Civil Rights. (Directive to
25 Take Action)

References

¹ The Commonwealth Fund, August 2016, <http://www.commonwealthfund.org/>

² The National Women's Law Center, State of Women's Coverage: Health Plan Violations of the Affordable Care Act (NWLC 2015), National Women's Law Center, <http://nwlc.org/wpcontent/uploads/2015/04/stateofwomenscoverage2015final.pdf>

³ The federal definition of habilitative services is health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings. Found in the CMS glossary of medical terms and finalized in 2016.

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

Received: 10/11/16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 815
(I-16)

Introduced by: Washington

Subject: Preservation of Physician-Patient Relationships and
Promotion of Continuity of Patient Care

Referred to: Reference Committee J
(Candace E. Keller, MD, Chair)

1 Whereas, Medicare (CMS) is rapidly moving towards bundled payment models (e.g. the
2 Comprehensive Care Joint Replacement Model and the Cardiac Bundled Payment Model); and
3
4 Whereas, Bundled payments involve setting one price per patient per episode of care; and
5
6 Whereas, There is interest in bundles encompassing chronic conditions and long-term diseases
7 including diabetes, obesity and cancer; and
8
9 Whereas, This promotes coordinated care but also requires data collection, reviewing care
10 processes and cost accounting; and
11
12 Whereas, CMS has both voluntary Bundled Payment for Care Improvement Initiatives as well as
13 mandatory bundled payments; and
14
15 Whereas, Bundled payment models can encourage in-hospital referrals, in turn interfering with
16 established relationships between patients and their preferred physicians; therefore be it
17
18 RESOLVED, That our American Medical Association support policies that encourage the
19 freedom of patients to choose the health care delivery system that best suits their needs and
20 provides them with a choice of physicians (New HOD Policy); and be it further
21
22 RESOLVED, That our AMA support the freedom of choice of physicians to refer their patients to
23 the physician practice or hospital that they think is most able to provide the best medical care
24 (New HOD Policy); and be it further
25
26 RESOLVED, That our AMA support policies that encourage patients to return to their
27 established primary care provider after emergency department visits, hospitalization or specialty
28 consultation. (New HOD Policy)

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

Received: 10/13/16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 816
(I-16)

Introduced by: Senior Physicians Section
Subject: Support for Seamless Physician Continuity of Patient Care
Referred to: Reference Committee J
(Candace E. Keller, MD, Chair)

- 1 Whereas, With an aging population and shortage of physicians facing America, the AMA Senior
2 Physicians Section (AMA-SPS) will work to engage senior physicians (age 65 and older), both
3 active and retired, to ensure high-quality care and safety for patients by collaboration with other
4 stakeholders in the changing health care system; and
5
6 Whereas, Senior physicians (and others) come out of training programs where continuity was
7 considered one of the critical foundations of a quality medical practice; and
8
9 Whereas, There has been extreme growth of the present day practice of separating inpatient
10 care from office care as far as the role of the physician is concerned; and
11
12 Whereas, Systems are not yet commonplace that assure seamless care between the inpatient
13 and office care settings; and
14
15 Whereas, Those physicians and others who choose to provide care in both the inpatient and
16 office settings are being precluded by health insurance system policies; therefore be it
17
18 RESOLVED, That our American Medical Association clearly support the concept of seamless
19 continuity of care between hospital inpatient and outpatient care (New HOD Policy); and be it
20 further
21
22 RESOLVED, That our AMA study whether there are instances of health insurers or HMO's
23 precluding physicians via contracts from providing care to their patients in the in-patient setting
24 for which the physician has clinical privileges. (Directive to Take Action)

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

Received: 10/13/16

RELEVANT AMA POLICY

Admitting Officer and Hospitalist Programs H-285.964

AMA policy states that: (1) managed care plan enrollees and prospective enrollees should receive prior notification regarding the implementation and use of "admitting officer" or "hospitalist" programs; (2) participation in "admitting officer" or "hospitalist programs" developed and implemented by managed care or other health care organizations should be at the voluntary discretion of the patient and the patient's physician; (3) hospitalist programs when initiated by a hospital or managed care organization should be developed consistent with AMA policy on medical staff bylaws and implemented with the formal approval of the organized medical staff by at least the same notification and voting threshold required to approve a bylaws change to assure that the principles and structure of the autonomous and self-governing medical staff are retained; (4) Hospitals and other health care organizations should not compel physicians by contractual obligation to assign their patients to "Hospitalists" and that no punitive measure should be imposed on physicians or patients who decline participation in "hospitalists programs"; and (5) AMA opposes any hospitalist model that disrupts the patient/physician relationship or the continuity of patient care and jeopardizes the integrity of inpatient privileges of attending physicians and physician consultants.

Sub. Res. 714, I-95 Amended by CMS Rep. 4, A-98 Reaffirmed: Res. 819, A-99 Reaffirmation I-99 Reaffirmed: Res. 812, A-02 Reaffirmed: BOT Rep. 15, A-05 Reaffirmed in lieu of Res. 734, A-05 Modified: Res. 731, A-07

Preserving Physician/Patient Relationships During Hospitalizations H-225.946

1. Our AMA advocates that hospital admission processes should include: a determination of whether the patient has an existing relationship with an actively treating primary care or specialty physician; where the patient does not object, prompt notification of such actively treating physician(s) of the patient's hospitalization and the reason for inpatient admission or observation status; to the extent possible, timely communication of the patient's medical history and relevant clinical information by the patient's primary care or specialty physician(s) to the hospital-based physician; notice to the patient that he/she may request admission and treatment by such actively treating physician(s) if the physician has the relevant clinical privileges at the hospital; honoring requests by patients to be treated by their physician(s) of choice; and allowing actively treating physicians to treat to the full extent of their hospital privileges.

2. Our AMA advocates that a medical staff incorporate the above principles into medical staff bylaws, rules and regulations.

Res. 812, I-15 Modified: CMS Rep. 06, A-16

The Emerging Use of Hospitalists: Implications for Medical Education D-225.999

(1) Our AMA, through its Council on Medical Education and Council on Medical Service, will collect data on the following areas: (a) the emergence of educational opportunities for hospitalist physicians at the residency level, including the curriculum of hospitalist tracks within residency training programs; (b) the availability and content of continuing medical education opportunities for hospitalist physicians; (c) the policies of hospitals and managed care organizations related to the maintenance of hospital privileges for generalist physicians who do not typically care for inpatients; and (d) the quality and costs of care associated with hospitalist practice.

(2) Our Council on Medical Education and Council on Medical Service will monitor the evolution of hospitalist programs, with the goal of identifying successful models.

(3) Our AMA will encourage dissemination of information about the education implications of the emergence of hospitalism to medical students, resident physicians, and practicing physicians.

CME Rep. 2, A-99 Reaffirmed: CME Rep. 2, A-09

Voluntary Use of Hospitalists and Required Consent H-225.960

It is the policy of our AMA that the use of a hospitalist physician as the physician of record during a hospitalization must be voluntary and the assignment of responsibility to the hospitalist physician must be based on the consent of the patient's personal physician and the patient.

CME Rep. 2, A-99 Reaffirmation I-99 Reaffirmed: Res. 812, A-02 Reaffirmed with change in title: BOT Rep. 15, A-05 Reaffirmed in lieu of Res. 734, A-05 Reaffirmed: CME Rep. 1, A-15

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 925
(I-16)

Introduced by: American College of Cardiology
Heart Rhythm Society
American Society of Echocardiography

Subject: Graphic Warning Label on all Cigarette Packages

Referred to: Reference Committee K
(Paul A. Friedrichs, MD, Chair)

- 1 Whereas, Diseases directly caused by cigarette tobacco smoking continue to be common,
2 resulting in death and disability of many Americans; and
3
4 Whereas, Positive advertising of cigarettes is known to promote smoking and is prohibited; and
5
6 Whereas, Negative advertising in the form of graphic warnings on cigarette packages is an
7 effective smoking deterrent; and
8
9 Whereas, The public health of the United States would be improved if smoking rates were
10 further reduced; and
11
12 Whereas, The Family Smoking Prevention and Control Act of 2009 required the Secretary of
13 Health and Human Services to issue regulations requiring color graphic depictions of the
14 negative health consequences of smoking to appear on all cigarette packages; and
15
16 Whereas, In 2011 the Food and Drug Administration finalized regulations establishing
17 requirements for graphic warning labels, but tobacco companies successfully challenged the
18 constitutionality of the requirements in federal appeals court; and
19
20 Whereas, The Department of Justice chose not to request Supreme Court review of the appeals
21 court decision and FDA has failed to issue revised regulations; therefore be it
22
23 RESOLVED, That our American Medical Association evaluate all opportunities for effective
24 advocacy by organized medicine to require graphic warning labels depicting the dangers of
25 smoking on all cigarette packages (Directive to Take Action); and be it further
26
27 RESOLVED, That our AMA endorse efforts of the Campaign for Tobacco Free Kids and the
28 Food and Drug Administration to require tobacco companies to include graphic warning labels
29 depicting the dangers of smoking on all cigarette packages. (Directive to Take Action)

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

Received: 10/12/16

REPORT OF THE HOUSE OF DELEGATES COMMITTEE
ON THE COMPENSATION OF THE OFFICERS

Report I-16

Subject: Report of the House of Delegates Committee on Compensation of the Officers

Presented by: Anthony M. Padula, MD, Chair

Referred to: Reference Committee F
(Jane C. Fitch, MD, Chair)

1 This report by the Committee at the 2016 Interim Meeting presents five recommendations. It also
2 documents the compensation paid to Officers for the period July 1, 2015 thru June 30, 2016 and
3 includes the 2015 calendar year IRS reported taxable value of benefits, perquisites, services, and
4 in-kind payments for all Officers.

5
6 BACKGROUND

7
8 At the 1998 Interim Meeting, the House of Delegates (HOD) established a House Committee on
9 Trustee Compensation, currently named the Committee on Compensation of the Officers, (the
10 “Committee”). The Officers are defined in the American Medical Association’s (AMA)
11 Constitution and Bylaws. (Note: under changes to the Constitution previously approved by the
12 HOD, Article V refers simply to “Officer,” which includes all 21 members of the Board among
13 whom are President, President-Elect, Immediate Past President, Secretary, Speaker of the HOD and
14 Vice Speaker of the HOD, collectively referred to in this report as Officers). The composition,
15 appointment, tenure, vacancy process and reporting requirements for the Committee are covered
16 under the AMA Bylaws. Bylaws 2.645 provides:

17
18 The Committee shall present an annual report to the House of Delegates recommending the
19 level of total compensation for the Officers for the following year. The recommendations of the
20 report may be adopted, not adopted or referred back to the Committee, and may be amended
21 for clarification only with the concurrence of the Committee.

22
23 At A-00, the Committee and the Board jointly adopted the American Compensation Association’s
24 definition of total compensation which was added to the Glossary of the AMA Constitution and
25 Bylaws. Total compensation is defined as the complete reward/recognition package awarded to an
26 individual for work performance including: (a) all forms of money or cash compensation; (b)
27 benefits; (c) perquisites; (d) services; and (e) in-kind payments.

28
29 Since the inception of this Committee, its reports document the process the Committee follows to
30 ensure that current or recommended Officer compensation is based on sound, fair, cost-effective
31 compensation practices as derived from research and use of independent external consultants,
32 expert in Board compensation. Reports beginning in December 2002 documented the principles the
33 Committee followed in creating its recommendations for Officer compensation.

1 At A-08, the HOD approved changes that simplified compensation practices with increased
2 transparency and consistency. At A-10, Reference Committee F requested that this Committee
3 recommend that the HOD affirm a codification of the current compensation principle, which
4 occurred at I-10. At that time, the HOD affirmed that this Committee has and will continue to base
5 its recommendations for Officer compensation on the principle of the value of the work performed,
6 consistent with IRS guidance and best practices as recommended by the Committee's external
7 independent consultant, who is expert in Board compensation.

8
9 At A-11, the HOD approved the alignment of Medical Student and Resident Officer compensation
10 with that of all other Officers (excluding Presidents and Chair) because these positions perform
11 comparable work.

12
13 Immediately following A-11, the Committee retained Mr. Don Delves, founder of the Delves
14 Group, to update his 2007 research by providing the Committee with comprehensive advice and
15 counsel on Officer compensation. The Committee asked for this update because it had been four
16 years since the last comprehensive review and because the Committee wanted to continue refining
17 its compensation practices to improve simplification and transparency. The updated compensation
18 structure was presented and approved by the HOD at I-11 with an effective date of July 1, 2012.

19
20 At I-11, Reference Committee F requested that the Committee list the specific benefits, perquisites
21 and in-kind payments provided to the Officers and to document annually the taxable value of these
22 benefits. The Committee first reported this information, as reported to the IRS, in its A-12 report.

23
24 The Committee's I-12 report referenced discussion and research concerning Presidents' travel on
25 regional airlines. The A-13 report expanded the travel discussion to include travel on airlines
26 without preferred status. The HOD approved the Committee's recommendation to provide a travel
27 allowance for each President to be used for upgrades, primarily on non-preferred status airlines,
28 because of the significant volume of travel by the Presidents in representing our AMA.

29 30 CASH COMPENSATION SUMMARY

31
32 The cash compensation of the Officers shown in the following table will not be the same as
33 compensation reported annually on the AMA's IRS Form 990 because Form 990s are based on a
34 calendar year. The total cash compensation in the summary is compensation for the days these
35 Officers spend away from home on AMA business approved by the Board Chair. The total cash
36 compensation in the summary includes work as defined by the Governance Honorarium and Per
37 Diem for Representation including conference calls with groups outside of the AMA, totaling 2
38 hours or more per calendar day as approved by the Board Chair. Detailed definitions are located in
39 the Appendix.

1 The summary covers July 1, 2015 to June 30, 2016:
 2

AMA Officers	Position	Total Compensation	Total Days
Maya A Babu, MD, MBA	Resident Officer	\$ 72,900	62
Susan R Bailey, MD	Speaker, House of Delegates	\$ 74,700	52
David O Barbe, MD, MHA	Officer	\$ 92,700	78
Willarda V Edwards, MD, MBA	Officer	-	2.5
Jesse M Ehrenfeld, MD, MPH	Young Physician Officer	\$ 87,900	64
Julie K Goonewardene	Public Board Member Officer	\$ 61,500	37
Andrew W Gurman, MD	President-Elect	\$ 274,000	128
Gerald E Harmon, MD	Secretary	\$ 65,700	57
Patrice A Harris, MD, MA	Chair-Elect	\$ 205,500	94
William E Kobler, MD	Officer	\$ 92,700	71
Russell WH Kridel, MD	Officer	\$ 73,500	54.5
Omar Z Maniya, MBA	Medical Student Officer	-	1.5
Barbara L McAneny, MD	Immediate Past Chair	\$ 87,300	75.5
Mary Anne McCaffree, MD	Officer	\$ 89,700	69.5
William A McDade, MD, PhD	Officer	-	1
Albert J Osbahr, III, MD	Officer	\$ 87,300	59
Stephen R Permut, MD, JD	Chair	\$ 269,500	106
Dina Marie Pitta, MPP	Medical Student Officer	\$ 61,500	31.5
Jack Resneck, Jr, MD	Officer	\$ 77,100	59
Bruce A Scott, MD	Vice Speaker, House of Delegates	\$ 61,500	44
Carl A Sirio, MD	Officer	\$ 106,500	80
Steven J Stack, MD	President	\$ 279,000	169
Georgia A Tuttle, MD	Officer	\$ 77,700	56
Robert M Wah, MD	Immediate Past President	\$ 274,000	129
Kevin W Williams	Public Board Member Officer	-	2

3
 4 President, President-Elect, Immediate Past President and Chair
 5 In 2015-2016, each of these positions received an annual Governance Honorarium which was paid
 6 in monthly increments. These four positions spent a total of 532 days on approved Assignment and
 7 Travel, or 133 days each on average.

8
 9 Chair-Elect
 10 This position received a Governance Honorarium of approximately 75% of the Governance
 11 Honorarium provided to the Chair.

12
 13 All other Officers
 14 All other Officers received cash compensation, which included a Governance Honorarium of
 15 \$61,500 paid in monthly installments. The remaining cash compensation is for Assignment and
 16 Travel Days that are approved by the Board Chair to externally represent the AMA. These days are
 17 compensated at a per diem rate of \$1,200.

18
 19 Assignment and Travel Days
 20 The total Assignment and Travel Days for all Officers (excluding the President, President-Elect,
 21 Immediate Past President and Chair) were 1051; this includes reimbursement for telephonic
 22 representation meetings for external organizations that are 30 minutes or longer during a calendar
 23 day and total 2 or more hours. These are reimbursed at ½ of the current per diem rate. During this
 24 reporting period, there were 30 reimbursed calls, representing 15 per diem days.

1 EXPENSES

2

3 Total expenses paid for the period, July 1, 2015 – June 30, 2016, were \$881,137 compared to
4 \$832,337 for the previous period, representing a 5.9% increase. This includes \$1,040 in upgrades
5 for Presidents’ travel per the approved Presidential Upgrade Allowance of \$2,500 per position per
6 term.

7

8 BENEFITS, PERQUISITES, SERVICES AND IN-KIND PAYMENTS

9

10 Officers are able to request benefits, perquisites, services and in-kind payments, as defined in the
11 “AMA Board of Trustees Standing Rules on Travel and Expenses.” These non-taxable business
12 expense items are provided to assist the Officers in performing their duties:

13

- 14 • AMA Standard laptop computer or iPad
- 15 • iPhone
- 16 • American Express card (for AMA business use)
- 17 • Combination fax/printer/scanner
- 18 • An annual membership to the airline club of choice offered each year during the Board
19 member’s tenure
- 20 • Personalized AMA stationery, business cards and biographical data for official use.

21

22 Additionally, all Officers are eligible for \$300,000 term life insurance and are covered under the
23 AMA’s \$500,000 travel accident policy and \$10,000 individual policy for medical costs arising out
24 of any accident while traveling on official business for the AMA. Life insurance premiums paid by
25 the AMA are reported as taxable income.

26

27 Secretarial support, other than that provided by AMA’s Board office, is available up to defined
28 annual limits as follows: President, during the Presidential year, \$15,000; \$5,000 each for the
29 President-Elect, Chair, Chair-Elect and Immediate Past president per year. Secretarial expenses
30 incurred by other Officers in connection with their official duties are paid up to \$750 per year per
31 Officer. This is reported as taxable income.

32

33 Travel expenses incurred by family members are not reimbursable, with the exception of the family
34 of the incoming President at the Annual Meeting of the HOD.

35

36 Calendar year taxable life insurance and taxable secretarial fees reported to the IRS totaled \$25,755
37 and \$20,375 respectively for 2015. An additional \$16,500 was paid to third parties for secretarial
38 services during 2015.

39

40 METHODOLOGY

41

42 As noted in its A-16 report, the Committee commissioned a comprehensive compensation review
43 with an outside consultant expert in Board compensation to refresh the Committee’s knowledge of
44 market conditions related to Board compensation because it has been five years since the last
45 compensation review. The purpose of the review is to ensure the Officers are compensated
46 appropriately for the work performed on behalf of the AMA. The Committee also continues to be
47 interested in reviewing and refining its compensation practices for increased simplification and
48 transparency. The Committee also asked the consultant to review the structure of Officer
49 compensation to ensure continued alignment with current trends in for-profit Board compensation
50 which had been to move away from paying for each individual Board or Board committee meeting
51 to one annual fee.

1 The Committee's review and subsequent recommendations for Officer compensation are based on
2 the principle of the value of the work performed, as affirmed by the HOD. In addition, the
3 following additional guidelines were followed:

- 4
- 5 • Compensation should be based on the value expected by the AMA from its Officers.
 - 6 • Compensation should take into account that the AMA is a complex organization when
7 comparing compensation provided to Board members by for-profit organizations and by
8 complex not-for-profit organizations of similar size and activities.
 - 9 • Compensation should be aligned with the long-term interests of AMA members and the
10 fulfillment of the fiduciary responsibilities of the Officers.
 - 11 • Officers should be adequately compensated for their value, time, and effort.
 - 12 • Compensation should reinforce choices and behaviors that enhance effectiveness.
 - 13 • Compensation should be approached on a comprehensive basis, rather than as an array of
14 separate elements.
- 15

16 It is important to note that the process the Committee followed along with the aforementioned
17 principles are consistent with the guidelines recommended by the IRS for determining reasonable
18 and competitive levels of Officer compensation.

19

20 To complete the compensation review, the Committee retained a new consultant, Becky Glantz
21 Huddleston, of Willis Towers Watson. Ms. Huddleston is an expert in Board compensation and
22 works with both for-profit and not-for profit organizations. The firm she works for, Willis Towers
23 Watson, is one of the largest, most prestigious and well-respected compensation consulting firms.

24

25 To develop her recommendations with the Committee, Ms. Huddleston:

- 26 • Met with internal AMA staff assigned to support this Committee to review and understand
27 the current compensation structure.
 - 28 • Interviewed certain Board members to gain an understanding of their thoughts and insights
29 related to the current Officer compensation program.
 - 30 • Discussed her interview results with the Committee.
 - 31 • Reviewed and analyzed Officer compensation data for the past three terms.
 - 32 • Analyzed and researched pay practices for Board of directors at for-profit and not-for-
33 profit organizations similar to the AMA who pay their Board members.
 - 34 • Prepared a final report to the Committee following a collaborative, deliberative and
35 objective process to arrive at the recommendations as documented in this report to the
36 House of Delegates.
- 37

38 39 FINDINGS

40

41 The Committee notes that Officers continue to make significant time commitments in supporting
42 our AMA in governance and representation functions. Given the amount of time required of Board
43 members, it is important that individuals seeking a position on the Board be aware of the scope of
44 the commitment and the related compensation.

45

46 The Committee further notes that external data indicates for-profit organizations are continuing the
47 trend of eliminating meeting fees while increasing the annual retainer in an effort to simplify the
48 program and to recognize that Board work has become more fluid in nature and is increasingly
49 completed outside of formal meetings; this is also a trend at the AMA based on Officer feedback.

1 In 2011, the HOD approved this Committee's recommendation to refine the AMA's compensation
2 structure for non-leadership Officers by expanding the Governance definition to include Chair-
3 assigned internal representation and increasing the amount of the annual Governance Honorarium.
4 Chair-assigned External Representation continued to be paid by a Per Diem. The \$61,500 annual
5 Governance Honorarium has been in effect since July 1, 2012 and the \$1200 Per Diem has been the
6 same amount since 2008.

7
8 The Committee and its consultant reviewed and considered feedback from the interviews with
9 Officers. The overall consensus from the Officers interviewed was that the Board compensation
10 program is generally working and while there were not any major issues, modest adjustments to the
11 compensation levels may be appropriate. However, Officer interviews included concerns that the
12 current structure resulted in an unequal internal time commitment among Officers because some
13 internal representation assignments result in greater time commitments which, by definition, are
14 included as part of the Governance Honorarium unlike external assignments compensated by per
15 diem.

16
17 Review of AMA data for the past three terms showed that the time commitment for Board-related
18 work was generally consistent among the Officers. Internal representation had more variability than
19 Board-related work and External Representation was the most variable. The Governance
20 Honorarium does not address the variability of internal representation. The wide variance in
21 External Representation reflects the unique skillset and expertise of each Officer and the
22 responsibility of the Board Chair to make assignments that optimize the Officers' expertise. The
23 current use of the Per Diem for External Representation addresses the wide variance in time
24 commitment of the Officers.

25
26 Compensation data from both for-profit and not-for-profit organizations was reviewed. For-profit
27 Board compensation data was sourced from the National Association of Corporate Directors
28 (NACD) 2015-2016 survey of organizations with revenue between \$50M - \$500M. This data
29 indicated for-profit Board compensation consisted of both a pay and stock component. The
30 Committee's external consultant noted that not-for-profit organizations do not have the ability to
31 grant stock awards and therefore do not necessarily intend to be competitive with the for-profit
32 sector from the perspective of total compensation. While AMA's Governance Honorarium was
33 close to the median cash compensation, it was well below the total Board compensation due to
34 absence of stock awards.

35
36 The consultant collected and analyzed data from not-for-profit organizations determined to be of
37 similar size and complexity as the AMA; AMA's not-for-profit peer group. This information was
38 collected from Form 990 filings, generally for 2014. This data showed that AMA non-leadership
39 Officers spend significantly more time on internal Board and representation when compared to the
40 peer group. Further analysis, to adjust for the variance in time commitments, showed that AMA's
41 Governance Honorarium was significantly lower than the peer group.

42
43 In determining the Governance Honorarium recommendation for non-leadership Officers, the
44 Committee balanced simplicity, transparency and comparability versus pay for internal
45 representation days as a compensation structure, Board feedback and the total cost of governance to
46 the AMA. There is no good external comparison for Per Diem pay for External Representation for
47 non-leadership Officers given the unique nature of this function at the AMA. However, the Per
48 Diem amount has not changed since 2008 and the Committee used the data from the not-for-profit
49 peer group Governance Honorarium comparison to directionally inform them.

1 Officers in leadership, the Board Chair, Chair-elect, President, President-elect and Immediate Past
2 President have a significant level of responsibility, representing a time commitment well above that
3 required by other non-profit Board leadership. This led to further analysis by the consultant to
4 adjust for the variance in time commitment. This analysis showed that compensation for AMA
5 Officers in leadership roles for the past three terms ranged near the median, resulting in the
6 recommendation that leadership compensation continues to be appropriate and no change is
7 necessary.

8
9 RECOMMENDATIONS

10
11 The Committee on Compensation of the Officers recommends the following recommendations be
12 adopted and the remainder of this report be filed:

- 13
14 1. That there be no change to the current Definitions effective July 1, 2012 as they appear in the
15 Travel and Expenses Standing Rules for AMA Officers for the Governance Honorarium, Per
16 Diem for External Representation and Telephonic Per Diem for External Representation except
17 for the Governance Honorarium and Per Diem amounts as recommended in 2, 3 and 4 below.

18
19 • Definition of Governance Honorarium effective July 1, 2012:

20 The purpose of this payment is to compensate Officers for all Chair-assigned internal AMA
21 work and related travel. This payment is intended to cover all currently scheduled Board
22 meetings, special Board or Board committee meetings, task forces, subcommittees, Board
23 orientation, development and media training, Board calls, sections, councils or other internal
24 representation meetings or calls, and any associated review or preparatory work, and all travel
25 days related to all meetings as noted above.

26
27 • Definition of Per Diem for Representation effective July 1, 2012:

28 The purpose of this payment is to compensate for Board Chair-assigned representation day(s)
29 and related travel for Officers, excluding Board Chairs and Presidents. Representation is either
30 external to the AMA, or for participation in a group or organization with which the AMA has a
31 key role in creating/partnering/facilitating achievement of the respective organization goals
32 such as the AMA Foundation, PCPI, etc. The Board Chair may also approve a per diem for
33 special circumstances that cannot be anticipated such as weather related travel delays.

34
35 • Definition of Telephonic Per Diem for External Representation effective July 1, 2011:

36 Officers, excluding the Board Chairs and the Presidents, who are assigned as the AMA
37 representative to outside groups as one of their specific Board assignments, receive a per diem
38 rate for teleconference meetings when the total of all teleconference meetings of 30 minutes or
39 longer during a calendar day equal 2 or more hours. Payment for these meetings would require
40 approval of the Chair of the Board.

- 41
42 2. That the Governance Honorarium for all Board members excluding leadership, Board Chair,
43 Board Chair-elect, President, President-elect, and Immediate Past President Board Chairs be
44 increased effective July 1, 2017 to \$65,000. (Directive to Take Action)
45
46 3. That the Per Diem for Chair-assigned representation external to the AMA or for participation
47 in a group or organization with which the AMA has a key role in creating/partnering/facilitating
48 achievement of the respective organization goals such as the AMA Foundation, PCPI, etc., and
49 related travel be increased effective July 1, 2017 to \$1,300 per day. (Directive to Take Action)

- 1 4. That the Per Diem for Chair-assigned Telephonic Per Diem for External Representation be
2 increased effective July 1, 2017 to \$650 as defined. (Directive to Take Action)
3
- 4 5. Except as noted above, there be no other changes to the Officers compensation for the period
5 beginning July 1, 2017. (Directive to Take Action)

Fiscal Note: Estimated annual cost of Recommendations 2, 3 and 4 is \$80,350 based on data reported for July 1, 2015 through June 30, 2016. This cost represents the impact of the Governance Honorarium increase (\$3,500 for each of the 16 non-leadership Officers), the Per Diem increase (\$100 per External Representation day as defined), and the Telephonic Per Diem increase (\$50 per teleconference meeting as defined).

APPENDIX

Current Leadership Compensation Summary

Officer compensation and definitions initially approved at I-11 and effective July 1, 2012.

POSITION	GOVERNANCE HONORARIUM
President	\$279,000
Immediate Past President & President-Elect	\$274,000
Chair	\$269,500
Chair-Elect	\$199,500
Other Officers	\$61,500

Definition of Governance Honorarium Effective July 1, 2012:

The purpose of this payment is to compensate Officers for all Chair-assigned internal AMA work and related travel. This payment is intended to cover all currently scheduled Board meetings, special Board or Board Committee meetings, task forces, subcommittees, Board orientation, development and media training, Board calls, sections, councils or other internal representation meetings or calls, and any associated review or preparatory work, and all travel days related to all meetings as noted above.

Definition of Per Diem for Representation effective July 1, 2012:

The purpose of this payment is to compensate for Board Chair-assigned representation day(s) and related travel. Representation is either external to the AMA, or for participation in a group or organization with which the AMA has a key role in creating/partnering/facilitating achievement of the respective organization goals such as the AMA Foundation, PCPI, etc. The Board Chair may also approve a per diem for special circumstances that cannot be anticipated such as weather related travel delays. Per Diem for Chair-assigned representation and related travel is \$1,200 per day.

Definition of Telephonic Per Diem for External Representation effective July 1, 2011:

Officers, excluding the Board Chair and the Presidents, who are assigned as the AMA representative to outside groups as one of their specific Board assignments, receive a per diem rate for teleconference meetings when the total of all teleconference meetings of 30 minutes or longer during a calendar day equal 2 or more hours. Payment for these meetings would require approval of the Chair of the Board. The amount of the Telephonic Per Diem will be ½ of the full Per Diem or \$600.