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
Whereas, Female genital mutilation (FGM) is the forcible mutilation of the clitoris and external genitalia of women and girls for non-medical reasons affecting not only women in Southern Asia, the Middle East and Africa, but also remains within the immigrant communities in the U.S. and Europe; and

Whereas, FGM practiced on girls typically between 4 and 12 years of age (but can range from birth to prior to marriage) is responsible for the torture, maiming, and mutilation of millions upon millions of women and girls worldwide; and

Whereas, FGM in any form is a violation of basic human rights and bodily autonomy. It denies the victim physical integrity, a normal sexual life, freedom from violence and subjugation, and most extreme cases, causes death; and

Whereas, The forcible mutilation of a girl's genitalia in any way sets the stage for male-dominant psychological torture, control, and dehumanization of that girl and woman will suffer in her family forever and can lead to a lifetime of depression, anxiety and trauma; and

Whereas, Existing AMA Policy H-525.980 explicitly condemns the practice of female genital mutilation (FGM); and

Whereas, In the U.S. an estimated 513,000 women and girls are at risk of undergoing the procedure back in their home country or the country of their parents and annual International Day of Zero Tolerance to FGM found that 70 million more women and girls have undergone the procedure than previously thought; and

Whereas, There has recently been significant media coverage in 2016 about recent attempts by some academics and physicians in the American medical community to redefine FGM and promote a type of FGM in the form of a genital ‘nick’ or ‘alteration’ as a “compromise” position; and

Whereas, Our AMA must remain clear in its stance on FGM and reject any type of patriarchal ‘nicking’ procedure as an unethical surrender to the barbaric underpinnings of the FGM culture; and

Whereas, Any compromise procedure is still FGM and entirely violates existing AMA policy H-525.980 last modified A-12; and

Whereas, Survivors and advocates against FGM like Khadija Gbla, Leyla Hussein (also a psychotherapist) as well as organizations like No FGM Australia and Amref Health Africa (led by Dr. Githinji Gitahi, a gynecologist) wholly rejected the compromise on FGM; and
Whereas, Our AMA, in the spirit of our existing Policy H-525.980, should listen to the victims, advocate on their behalf in the ethical practice of medicine, and update our policy to make it clear in 2016 that our AMA rejects any compromise procedures and that we uncompromisingly stand with individuals and organizations who have experienced FGM and who are surrounded by the horrors of FGM in all its incarnations; and

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

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

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

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

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

RESOLVED, That our AMA educate its membership and the American public about the harm of FGM prominently through its website and provide resources about the ethics and medical harm 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, it's 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
Whereas, The Health Care Quality Improvement Act of 1986 (HCQIA) intended to protect the public from incompetent physicians by allowing those physicians on peer review committees to communicate in an open and honest environment and thus weed out incompetent physicians, without the specter of a retaliatory lawsuit by the reviewed physician; and

Whereas, Most states have passed statutes that broaden the protections afforded by the HCQIA in order to further promote peer review while severely limiting whistleblower protections to very limited specific situations; and

Whereas, A number of states have specific whistleblower protections; however, California’s Health and Safety Code 1278.5(b)(1)(A) states that no health care facility shall discriminate or retaliate against any person who has "presented a grievance, complaint or report to the facility"; and

Whereas; Common law protections are usually limited to situations where the offensive action violates a clearly articulated public policy; and

Whereas; Many, if not most, physicians are now either employed or controlled by hospital conglomerates; therefore, the threat of a retaliatory lawsuit is far less threatening than termination of employment or elimination of hospital privileges; and

Whereas; Our AMA policy does not seem to reflect the dramatic recent change in workplace arrangements nor protect employed physicians from retaliation as a result of effective peer review; therefore be it

RESOLVED, That our American Medical Association study the current environment for effective peer review, on both a federal and state basis, in order to update its current policy to include strategies for promoting effective peer review by employed physicians as well as consider a national strategy for protecting all physicians from retaliation as a result from participating in effective peer review. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.
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
WHEREAS, Employed physicians face unique challenges in that they are held accountable but sometimes not given enough resources or authority; and

WHEREAS, Employed physicians sometimes face moral dilemmas within the workplace regarding processes beyond their control, creating increased stress and even depression; often contributing to physician burnout; and

WHEREAS, Fear of retaliation and the stigma associated with being a "troublemaker" or not being a team player contributes to underreporting of problems in health care; and

WHEREAS, The more responsibility the physician has, the greater the exposure to serious events; and

WHEREAS, Physicians find themselves facing a dilemma if their employer will not correct the problem/situation; therefore be it

RESOLVED, That our American Medical Association support whistleblower protections for health care providers and parties who raise questions of quality, safety, and efficacy of health care and are adversely treated by any health care organization or entity (New HOD Policy); and be it further

RESOLVED, That our AMA advocate for protection in medical staff bylaws to minimize negative repercussions for physicians who report problems within their workplace. (New HOD Policy)

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

Received: 10/13/16
Whereas, The Centers for Medicare and Medicaid Services now allows commercial healthcare insurers to “auto-enroll” their insured into that carrier’s Medicare Advantage Plan with a single letter of notification during that insured’s pre-Medicare enrollment period; and

Whereas, During the pre-Medicare enrollment period each individual will receive dozens of communications from multiple healthcare insurers regarding a wide variety of Medicare insurance products that many Medicare-eligible individuals find confusing; and

Whereas, The insured receiving notification by their healthcare carrier of “auto-enrollment” in that carrier’s Medicare Advantage Plan must actively “opt-out” of that plan within 60 days or lose their ability to enroll in traditional Medicare for a year; therefore be it

RESOLVED, The our American Medical Association work with the Centers for Medicare and Medicaid Services and/or Congress to end the procedure of “auto-enrollment” of individuals into Medicare Advantage Plans. (Directive to Take Action)

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

Received: 10/05/16
Whereas, Blepharoplasty and blepharoptosis repair are distinct surgical procedures directed at correcting different pathology of the upper eyelids; and

Whereas, Each may be performed for medically necessary (functional) or aesthetic indications; and

Whereas, These distinctions are dictated by coverage rules of third party payers regarding medical necessity; and

Whereas, In 2009, NCCI bundled payments for blepharoplasty and ptosis repair and the bundling applied to procedures that met medical necessity criteria but aesthetic procedures would be performed per agreement between patients, surgeons and facilities in accordance with current practice and regulations; and

Whereas, In May, 2016, CMS issued a guidance that interpreted the bundles to include all ptosis procedures and all functional and aesthetic aspects of blepharoplasty (CMS MLN Matters Number M9658); and

Whereas, This guidance makes it a violation of policy for aesthetic surgery to be done on the same eyelid, at the same time as functional surgery or at any time by the initial surgeon or by a second surgeon at the same time or at any future time; and

Whereas, This prohibits the rights of a patient to contract with a surgeon to obtain aesthetic surgery involving an eyelid once any functional surgery has been performed on that lid at the time of the functional surgery or at any time in the future by the same or any surgeon; and

Whereas, Medical third party payers are not obligated to pay for procedures that do not meet their medical necessity criteria but DO NOT have authority to regulate choices made by patients and providers regarding procedures that do not meet their criteria for medical necessity and decisions regarding non-covered benefits are to be made by agreement between patients, providers and facilities (AMA Policy D-380.997); and
Whereas, CMS Matter Number MM9658 violates the rights of patients, facilities and providers to privately contract for non-covered services; and

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

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

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

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

WHEREAS, State prescription drug monitoring programs (PDMPs) have been established to collect and monitor prescribing and dispensing data of controlled substances; and

WHEREAS, PDMPs are currently established in 49 states, the District of Columbia, and Guam; and

WHEREAS, Data from PDMPs help physicians to assess risks of abuse or diversion of controlled substances; and

WHEREAS, Patients may acquire controlled substances from health care providers and/or pharmacies in more than one state; and

WHEREAS, State-based PDMPs currently are not interactive across state lines, limiting the data to which physicians have access, thereby limiting their ability to determine individual patients’ risks for addiction or diversion; and

WHEREAS, The National All Schedules Prescription Electronic Reporting Act (NASPER) was first passed by Congress in 2005 and last re-authorized in the Comprehensive Addiction and Recovery Act of 2016; and

WHEREAS, NASPER contains the initial mandate that PDMPs be interactive between states; and

WHEREAS, NASPER does not remain fully funded; and

WHEREAS, Our AMA has been supportive of full appropriations for NASPER; therefore be it

RESOLVED, That our American Medical Association continue to encourage Congress to assure that the National All Schedules Prescription Electronic Reporting Act (NASPER) and/or similar programs be fully funded to allow state prescription drug monitoring programs (PDMPs) to remain viable and active (New HOD Policy); and be it further

RESOLVED, That our AMA work to assure that interstate operability of PDMPs in a manner that allows data to be easily accessed by physicians and does not place an onerous burden on their 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
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.

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

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

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

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

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

Whereas, Any physician in the practice of Allergy/Immunology would have to consider immediately halting treatment already underway for patients on allergen immunotherapy, including those in treatment for allergies with a significant risk of life threatening anaphylaxis, under threat of potential recourse by states implementing these standards as soon as a finalized guidance might be issued, thereby putting these patients at serious risk of physical harm; and
Whereas, Allergen immunotherapy, which has been provided in the U.S. for more than 100 years with no known documented adverse infectious events, requires the allergist to compound not only initial individualized treatment sets, but sometimes also to make modifications to a patients’ allergen extract over the course of this highly personalized treatment; and this generally would not be possible under the standards suggested in the draft guidance, therefore creating a significant barrier to the physician’s ability to practice evidence based medicine; and

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

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

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

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

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

Received: 10/13/16
WHEREAS, It may be difficult to recruit physicians to underserved areas where there are physician shortages; and

WHEREAS, Private employers offering student loan repayment to physicians that agree to work in underserved areas could help to alleviate physician shortages in these areas; and

WHEREAS, The current tax code requires funds given by the private employers to physicians to repay student loans to be considered ordinary income and a tax liability; and

WHEREAS, The private employers would need to provide additional funds to the physicians to cover the tax liability which significantly increases the cost of repayment of student loans; therefore be it

RESOLVED, That our American Medical Association work with the Internal Revenue Service to eliminate the tax liability when private employers provide the funds to repay student loans for 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).
Whereas, Our AMA encourages our members to reduce firearm morbidity and mortality by asking their patients about household firearms and educating their patients about the dangers such firearms may pose. The AMA opposes laws that restrict physicians from discussing firearms safety with their patients; and

Whereas, The state of Florida enacted the Firearms Owner’s Privacy Law (FOPL), which prohibits health care providers from;

(i) intentionally recording information concerning firearm ownership in a patient’s medical record if the information is not relevant to the patient’s medical care or safety or the safety of others;
(ii) asking a patient whether he or she owns a firearm unless the information is relevant to the patient’s medical care or safety or the safety of others:
(iii) discriminating against a patient based solely on firearms ownership; and
(iv) unnecessarily harassing a patient about firearm ownership. Violation of the law constitutes grounds for discipline under the Florida licensure statutes; and

Whereas, Our sister organizations, American Academy of Pediatrics, the American Academy of Family Physicians, and the American College of Physicians have challenged the Florida Firearms Owners Privacy law in court; and

Whereas, Our AMA has filed an amicus brief in support of our sister organizations seeking to overturn the Firearms Owner Privacy Law; and

Whereas, Our AMA is holding our 2016 Interim House of Delegates meeting in Orlando, Florida; and

Whereas, Orlando, Florida joins a long list of U.S. cities who have suffered directly from mass shootings; therefore be it

RESOLVED, That our American Medical Association adopt policy that bars our AMA from holding House of Delegates meetings in states that enact physician gun gag rule laws (New HOD Policy); and be it further

RESOLVED, That our AMA contact governors and convention bureaus of states that have enacted physician gun gag rules and inform them that our AMA will no longer hold House of Delegates meetings in their state, until the restrictive physician gun gag rule is repealed or struck down by the courts. (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000.
Received: 10/11/16
Whereas, Physicians with pre-school age children face significant difficulties finding childcare that is easily accessible to their workplace, is affordable, and accommodates the unpredictable work hours faced by physicians; and

Whereas, This lack of childcare can place additional stress on already stressful careers, especially for younger physicians; and

Whereas, Some businesses are starting to provide childcare services, utilizing a variety of funding models; and

Whereas, Some healthcare institutions are also starting to provide these services; and

Whereas, Provision of these services could help with retention of physicians, especially those earlier in their careers; and

Whereas, The number and size of institutions offering this and the models that they use to do so are unknown; therefore be it

RESOLVED, That our American Medical Association study which healthcare institutions currently provide accessible, affordable childcare services, the size of the institutions (in terms of number of physicians) providing these services, the impact of these services on residents and faculty (especially in terms of decreasing stress and increasing retention), and the various funding models used for these (Directive to Take Action); and be it further

RESOLVED, That our AMA report back to the House of Delegates with this information at the Annual Meeting in 2017. (Directive to Take Action)

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

Received: 11/12/16
Whereas, Improving patient outcomes is an American Medical Association goal; and

Whereas, The Affordable Care Act requires that benefits are provided without discrimination based on health condition, race, color, national origin, age, disability, sex, sexual orientation or gender identity; and

Whereas, Covered benefits in states still vary widely, including gaps in coverage, arbitrary limits, discriminatory benefit designs and/or cost-sharing on the basis of age, sex, gender, degree of medical dependency, gender identity, disability, and quality of life; and

Whereas, Gaps in women’s health coverage persist because insurers often exclude health services women are likely to need, leaving women vulnerable to higher costs and denied claims that threaten economic security and physical health; and

Whereas, Six categories of services are frequently excluded from insurance coverage that disproportionately affect women such as treatment of conditions resulting from non-covered services, (e.g. Treatment of an infection after a non-covered prophylactic mastectomy) maternity care, gender transition, maintenance therapy, genetic testing, self-inflicted conditions, fetal surgeries, and preventive services; and

Whereas, Parity violations persist for a number of critical services, including, but not limited to mental health and substance abuse disorders, and gaps persist in coverage for pediatric services, including dental and vision services, habilitative services and prescription drugs; and

Whereas, Service exclusions and benefit substitutions are often described in health plan materials in language that is difficult to fully comprehend; therefore be it
RESOLVED, That our American Medical Association work with state medical societies and their state regulators to facilitate the following:

1. Prohibit health plans from imposing arbitrary limits that are unreasonable or potentially discriminatory for coverage of the Essential Health Benefits.
2. Require any insurer, whose plans contain exclusions that are not in the state Essential Health Benefits benchmark plan, demonstrate that its benefits are substantially similar and actuarially equivalent to the benchmark, in compliance with federal regulations.
3. Define the state habilitative Essential Health Benefits definition that goes beyond the federal minimum definition.¹
4. Review current plans for discriminatory exclusions and require insurers to revise these plans if discriminatory exclusions present;
5. Review consumer complaints for incidents of discriminatory benefit and formulary design, cost-sharing, problematic Essential Health Benefits substitutions or exclusions.
6. Prohibit insurer benefit substitutions in the Essential Health Benefits (Directive to Take Action); and be it further

RESOLVED, That our AMA work with federal regulators to:

1. Improve the Essential Health Benefits benchmark plan selection process to ensure arbitrary limits and exclusions do not impede access to healthcare and coverage.
2. Develop policy to prohibit Essential Health Benefits substitutions that do not exist in a state’s benchmark plan or selective use of exclusions or arbitrary limits to prevent high-cost claims or that encourage high-cost enrollees to drop coverage.
3. Review current plans for discriminatory exclusions and submit any specific incidents of discrimination through an administrative complaint to Office for Civil Rights. (Directive to Take Action)

References
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
Whereas, Medicare (CMS) is rapidly moving towards bundled payment models (e.g. the Comprehensive Care Joint Replacement Model and the Cardiac Bundled Payment Model); and

Whereas, Bundled payments involve setting one price per patient per episode of care; and

Whereas, There is interest in bundles encompassing chronic conditions and long-term diseases including diabetes, obesity and cancer; and

Whereas, This promotes coordinated care but also requires data collection, reviewing care processes and cost accounting; and

Whereas, CMS has both voluntary Bundled Payment for Care Improvement Initiatives as well as mandatory bundled payments; and

Whereas, Bundled payment models can encourage in-hospital referrals, in turn interfering with established relationships between patients and their preferred physicians; therefore be it

RESOLVED, That our American Medical Association support policies that encourage the freedom of patients to choose the health care delivery system that best suits their needs and provides them with a choice of physicians (New HOD Policy); and be it further

RESOLVED, That our AMA support the freedom of choice of physicians to refer their patients to the physician practice or hospital that they think is most able to provide the best medical care (New HOD Policy); and be it further

RESOLVED, That our AMA support policies that encourage patients to return to their established primary care provider after emergency department visits, hospitalization or specialty consultation. (New HOD Policy)

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

Received: 10/13/16
Whereas, With an aging population and shortage of physicians facing America, the AMA Senior Physicians Section (AMA-SPS) will work to engage senior physicians (age 65 and older), both active and retired, to ensure high-quality care and safety for patients by collaboration with other stakeholders in the changing health care system; and

Whereas, Senior physicians (and others) come out of training programs where continuity was considered one of the critical foundations of a quality medical practice; and

Whereas, There has been extreme growth of the present day practice of separating inpatient care from office care as far as the role of the physician is concerned; and

Whereas, Systems are not yet commonplace that assure seamless care between the inpatient and office care settings; and

Whereas, Those physicians and others who choose to provide care in both the inpatient and office settings are being precluded by health insurance system policies; therefore be it

RESOLVED, That our American Medical Association clearly support the concept of seamless continuity of care between hospital inpatient and outpatient care (New HOD Policy); and be it further

RESOLVED, That our AMA study whether there are instances of health insurers or HMO’s precluding physicians via contracts from providing care to their patients in the in-patient setting 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 "hospitalist 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.

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.

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.
Whereas, Diseases directly caused by cigarette tobacco smoking continue to be common, resulting in death and disability of many Americans; and

Whereas, Positive advertising of cigarettes is known to promote smoking and is prohibited; and

Whereas, Negative advertising in the form of graphic warnings on cigarette packages is an effective smoking deterrent; and

Whereas, The public health of the United States would be improved if smoking rates were further reduced; and

Whereas, The Family Smoking Prevention and Control Act of 2009 required the Secretary of Health and Human Services to issue regulations requiring color graphic depictions of the negative health consequences of smoking to appear on all cigarette packages; and

Whereas, In 2011 the Food and Drug Administration finalized regulations establishing requirements for graphic warning labels, but tobacco companies successfully challenged the constitutionality of the requirements in federal appeals court; and

Whereas, The Department of Justice chose not to request Supreme Court review of the appeals court decision and FDA has failed to issue revised regulations; therefore be it

RESOLVED, That our American Medical Association evaluate all opportunities for effective advocacy by organized medicine to require graphic warning labels depicting the dangers of smoking on all cigarette packages (Directive to Take Action); and be it further

RESOLVED, That our AMA endorse efforts of the Campaign for Tobacco Free Kids and the Food and Drug Administration to require tobacco companies to include graphic warning labels 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)

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

BACKGROUND

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

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

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

Since the inception of this Committee, its reports document the process the Committee follows to ensure that current or recommended Officer compensation is based on sound, fair, cost-effective compensation practices as derived from research and use of independent external consultants, expert in Board compensation. Reports beginning in December 2002 documented the principles the Committee followed in creating its recommendations for Officer compensation.
At A-08, the HOD approved changes that simplified compensation practices with increased transparency and consistency. At A-10, Reference Committee F requested that this Committee recommend that the HOD affirm a codification of the current compensation principle, which occurred at I-10. At that time, the HOD affirmed that this Committee has and will continue to base its recommendations for Officer compensation on the principle of the value of the work performed, consistent with IRS guidance and best practices as recommended by the Committee’s external independent consultant, who is expert in Board compensation.

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

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

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

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

### CASH COMPENSATION SUMMARY

The cash compensation of the Officers shown in the following table will not be the same as compensation reported annually on the AMA’s IRS Form 990 because Form 990s are based on a calendar year. The total cash compensation in the summary is compensation for the days these Officers spend away from home on AMA business approved by the Board Chair. The total cash compensation in the summary includes work as defined by the Governance Honorarium and Per Diem for Representation including conference calls with groups outside of the AMA, totaling 2 hours or more per calendar day as approved by the Board Chair. Detailed definitions are located in the Appendix.
The summary covers July 1, 2015 to June 30, 2016:

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

President, President-Elect, Immediate Past President and Chair

In 2015-2016, each of these positions received an annual Governance Honorarium which was paid in monthly increments. These four positions spent a total of 532 days on approved Assignment and Travel, or 133 days each on average.

Chair-Elect

This position received a Governance Honorarium of approximately 75% of the Governance Honorarium provided to the Chair.

All other Officers

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

Assignment and Travel Days

The total Assignment and Travel Days for all Officers (excluding the President, President-Elect, Immediate Past President and Chair) were 1051; this includes reimbursement for telephonic representation meetings for external organizations that are 30 minutes or longer during a calendar day and total 2 or more hours. These are reimbursed at ¾ of the current per diem rate. During this reporting period, there were 30 reimbursed calls, representing 15 per diem days.
EXPENSES

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

BENEFITS, PERQUISITES, SERVICES AND IN-KIND PAYMENTS

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

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

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

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

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

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

METHODOLOGY

As noted in its A-16 report, the Committee commissioned a comprehensive compensation review with an outside consultant expert in Board compensation to refresh the Committee’s knowledge of market conditions related to Board compensation because it has been five years since the last compensation review. The purpose of the review is to ensure the Officers are compensated appropriately for the work performed on behalf of the AMA. The Committee also continues to be interested in reviewing and refining its compensation practices for increased simplification and transparency. The Committee also asked the consultant to review the structure of Officer compensation to ensure continued alignment with current trends in for-profit Board compensation which had been to move away from paying for each individual Board or Board committee meeting to one annual fee.
The Committee’s review and subsequent recommendations for Officer compensation are based on the principle of the value of the work performed, as affirmed by the HOD. In addition, the following additional guidelines were followed:

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

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

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

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

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

FINDINGS

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

The Committee further notes that external data indicates for-profit organizations are continuing the trend of eliminating meeting fees while increasing the annual retainer in an effort to simplify the program and to recognize that Board work has become more fluid in nature and is increasingly completed outside of formal meetings; this is also a trend at the AMA based on Officer feedback.
In 2011, the HOD approved this Committee’s recommendation to refine the AMA’s compensation structure for non-leadership Officers by expanding the Governance definition to include Chair-assigned internal representation and increasing the amount of the annual Governance Honorarium. Chair-assigned External Representation continued to be paid by a Per Diem. The $61,500 annual Governance Honorarium has been in effect since July 1, 2012 and the $1200 Per Diem has been the same amount since 2008.

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

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

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

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

In determining the Governance Honorarium recommendation for non-leadership Officers, the Committee balanced simplicity, transparency and comparability versus pay for internal representation days as a compensation structure, Board feedback and the total cost of governance to the AMA. There is no good external comparison for Per Diem pay for External Representation for non-leadership Officers given the unique nature of this function at the AMA. However, the Per Diem amount has not changed since 2008 and the Committee used the data from the not-for-profit peer group Governance Honorarium comparison to directionally inform them.
Officers in leadership, the Board Chair, Chair-elect, President, President-elect and Immediate Past
President have a significant level of responsibility, representing a time commitment well above that
required by other non-profit Board leadership. This led to further analysis by the consultant to
adjust for the variance in time commitment. This analysis showed that compensation for AMA
Officers in leadership roles for the past three terms ranged near the median, resulting in the
recommendation that leadership compensation continues to be appropriate and no change is
necessary.

RECOMMENDATIONS

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

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

- 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 for Officers, excluding Board Chairs and Presidents. Representation is either
external to the AMA, or for participation in a group or organization with which the AMA has a
key role in creating/partnering/facilitating achievement of the respective organization goals
such as the AMA Foundation, PCPI, etc. The Board Chair may also approve a per diem for
special circumstances that cannot be anticipated such as weather related travel delays.

- Definition of Telephonic Per Diem for External Representation effective July 1, 2011:
Officers, excluding the Board Chairs 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.

2. That the Governance Honorarium for all Board members excluding leadership, Board Chair,
Board Chair-elect, President, President-elect, and Immediate Past President Board Chairs be
increased effective July 1, 2017 to $65,000. (Directive to Take Action)

3. That the Per Diem for Chair-assigned representation external to the AMA or for participation
in a group or organization with which he AMA has a key role in creating/partnering/facilitating
achievement of the respective organization goals such as the AMA Foundation, PCPI, etc., and
related travel be increased effective July 1, 2017 to $1,300 per day. (Directive to Take Action)
4. That the Per Diem for Chair-assigned Telephonic Per Diem for External Representation be increased effective July 1, 2017 to $650 as defined. (Directive to Take Action)

5. Except as noted above, there be no other changes to the Officers compensation for the period 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.

<table>
<thead>
<tr>
<th>POSITION</th>
<th>GOVERNANCE HONORARIUM</th>
</tr>
</thead>
<tbody>
<tr>
<td>President</td>
<td>$279,000</td>
</tr>
<tr>
<td>Immediate Past President &amp; President-Elect</td>
<td>$274,000</td>
</tr>
<tr>
<td>Chair</td>
<td>$269,500</td>
</tr>
<tr>
<td>Chair-Elect</td>
<td>$199,500</td>
</tr>
<tr>
<td>Other Officers</td>
<td>$61,500</td>
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</table>

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.