Resolutions Committee No. 2
Resolutions – Policy Background

Resolution 14: Safer Care of Obese Patients

AMA Policy - Encouraging Protocols to Assist with the Management of Patients with Obesity During Positioning and Transportation H-10.962 (Last Modified: 2015)
Our American Medical Association encourages health care professionals to learn about techniques and devices to prevent potential injury and to provide safe and effective care for patients with obesity.

AMA Policy - Recognition of Obesity as a Disease H-440.842 (Last Modified: 2013)
Our AMA recognizes obesity as a disease state with multiple pathophysiological aspects requiring a range of interventions to advance obesity treatment and prevention.

AMA Policy - Recognizing and Taking Action in Response to the Obesity Crisis D-440.980 (Last Modified: 2017)
Our AMA will: (1) collaborate with appropriate agencies and organizations to commission a multidisciplinary task force to review the public health impact of obesity and recommend measures to better recognize and treat obesity as a chronic disease; (2) actively pursue, in collaboration and coordination with programs and activities of appropriate agencies and organizations, the creation of a "National Obesity Awareness Month"; (3) strongly encourage through a media campaign the re-establishment of meaningful physical education programs in primary and secondary education as well as family-oriented education programs on obesity prevention; (4) promote the inclusion of education on obesity prevention and the medical complications of obesity in medical school and appropriate residency curricula; and (5) make Council on Medical Education Report 3, A-17, Obesity Education, available on the AMA website for use by medical students, residents, teaching faculty, and practicing physicians.

Resolution 15: Supporting Gender-Affirming Care for Transgender and Gender Minority Patients

OSMA Policy 22 – 2016 - Lesbian Gay Bisexual Transgender Queer (LGBTQ) Protection Laws
1. The OSMA supports the protection of Lesbian Gay Bisexual Transgender Queer (LGBTQ) individuals from discriminating practices and harassment.

2. The OSMA advocates for equal rights protections to all patient populations.

OSMA Policy 23 – 2016 - Expanding Gender Identity Options on Physician Intake Forms
1. The OSMA supports non-mandatory patient intake forms that allows for sex (assigned at

birth) and gender identification that are more inclusive than the binary male/female traditionally asked.

OSMA Policy 25 – 2017 - Longitudinal Approach to Cultural Competency Dialogue on Eliminating Health Care Disparities

1. The OSMA encourages all medical education institutions in Ohio to engage in expert facilitated, evidence-based dialogue in cultural competency and the physician's role in eliminating cultural health care disparities in medical treatment.

OSMA Policy 22 – 2017 - Opposition to the Practice of LGBTQ "Conversion Therapy" or "Reparative Therapy"

1. The OSMA affirms that individuals who identify as homosexual, bisexual, transgender, or are otherwise not heteronormative are not inherently suffering from a mental disorder.

2. The OSMA strongly opposes the practice of "Conversion Therapy," "Reparative Therapy" or other techniques aimed at changing a person's sexual orientation or gender identity.

AMA Policy - Promoting Inclusive Gender, Sex, and Sexual Orientation Options on Medical Documentation H-315.967 (Last Modified: 2019)

Our AMA: (1) supports the voluntary inclusion of a patient's biological sex, current gender identity, sexual orientation, preferred gender pronoun(s), preferred name, and clinically relevant, sex specific anatomy in medical documentation, and related forms, including in electronic health records, in a culturally-sensitive and voluntary manner; (2) will advocate for collection of patient data in medical documentation and in medical research studies, according to current best practices, that is inclusive of sexual orientation, gender identity, and other sexual and gender minority traits for the purposes of research into patient and population health; (3) will research the problems related to the handling of sex and gender within health information technology (HIT) products and how to best work with vendors so their HIT products treat patients equally and appropriately, regardless of sexual or gender identity; (4) will investigate the use of personal health records to reduce physician burden in maintaining accurate patient information instead of having to query each patient regarding sexual orientation and gender identity at each encounter; and (5) will advocate for the incorporation of recommended best practices into electronic health records and other HIT products at no additional cost to physicians.

AMA Policy - Promotion of LGBTQ-Friendly and Gender-Neutral Intake Forms D-315.974 (Last Modified: 2018)

Our AMA will develop and implement a plan with input from the Advisory Committee on LGBTQ Issues and appropriate medical and community based organizations to distribute and promote the adoption of the recommendations pertaining to medical documentation and related forms in AMA policy H-315.967, "Promoting Inclusive Gender, Sex, and Sexual Orientation Options on

Medical Documentation," to our membership.

AMA Policy - Medical Spectrum of Gender D-295.312 (Last Modified: 2018)
Given the medical spectrum of gender identity and sex, our AMA: (1) will work with appropriate medical organizations and community based organizations to inform and educate the medical community and the public on the medical spectrum of gender identity; (2) will educate state and federal policymakers and legislators on and advocate for policies addressing the medical spectrum of gender identity to ensure access to quality health care; and (3) affirms that an individual's genotypic sex, phenotypic sex, sexual orientation, gender and gender identity are not always aligned or indicative of the other, and that gender for many individuals may differ from the sex assigned at birth.

AMA Policy - Affirming the Medical Spectrum of Gender H-65.962 (Last Modified: 2018)
Our AMA opposes any efforts to deny an individual's right to determine their stated sex marker or gender identity.

AMA Policy - Health Care Needs of Lesbian, Gay, Bisexual, Transgender and Queer Populations H-160.991 (Last Modified: 2018)
1. Our AMA: (a) believes that the physician's nonjudgmental recognition of patients' sexual orientations, sexual behaviors, and gender identities enhances the ability to render optimal patient care in health as well as in illness. In the case of lesbian, gay, bisexual, transgender, queer/questioning, and other (LGBTQ) patients, this recognition is especially important to address the specific health care needs of people who are or may be LGBTQ; (b) is committed to taking a leadership role in: (i) educating physicians on the current state of research in and knowledge of LGBTQ Health and the need to elicit relevant gender and sexuality information from our patients; these efforts should start in medical school, but must also be a part of continuing medical education; (ii) educating physicians to recognize the physical and psychological needs of LGBTQ patients; (iii) encouraging the development of educational programs in LGBTQ Health; (iv) encouraging physicians to seek out local or national experts in the health care needs of LGBTQ people so that all physicians will achieve a better understanding of the medical needs of these populations; and (v) working with LGBTQ communities to offer physicians the opportunity to better understand the medical needs of LGBTQ patients; and (c) opposes, the use of "reparative" or "conversion" therapy for sexual orientation or gender identity.

2. Our AMA will collaborate with our partner organizations to educate physicians regarding: (i) the need for sexual and gender minority individuals to undergo regular cancer and sexually transmitted infection screenings based on anatomy due to their comparable or elevated risk for these conditions; and (ii) the need for comprehensive screening for sexually transmitted diseases in men who have sex with men; (iii) appropriate safe sex techniques to avoid the risk for sexually transmitted diseases; and (iv) that individuals who identify as a sexual and/or

gender minority (lesbian, gay, bisexual, transgender, queer/questioning individuals) experience intimate partner violence, and how sexual and gender minorities present with intimate partner violence differs from their cisgender, heterosexual peers and may have unique complicating factors.

3. Our AMA will continue to work alongside our partner organizations, including GLMA, to increase physician competency on LGBTQ health issues.

4. Our AMA will continue to explore opportunities to collaborate with other organizations, focusing on issues of mutual concern in order to provide the most comprehensive and up-to-date education and information to enable the provision of high quality and culturally competent care to LGBTQ people.

AMA Policy - Eliminating Health Disparities - Promoting Awareness and Education of Sexual Orientation and Gender Identity Health Issues in Medical Education H-295.878 (Last Modified: 2019)
Our AMA: (1) supports the right of medical students and residents to form groups and meet on-site to further their medical education or enhance patient care without regard to their gender, gender identity, sexual orientation, race, religion, disability, ethnic origin, national origin or age; (2) supports students and residents who wish to conduct on-site educational seminars and workshops on health issues related to sexual orientation and gender identity; and (3) encourages medical education accreditation bodies to both continue to encourage and periodically reassess education on health issues related to sexual orientation and gender identity in the basic science, clinical care, and cultural competency curricula in undergraduate and graduate medical education.

AMA Policy - Opposing Mandated Reporting of People Who Question Their Gender Identity H-65.959 (Last Modified: 2019)
Our AMA opposes mandated reporting of individuals who question or express interest in exploring their gender identity.

Resolution 16: Strengthen Awareness of the Importance of Good-Faith Prescription Donations to the Ohio Drug Donation Repository and the Free Clinics It Serves

OSMA Policy 31 - 1983 - Drug Availability
1. Every patient should have available any drug approved by the FDA that his or her physician thinks is needed and helpful.

2. The FDA-approved drugs should be reimbursed by third party payers.

OSMA Policy 62 - 1988 - Donation of Professional Time to Poor
1. The OSMA commends its members for continuing to donate professional time to serving the poor.

OSMA Policy 06 - 2019 - Increase Awareness of Disparities in Medical Access and Treatment in Ohio
1. That the OSMA work with appropriate stakeholders to increase awareness of Ohio physicians, residents, and medical students of disparities in medical access and treatment in Ohio based on disability, race, ethnicity, geography, and other social and demographic factors through the utilization of existing resources.

AMA Policy - Prescription Drug Donation H-120.925 (Last Modified: 2018)
Our AMA encourages: (1) states with laws establishing prescription drug repository and/or "return and reuse" programs to implement such laws and to consider integrating them with existing recycling or disposal programs; (2) states that lack drug repository and/or "return and reuse" programs to enact such laws in consultation with their state board of pharmacy; and (3) state medical associations in states where there is a prescription drug repository or a "return and reuse" program for unused medication supplies to educate physicians in their state regarding the existence of such programs.

Resolution 17: Refining OSMA Position on Healthcare Financing Reform

AMA page with extensive policy information on healthcare financing reform: AMA vision on health care reform

Resolution 18: Time Frames for Insurance Charge Submission

No specific policy on this topic identified.

Resolution 19: Out-of-Network Billing

OSMA Policy 19 – 2010 – Lifting the Restrictions on Balance Billing
1. The OSMA supports repeal of regulations currently in place that prohibit balance billing for physicians.

OSMA Policy 42 – 1979 – Retrospective Review
1. The OSMA opposes retrospective review payment for health care claims.
2. Where retrospective review and denial is presently being carried out by third-party payers,

the OSMA supports an appeal mechanism available upon request of physician or patient which is not under the control of the third-party payor and consists of a committee of the physician's peers.

AMA Policy - Out-of-Network Care H-285.904 (Last Modified: 2019)

1. Our AMA adopts the following principles related to unanticipated out-of-network care:

A. Patients must not be financially penalized for receiving unanticipated care from an out-of-network provider.

B. Insurers must meet appropriate network adequacy standards that include adequate patient access to care, including access to hospital-based physician specialties. State regulators should enforce such standards through active regulation of health insurance company plans.

C. Insurers must be transparent and proactive in informing enrollees about all deductibles, copayments and other out-of-pocket costs that enrollees may incur.

D. Prior to scheduled procedures, insurers must provide enrollees with reasonable and timely access to in-network physicians.

E. Patients who are seeking emergency care should be protected under the "prudent layperson" legal standard as established in state and federal law, without regard to prior authorization or retrospective denial for services after emergency care is rendered.

F. Out-of-network payments must not be based on a contrived percentage of the Medicare rate or rates determined by the insurance company.

G. Minimum coverage standards for unanticipated out-of-network services should be identified. Minimum coverage standards should pay out-of-network providers at the usual and customary out-of-network charges for services, with the definition of usual and customary based upon a percentile of all out-of-network charges for the particular health care service performed by a provider in the same or similar specialty and provided in the same geographical area as reported by a benchmarking database. Such a benchmarking database must be independently recognized and verifiable, completely transparent, independent of the control of either payers or providers and maintained by a non-profit organization. The non-profit organization shall not be affiliated with an insurer, a municipal cooperative health benefit plan or health management organization.

H. Mediation should be permitted in those instances where a physician's unique background or skills (e.g. the Gould Criteria) are not accounted for within a minimum coverage standard.

2. Our AMA will advocate for the principles delineated in Policy H-285.904 for all health plans, including ERISA plans.

3. Our AMA will advocate that any legislation addressing surprise out of network medical bills use an independent, non-conflicted database of commercial charges.

Resolution 20: Network Adequacy

OSMA Policy 11 – 2017 – Third Party Patient Reimbursement for Out-of-Network Physicians

1. The OSMA adopts a policy and provides support to physicians and patients which requires insurers and third-party payors to properly reimburse patients and/or out-of-network physicians their usual charges, and that there be no increase in deductibles or co-payments for those patients requiring care from out-of-network physicians because of urgent and emergent treatment needed in emergency rooms and hospitals.
2. The OSMA adopts a policy which requires insurers and third-party payors to reimburse patients and/or out-of-network physicians their usual charges in non-emergent care, if insurer and third-party payor are not able to arrange participating network physician care in a reasonable time, and that there be no increase in deductible or co-payments for those patients.
3. The OSMA directs the AMA Delegation to carry a request to our AMA to adopt a policy which requires insurers and third party payors to properly reimburse patients and/or out-of-network physicians their usual charges, and that there be no increase in deductibles or co-payments for those patients requiring care from out-of-network physicians because of urgent and emergent treatment needed in emergency rooms and hospitals and/or seek federal legislation addressing these issues.

OSMA Policy 21 – 2018 - Fairness in Commercial Health Insurance Network Panels

1. The OSMA adopt a position that commercial health insurance companies should be transparent in all policies toward physicians.

AMA Policy - H-285.908: Network Adequacy (Last Modified: 2019)

1. Our AMA supports state regulators as the primary enforcer of network adequacy requirements.
2. Our AMA supports requiring that provider terminations without cause be done prior to the enrollment period, thereby allowing enrollees to have continued access throughout the coverage year to the network they reasonably relied upon when purchasing the product. Physicians may be added to the network at any time.
3. Our AMA supports requiring health insurers to submit and make publicly available, at least quarterly, reports to state regulators that provide data on several measures of network adequacy, including the number and type of providers that have joined or left the network; the number and type of specialists and subspecialists that have left or joined the network; the number and types of providers who have filed an in network claim within the calendar year; total number of claims by provider type made on an out-of-network basis; data that indicate the provision of Essential Health Benefits; and consumer complaints received.
4. Our AMA supports requiring health insurers to indemnify patients for any covered medical expenses provided by out-of-network providers incurred over the co-payments and deductibles that would apply to in-network providers, in the case that a provider network is deemed inadequate by the health plan or appropriate regulatory authorities.
5. Our AMA advocates for regulation and legislation to require that out-of-network expenses

count toward a participant's annual deductibles and out-of-pocket maximums when a patient is enrolled in a plan with out-of-network benefits, or forced to go out-of-network due to network inadequacies.
6. Our AMA supports fair and equitable compensation to out-of-network providers in the event that a provider network is deemed inadequate by the health plan or appropriate regulatory authorities.
7. Our AMA supports health insurers paying out-of-network physicians fairly and equitably for emergency and out-of-network bills in a hospital. AMA policy is that any legislation which addresses this issue should assure that insurer payment for such care be based upon a number of factors, including the physicians' usual charge, the usual and customary charge for such service, the circumstances of the care and the expertise of the particular physician.
8. Our AMA provides assistance upon request to state medical associations in support of state legislative and regulatory efforts, and disseminate relevant model state legislation, to ensure physicians and patients have access to adequate and fair appeals processes in the event that they are harmed by inadequate networks.
9. Our AMA supports the development of a mechanism by which health insurance enrollees are able to file formal complaints about network adequacy with appropriate regulatory authorities.
10. Our AMA advocates for legislation that prohibits health insurers from falsely advertising that enrollees in their plans have access to physicians of their choosing if the health insurer's network is limited.
11. Our AMA advocates that health plans should be required to document to regulators that they have met requisite standards of network adequacy including hospital-based physician specialties (i.e. radiology, pathology, emergency medicine, anesthesiologists and hospitalists) at in-network facilities, and ensure in-network adequacy is both timely and geographically accessible.
12. Our AMA supports requiring that health insurers that terminate in-network providers: (a) notify providers of pending termination at least 90 days prior to removal from network; (b) give to providers, at least 60 days prior to distribution, a copy of the health insurer’s letter notifying patients of the provider’s change in network status; and (c) allow the provider 30 days to respond to and contest if necessary the letter prior to its distribution.

Resolution 21: Insurance and Third-Party Networks

AMA Policy - Antitrust Relief H-383.992 (Last Modified: 2019)
Our AMA will: (1) redouble efforts to make physician antitrust relief a top legislative priority, providing the necessary foundation for fair contract negotiations designed to preserve clinical autonomy and patient interest and to redirect medical decision making to patients and physicians; and (2) affirm its commitment to undertake all appropriate efforts to seek legislative and regulatory reform of state and federal law, including federal antitrust law, to enable

physicians to negotiate effectively with health insurers.

AMA Policy - AMA's Aggressive Pursuit of Antitrust Reform D-383.990 (Last Modified: 2019)
Our AMA will: (1) place a high priority on the level of support provided to AMA's Public and Private Sector Advocacy Units, which are key to successfully addressing the problems physicians face as a result of the current application of federal antitrust laws;
(2) through its private and public sector advocacy efforts, continue to aggressively advocate for a level playing field for negotiations between physicians and health insurers by aggressively pursuing legislative relief at the federal level and providing support to state medical society efforts to pass legislation based on the "state action doctrine";
(3) continue to advocate to the Federal Trade Commission and Department of Justice for more flexible and fair treatment of physicians under the antitrust laws and for greater scrutiny of insurers;
(4) continue to develop and publish objective evidence of the dominance of health insurers through its comprehensive study, Competition in Health Insurance: Comprehensive Study of US Markets, and other appropriate means;
(5) identify consequences of the concentration of market power by health plans to enlist a Senate sponsor for a bill allowing collective negotiation by physicians; and
(6) develop practical educational resources to help its member physicians better understand and use the currently available, effective modalities by which physician groups may legally negotiate contracts with insurers and health plans.

Resolution 22: Improving the Veterans Health Administration Referrals for Veterans for Care outside the VA System

OSMA Policy 11 – 2016 – Expansion of U.S. Veterans' Healthcare Choices
1. The OSMA advocates that the Veterans Health Administration expand all eligible health care choices for veterans by permitting veterans to use funds currently spent on them through the VA system, through a mechanism known as premium support, to purchase private health care coverage, and for veterans over age 65, to use these funds to defray the costs of Medicare premiums and supplemental coverage.
2. The OSMA House of Delegates directs the OSMA AMA Delegation to take this policy regarding expansion of health insurance choices for all veterans served by the Veterans Health Administration to our American Medical Association House of Delegates 2016 Annual Meeting with the further request that our AMA support federal legislation to achieve this reform.
3. The OSMA, by means of the OSMA website, as well as written letters to elected federal legislators and the U.S. President, supports federal legislation to achieve reform of veterans' health care choices through premium support to purchase private health care coverage or defray the costs of Medicare premiums and supplemental coverage.

AMA Policy - Ensuring Access to Safe and Quality Care for our Veterans H-510.986 (Last Modified: 2019)

1. Our AMA encourages all physicians to participate, when needed, in the health care of veterans.
2. Our AMA supports providing full health benefits to eligible United States Veterans to ensure that they can access the Medical care they need outside the Veterans Administration in a timely manner.
3. Our AMA will advocate strongly: a) that the President of the United States take immediate action to provide timely access to health care for eligible veterans utilizing the healthcare sector outside the Veterans Administration until the Veterans Administration can provide health care in a timely fashion; and b) that Congress act rapidly to enact a bipartisan long term solution for timely access to entitled care for eligible veterans.
4. Our AMA recommends that in order to expedite access, state and local medical societies create a registry of doctors offering to see our veterans and that the registry be made available to the veterans in their community and the local Veterans Administration.
5. Our AMA supports access to clinical educational resources for all health care professionals involved in the care of veterans such as those provided by the U.S. Department of Veterans Affairs to their employees with the goal of providing better care for all veterans.
6. Our AMA will strongly advocate that the Veterans Health Administration and Congress develop and implement necessary resources, protocols, and accountability to ensure the Veterans Health Administration recruits, hires and retains physicians and other health care professionals to deliver the safe, effective and high-quality care that our veterans have been promised and are owed.

Resolution 23: Government Pay for Government Mandates

OSMA Policy 27 – 2012 – Transparency in Insurance Coverage Information

1. The OSMA shall work with the Ohio Department of Insurance to develop transparency in the Insurance Card information presented by patients so that physicians are aware of the coverage provided by the insurance program including the patient's responsibility.

OSMA Policy 12 – 2017 – Medical Price Transparency

1. The OSMA supports legislative efforts to develop medical price transparency which are congruent with the principles of price transparency found in AMA policies such as D-155.987 and CMS Report 4-A-15 on price transparency.

OSMA Policy 42 – 1979 – Retrospective Review

1. The OSMA opposes retrospective review payment for health care claims.
2. Where retrospective review and denial is presently being carried out by third-party payers, the OSMA supports an appeal mechanism available upon request of physician or patient which is not under the control of the third-party payor and consists of a committee of the physician's peers.

Resolution 24: Determination of Inpatient/Outpatient Hospital Status

No specific policy on this topic identified.

Resolution 25: Co-Pay Accumulator

AMA Policy - Co-Pay Accumulators D-110.986 (Last Modified: 2019)
Our AMA will develop model state legislation regarding Co-Pay Accumulators for all pharmaceuticals, biologics, medical devices, and medical equipment.

Resolution 26: Bundled Payments and Medically Necessary Care

AMA Policy - Inappropriate Bundling of Medical Services by Third Party Payers D-70.983 (Last Modified: 2011)
Our AMA will: (1) continue to promote its Private Sector Advocacy activities and initiatives associated with the collection of information on third party payer modifier acceptance and inappropriate bundling practices;
(2) use the data collected as part of its Private Sector Advocacy information clearinghouse to work, in a legally appropriate manner, with interested state medical associations and national medical specialty societies to identify and address inappropriate third party payer coding and reimbursement practices, including inappropriate bundling of services, rejection of CPT modifiers, and denial and delay of payment;
(3) continue to monitor the class action lawsuits of state medical associations, and provide supportive legal and technical resources, as appropriate;
(4) develop model state legislation to prohibit third party payers from bundling services inappropriately by encompassing individually coded services under other separately coded services unless specifically addressed in CPT guidelines, or unless a physician has been specifically advised of such bundling practices at the time of entering into a contractual agreement with the physician;
(5) urge state medical associations to advocate the introduction and enactment of AMA model state legislation on claims bundling by their state legislatures; and
(6) highlight its Private Sector Advocacy document on bundling and downcoding, the related section of the AMA Model Managed Care Contract, and its advocacy initiatives on its web site and other communications measures to assure that physicians are aware of the AMA's advocacy on this issue.