



**2025 OSMA Annual Meeting
Resolution Committee Two
Resolutions 29-57**

- #29 - Removing Ambiguous Language about Fetal Heartbeat**
- #30 - Reasoned Approach to Vaccine Administration and Reporting**
- #31 – No Surprises Act - Prover Protections**
- #32 - Prohibit Fees by Health Plans for Physician Standard Electronic Funds (EFT) Payment Transactions**
- #33 - Opposing Co-Pay Maximizer Programs**
- #34 - Oversight of Medicare Advantage Plans**
- #35 - Insurance Subsidies for Undocumented Immigrants**
- #36 - Inclusive Insurance Coverage for Fertility-Related Healthcare**
- #37 - Increasing Awareness of DEA Prescription Drug Take Back Programs**
- #38 - Support for Mandatory Stock of Epinephrine Autoinjectors and Dispense Training for K-12 School Administrators and Staff**
- #39 - Overdose Prevention Education**
- #40 - Action to Address the Increase in Xylazine-Related Overdoses**
- #41 - Improving Patient Access to Pharmacies and Medications in Pharmacy Deserts**
- #42 - Automatic Pharmacy Refill Requests**
- #43 - Support for Medical Professionals and Trainees Who Breastfeed**
- #44 - Support for Increased Training for Physicians on Screening for Elder Abuse and Injustice**
- #45 - Opposing the Targeting of Healthcare Workers and Facilities in Conflict Zones**
- #46 - Equitable Access to Healthcare Through Paid Time Off**
- #47 - Reducing the Burden of Medical Debt on Patients**

- #48 – Support for Proactive and Strategic Stockpiling of Health Care Supplies in Times of Crises**
- #49 – Reaffirmation of Policy 06-2013: Graduate Medical Education, and Identification of Potential Funding Solutions through Legislative Initiatives**
- #50 – Increase State Funding for Graduate Medical Education (GME)**
- #51 – Support of Comprehensive Healthcare Reform through Exploration of Other Models**
- #52 – Supporting the Integration of Blood Pressure Variability Data in Electronic Medical Records**
- #53 – Protecting Access to IVF Treatment**
- #54 – Third Party Payer Denials without Review of the Medical Record**
- #55 – Interstate Compact to Facilitate Out-of-State Medicaid Provider Enrollment for Emergency Care**
- #56 - Advocating for Street Medicine and Mobile Medical Units through Established Healthcare Systems for Underserved Populations**
- #57 - Copayments for Primary Care and Preventative Services Should be Eliminated**

46 cases of cardiac arrest at the end of life, but is not observed in developing fetuses at the
47 beginning of life; and

48
49 **WHEREAS**, it is not a good use of time and energy and damages the credibility of
50 our lobbyists to ask them to distinguish between two synonymous terms; and therefore
51 be it

52
53 **RESOLVED**, that the OSMA amend Policy 6 – 2024 as follows:

54
55 Policy 6– 2024 – Policy on Abortion

- 56
57 1. The OSMA recognizes and supports each individual physician’s right to
58 maintain their own personal views. It is neither our duty nor our intent to alter
59 personal views.
60
61 2. The OSMA shall take a position of opposition to any proposed Ohio
62 legislation or rule that would:
63 • Require or compel Ohio physicians to perform treatment actions,
64 investigative tests, or questioning and or education of a patient which are
65 not consistent with the medical standard of care; or,
66 • Require or compel Ohio physicians to discuss treatment options that are
67 not within the standard of care and/or omit discussion of treatment options
68 that are within the standard of care.
69
70 3. The OSMA supports an individual’s right to decide whether to have children,
71 the number and spacing of children, as well as the right to have the
72 information, education, and access to evidence-based reproductive health
73 care services to make these decisions.
74
75 4. The OSMA opposes non-evidence based limitations on access to evidence-
76 based reproductive health care services, including fertility treatments,
77 contraception, and abortion.
78
79 5. The OSMA opposes the imposition of criminal and civil penalties or other
80 retaliatory efforts against patients, patient advocates, physicians, other
81 healthcare workers, and health systems for receiving, assisting in, referring
82 patients to, or providing evidence-based reproductive health care services
83 within the medical standard of care.
84
85 6. ~~The OSMA collaborates with relevant stakeholders to educate legislators and
86 amend existing state laws so that the term “fetal heartbeat” is not used to
87 inaccurately represent physiological electrical activity.~~

88
89
90 **Fiscal Note:** \$ (Sponsor)
91 \$500 (Staff)

92 **References:**

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WHEREAS, alternative treatments, both prophylactic and therapeutic, were available as alternates to mandated, experimental vaccines during the recent C-19 pandemic, and FDA and CDC recommendations were driven by political, financial and commercial interests; (12),(13),(14); and

WHEREAS, physicians were incentivized to use the C-19 vaccines, which were approved under EUA (15); and

WHEREAS, childhood diseases such as diabetes, allergies, and autism have been increasing year by year, and many authorities are linking this increased morbidity to the childhood vaccine schedules which include 33 immunizations not including recommended influenza and Covid-19 vaccinations (16), (17); and

WHEREAS, gain-of-function research is ongoing, and can result in pathogenic strains released into the population (18): and therefore be it

RESOLVED, that OSMA encourages physicians to become familiar with vaccine adverse safety effects, in order to give full informed consent concerning the risks of any Vaccination, including references to VAERS; and be it further

RESOLVED, that OSMA supports encouraging AMA to lobby CDC to simplify the VAERS, allowing vaccine adverse events to be easily reported by health care providers; and be it further

RESOLVED, that OSMA supports liability for pharmaceuticals; and be it further

RESOVLED that OSMA opposes vaccine mandates for all citizens, including health-care personnel; and be it further

RESOLVED, that Policy 21-2017 be amended as follows:

Policy 21 – 2017 – Removal of Non-Medical Exemptions for Mandated Immunizations and Support of Immunization Registries

1. The OSMA supports the use of immunizations ~~to reduce the incidence of preventable diseases.~~ THAT ARE SUPPORTED BY PEER-REVIEWED, PLACEBO-CONTROLLED STUDIES.
- ~~2. The OSMA supports the removal of non-medical exemptions for required school immunizations.~~
3. The OSMA encourages the use of immunization reporting systems for patients of all ages;

and be it further

94
95 **RESOLVED**, that Policy -- 08-2019: HPV Immunization be rescinded; and be it
96 further

97
98 **RESOLVED**, that Policy-- 07-2021 – Protection of Informed Consent and Patient
99 Autonomy with Administration of COVID-19 Vaccinations be amended as follows:

100
101 **Policy 07-2021 – Protection of Informed Consent and Patient Autonomy with**
102 **Administration of ~~COVID-19 Vaccinations~~ ANY VACCINE**

- 103
104 1. ~~The OSMA strongly encourages healthcare workers and first responders to~~
105 ~~receive the COVID-19 vaccine.~~
106 2. ~~The OSMA supports the freedom of schools and public and private employers~~
107 ~~to require the COVID-19 vaccine, which is in the best interest of their~~
108 ~~employees, students and/or patrons, with reasonable religious and medical~~
109 ~~exemptions.~~
110 3. The OSMA strongly encourages protection of patient autonomy and informed
111 consent with respect to COVID-19 vaccinations.
112 4. The OSMA AMA Delegation shall take this resolution to the AMA
113 for consideration.

114
115 ; and be it further

116
117 **RESOLVED**, that Policy -- 16-2022 – Allowing Mature Minors to Consent for
118 Vaccination and Policy 17 – 2022 – Supporting Vaccination in Ohio be rescinded; and be
119 it further

120
121 **RESOLVED**, that OSMA supports research and use of alternative therapeutics for
122 diseases aside from vaccines, and opposes restrictions on physicians who recommend
123 these alternatives for their patients; and be it further

124
125 **RESOLVED**, that OSMA oppose gain-of-function research without appropriate
126 oversight and transparency.

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128
129 **Fiscal Note:** 100 \$ (Sponsor)
130 500 \$ (Staff)

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48 **Relevant OSMA Policy:**

49 Policy 19 – 2020 – Out-of-Network Billing

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

51 Policy 17 – 2018 – OSMA to Seek Time Parity for Physician Claims Filing and

52 Insurance Take Back

53 Policy 15 – 2021 – OSMA Lobbying for Revision on Payment for Out-of-Network

54 Services

45 **WHEREAS**, copay maximizers continue to create financial burdens, stress, and
46 confusion for patients, especially for those with chronic diseases requiring high annual
47 medical care spending¹; and

48
49 **WHEREAS**, non-white, historically marginalized populations are significantly more
50 likely to be enrolled in a maximizer program than White patients⁴; and

51
52 **WHEREAS**, although maximizers should not increase cost-sharing for the patient's
53 prescription compared to standard plans, the average OOP costs for medications in
54 conditions like multiple sclerosis still more than doubled under maximizer programs,
55 leading to increased costs of over \$250 annually for each patient enrolled⁵; and

56
57 **WHEREAS**, there has been a substantial increase in maximizer prevalence
58 nationwide from 14% of commercially insured patients enrolled in such a plan design in
59 2018 to 72% in 2023⁶; and

60
61 **WHEREAS**, copay maximizer prevalence has more than tripled since 2019 in
62 specialties like oncology, where medications are critical for patients' health outcomes⁷;
63 and

64
65 **WHEREAS**, copay maximizers have amounted to \$2.7 billion, approximately a
66 quarter of total patient support spent in the country⁷; and

67
68 **WHEREAS**, the pharmacy benefit managers (PBMs) that oversee maximizer
69 programs earn 25% or more of the value of a manufacturer copay assistance program⁸;
70 and

71
72 **WHEREAS**, more than 100 employers take part in maximizer programs with non-
73 EHB designation loophole for their sponsored health insurance plans, including
74 employers based in or have operations in Ohio, such as the Ohio State University, Ohio
75 University, State Teachers Retirement System of Ohio, and Clermont County, OH⁹; and

76
77 **WHEREAS**, two-thirds of health plan sponsors view manufacturer copay
78 assistance programs as a mechanism to save money for themselves¹⁰; and

79
80 **WHEREAS**, SaveOnSP, a maximizer program, is managed by Express Scripts, a
81 PBM, which is owned by Cigna health insurance, which has contracts with major health
82 systems in Ohio such as the Ohio State Wexner Medical Center and Cleveland
83 Clinic^{11,12,13}; and

84
85 **WHEREAS**, Ohio has yet to join the 21 states that have implemented legislation
86 addressing copay adjustment by insurers¹⁴; and

87
88 **WHEREAS**, Ohio House Bill 135 (HB 135) by the 134th General Assembly would
89 prohibit harmful health insurance cost-sharing practices was passed by the House but
90 never made it out of the Senate Health Committee in 2022¹⁵; and

91
92 **WHEREAS**, Ohio HB 135 received written testimony from the Ohio State Medical
93 Association (OSMA) in support of its passage, highlighting the OSMA's commitment to
94 reduce the cost of prescriptions for patients¹⁶; and

95
96 **WHEREAS**, despite the existing state-level bans, accumulators remain in states
97 with bans, and maximizers have risen at a higher rate (+272%) compared to states
98 without any bans (+243%) due to the state's omission of maximizer programs in the bills
99 and failure to take action on their bans⁵; and

100
101 **WHEREAS**, the HELP Copays Act (H.R. 830) would require health plans to count
102 all payments made by or on behalf of patients, for all covered items or services, toward
103 patient deductibles and OOP but has not left the U.S. House of Representatives
104 Subcommittee on Health since 2023¹⁷; and therefore be it

105
106 **RESOLVED**, that our OSMA supports the restriction of insurance companies'
107 ability to adjust copay costs based on a patient's participation in a manufacturer's
108 assistance program.

109
110 **Fiscal Note:** \$ (Sponsor)
111 \$ 500+(Staff)

112
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176

177 **Relevant OSMA Policy:**

178 **Policy 25 – 2020 – Co-Pay Accumulators**

179 1. The OSMA takes legislative actions to mandate that the value of any vouchers
180 provided to patients by pharmaceutical and durable medical equipment
181 companies and submitted by patients, be counted towards patient’s deductibles
182 or out of pocket maximum (Co-Pay Accumulators).

183

184 **Relevant AMA and AMA-MSS Policy:**

185 **Co-Pay Accumulators D-110.986**

186 1. Our AMA will develop model state legislation regarding Co-Pay Accumulators for
187 all pharmaceuticals, biologics, medical devices, and medical equipment, and
188 support federal and state legislation or regulation that would ban co-pay
189 accumulator policies, including in federally regulated ERISA plans.

190

45 **WHEREAS**, federal payments to MA plan enrollees are high, and annual costs
46 were found to be \$321 higher per MA enrollee than if the same enrollee had been covered
47 by TM^{11,12}; and

48
49 **WHEREAS**, MA insurance plans have higher rates of overhead or administrative
50 costs (13% to 18.5%) compared to Traditional Medicare (2%) and have a higher overhead
51 and profit margins than even the individual market (12.3%)^{13,14}; and

52
53 **WHEREAS**, the federal government pays MAOs a fixed rate per enrollee plus risk-
54 adjusted rebates that are calculated as the difference between a) the benchmark of
55 spending on TM adjusted for a given county and b) a bid, or the cost that an MAO
56 estimates it will take to provide healthcare services to the average enrollee¹⁵; and

57
58 **WHEREAS**, the Medicare Payment Advisory Commission (MedPAC) estimates
59 that the current system of benchmarks and risk-adjustments has led to increased
60 spending of 6% more for each MA enrollee than if the same enrollee had been covered
61 by TM, a difference that is estimated to be \$27 billion in 2023 alone¹⁶,

62
63 **WHEREAS**, MedPAC has recommended that the Centers for Medicare & Medicaid
64 Services (CMS) reform the current benchmark payment system to more closely align with
65 spending within TM17 and changes based on MedPAC recommendations are projected
66 to reduce total Medicare spending by an estimated \$82 billion dollars by 2029¹¹; and

67
68 **WHEREAS**, MAOs charge taxpayers a minimum of \$88 billion per year, for
69 supplementary benefits which often attract enrollees however, a Congressional Budget
70 Office analysis completed in 2019 found that adding dental, hearing, and vision benefits
71 to TM and Medicaid would only cost a combined \$84 billion in the most expensive year
72 of its implementation¹⁸; and

73
74 **WHEREAS**, the American Medical Association (AMA) has adopted Medicare
75 Advantage Policies D-285.959 and H-330.867 to prevent access to care limitations and
76 improve risk-adjustment for MA enrollees^{17,18}; and

77
78 **WHEREAS**, our OSMA recognizes the need for universal access to healthcare
79 (Policy 13-2024) and supports increased access to comprehensive high quality care
80 (Policy 6 - 2023) while providing oversight of health insurance plans (Policy 21 - 2024);
81 and therefore be it

82
83 **RESOLVED**, that our OSMA supports equivalence in treatment and prior-
84 authorization guidelines between Medicare Advantage plans and Traditional Medicare;
85 and be it further

86
87 **RESOLVED**, that our OSMA supports that proprietary criteria shall not supersede
88 the professional judgment of the patient's physician when determining Medicare and
89 Medicare Advantage patient eligibility for procedures and admissions; and be it further

90

91 **RESOLVED**, that our OSMA support that Medicare Advantage risk adjustment
92 formulas be revised so that claims data is based on the actual cost of providing care; and
93 be it further
94

95 **RESOLVED**, that our OSMA ask our AMA to lobby in support of MedPAC
96 recommendations to develop an improved risk adjustment model and change the current
97 benchmark policy to one that bases federal payments to Medicare Advantage
98 organizations and Medicare Advantage payments to physicians/healthcare centers on
99 more accurate Fee-For-Service-derived benchmarks; and be it further
100

101 **RESOLVED**, that our OSMA ask our AMA to study how financial savings
102 generated through enactment of MedPAC recommendations and AMA policies for reform
103 of the Medicare Advantage program can be used to improve Traditional Medicare.
104

105 **Fiscal Note:** \$ (Sponsor)
106 \$ 50,000+(Staff)
107

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177

178 **Relevant OSMA Policy:**

179 **Policy 21 – 2024 - Oversight of Health Insurance Companies**

- 180 1. OSMA supports proactive oversight of health insurance carrier policies and
181 practices by the ODI by encouraging the ODI to develop a panel, with physician
182 participation, to provide oversight of health insurance carrier policies and practices.
183 2. OSMA actively encourages, educates and supports physicians, patients, and
184 hospitals regarding the process for reporting inappropriate and unfair practices by
185 health insurance carriers directly to the Department of Insurance.
186 3. OSMA will create a structure to which physicians can report concerns and submit
187 gathered information, regarding inappropriate, unsafe, or unfair health insurance carrier
188 policies to be compiled, evaluated for merit, and, if validated, reported to the ODI, with
189 appropriate supporting information from the OSMA.

190

191 **Policy 18 – 2024 - “Guarantee Issue” Protections for Traditional Medicare**

- 192 1. The Ohio State Medical Association (OSMA) will take all necessary steps to
193 require guaranteed issue protections allowing access to Medigap Insurance coverage
194 for beneficiaries switching from Medicare Advantage to traditional Medicare during the
195 annual open enrollment period.
196 2. The OSMA delegation to AMA will take this resolution to AMA seeking all
197 necessary actions (legislative or administrative) to allow Medicare beneficiaries the
198 freedom to change back to Traditional Medicare with federal guaranteed issue
199 protection to obtain Medigap insurance once they have disenrolled from Medicare
200 Advantage Plans.

201

202 **Policy 20 – 2019 - Establishing Fair Medicare Payor Rates**

- 203 1. The OSMA Delegation to the AMA ask the AMA to pursue CMS intervention and
204 direction to prevent commercial Medicare payors from compensating physicians at rates
205 below Medicare’s established rates.

206

207 **Policy 20 – 2018 - Compensation for Pre-Authorization Requests**

- 208 1. The OSMA supports the ability for all Ohio physicians to be compensated for
209 time dedicated to the pre-authorization process.
210 2. The OSMA requests that payors provide an explanation of their appeals review
211 processes.
212 3. The OSMA-AMA representatives carry a resolution to the AMA asking the AMA
213 to petition the Centers for Medicare and Medicaid services that CPT code 99080 be
214 reimbursed by Medicare.

215

216 **Relevant AMA and AMA-MSS Policy:**

217 **AMA Policy D-285.959 - Prevent Medicare Advantage Plans from Limiting Care**

- 218 1. Our American Medical Association will ask the Centers for Medicare and
219 Medicaid Services to further regulate Medicare Advantage Plans so that the same
220 treatment and authorization guidelines are followed for both fee-for-service Medicare
221 and Medicare Advantage patients, including admission to inpatient rehabilitation
222 facilities.
223 2. Our AMA will advocate that proprietary criteria shall not supersede the
224 professional judgment of the patient’s physician when determining Medicare and
225 Medicare Advantage patient eligibility for procedures and admissions.”

226

227 **AMA Policy H-330.867 - Medicare Advantage Plans**

228 1. Our American Medical Association encourages that Medicare Advantage risk
229 adjustment formulas be revised so that claims data is based on the actual cost of
230 providing care.

231 2. Our AMA will provide or create educational materials such as an infographic to
232 compare Traditional Medicare and Medicare Advantage plans so that patients are able
233 to make informed choices that best meet their health care needs.”; and be it further

234

235

46 **WHEREAS**, but for the contribution of undocumented immigrants to the Medicare
47 Trust Fund, it would become insolvent 1 year earlier than currently predicted,
48 suggesting that undocumented immigrants stabilize government health programs;⁷ and
49

50 **WHEREAS**, twelve states have used state dollars to extend Medicaid coverage
51 to children without legally recognized immigration status;⁸ and
52

53 **WHEREAS**, California and Oregon have extended full Medicaid benefits for all
54 low-income residents who would otherwise be eligible for the program but for their
55 immigration status;^{2,8} and
56

57 **WHEREAS**, eleven states have extended coverage to unborn children and
58 certain otherwise eligible adult undocumented immigrants using state-only funds;⁸ and
59

60 **WHEREAS**, the HEAL for Immigrant Families Act of 2023 would alleviate many
61 of the obstacles preventing immigrant families from accessing affordable health care,
62 ensuring access to health coverage for immigrants by (a) restoring Medicaid and CHIP
63 eligibility, (b) removing discriminatory Medicare eligibility requirements regarding length
64 of stay in the U.S. for many lawful permanent residents (LPRs), (c) ending the exclusion
65 of undocumented immigrants from accessing health insurance coverage on the
66 Affordable Care Act's (ACA) Health Insurance Exchanges, (d) ensuring access to public
67 and affordable health coverage for Deferred Action for Childhood Arrivals (DACA), and
68 (e) creates a state plan option to expand Medicaid and CHIP eligibility to immigrants
69 without lawful presence;⁹ and
70

71 **WHEREAS**, immigrants residing in states with more expansive coverage policies
72 have higher rates of coverage, are less likely to postpone or go without care, are more
73 likely to receive care and to have a trusted health care provider compared to their
74 counterparts living in states with less expansive coverage policies;¹⁰ and
75

76 **WHEREAS**, the cost of providing insurance to immigrant adults through Medicaid
77 expansion is less than half the per person cost of doing so for U.S-born adults;¹¹ and
78

79 **WHEREAS**, state-funded expansion of health coverage to all undocumented
80 immigrants could lower poverty among non-citizens by as much as 2.9%;¹² and
81

82 **WHEREAS**, at the 2024 Interim Meeting, the American Medical Association
83 (AMA) adopted Resolution 817 - ACA Subsidies for Undocumented Immigrants, which
84 "supports federal and state efforts to provide subsidies for undocumented immigrants to
85 purchase health insurance, including by extending eligibility for premium tax credits and
86 cost-sharing reductions to purchase Affordable Care Act (ACA) plans";¹³ and
87

88 **WHEREAS**, our OSMA recognizes "that health and access to healthcare are a
89 fundamental human right, and supports efforts to achieve universal, timely, and
90 affordable high quality care for everyone";¹⁴ and
91

92 **WHEREAS**, our OSMA currently supports health insurance coverage for all
93 Ohioans and policies that increase coverage and expand benefits, but limits its
94 advocacy to Ohio citizens;^{15,16} therefore be it
95

96 **RESOLVED**, that our OSMA support federal efforts to provide subsidies for
97 undocumented immigrants to purchase health insurance, including by extending
98 eligibility for premium tax credits and cost-sharing reductions to purchase Affordable
99 Care Act (ACA) plans; and be it further
100

101 **RESOLVED**, that our OSMA support state efforts to expand health coverage to
102 all Ohio residents, including children, adults, and pregnant people, regardless of
103 immigration status; and, be it further
104

105 **RESOLVED**, That our OSMA amend Policy 5 - 2008 by addition and deletion as
106 follows; and be it further
107

108 **Policy 5 – 2008 – Health Insurance Coverage for All Ohioans**

109 1. The OSMA supports guaranteed access to individually owned, affordable and
110 sustainable health care insurance for all Ohio ~~citizens~~ RESIDENTS.
111

112 **RESOLVED**, that our OSMA amend Policy 01 - 2017 as follows:
113

114 **Policy 01 – 2017 – Supporting Changes in Health Care Policy that Increase**
115 **Coverage and Expand Benefits**

116 1. The OSMA supports the elimination of pre-existing condition exclusions
117 from health insurance contracts and supports providing all Ohio ~~citizens~~
118 RESIDENTS with high quality health care.

119 2. The OSMA opposes changes to healthcare policy that would decrease
120 access to health care coverage for the ~~citizens~~ RESIDENTS of Ohio.

121 3. The OSMA supports the inclusion of young adults up to age 26 on their
122 parents'/guardians' health care plans.

123 4. The OSMA supports health care policies that allow states and institutions
124 the right to explore and develop individualized models for covering the
125 uninsured.
126

127 **Fiscal Note:** \$ (Sponsor)
128 \$ 500+(Staff)
129

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185

186 **Policy 5 – 2008 – Health Insurance Coverage for All Ohioans**

187 1. The OSMA supports guaranteed access to individually owned, affordable and
188 sustainable health care insurance for all Ohio citizens.

189 **Policy 01 – 2017 – Supporting Changes in Health Care Policy that Increase**
190 **Coverage and Expand Benefits**

- 191 1. The OSMA supports the elimination of pre-existing condition exclusions from health
192 insurance contracts and supports providing all Ohio citizens with high quality health
193 care.
194 2. The OSMA opposes changes to healthcare policy that would decrease access to
195 health care coverage for the citizens of Ohio.
196 3. The OSMA supports the inclusion of young adults up to age 26 on their
197 parents'/guardians' health care plans.
198 4. The OSMA supports health care policies that allow states and institutions the right to
199 explore and develop individualized models for covering the uninsured.
200

201 **Relevant AMA and AMA-MSS Policy:**

202 **Policy Number Pending: ACA Subsidies for Undocumented Immigrants**

203 1. Our American Medical Association supports federal and state efforts to provide
204 subsidies for undocumented immigrants to purchase health insurance, including by
205 extending eligibility for premium tax credits and cost-sharing reductions to purchase
206 Affordable Care Act 2 (ACA) plans.
207

47
48 **WHEREAS**, discrimination against queer, transgender, and gender-diverse
49 individuals in fertility service policies, including non-inclusion, limits this population’s
50 ability to access medically necessary fertility services by introducing an additional
51 financial barrier; and

52
53 **WHEREAS**, if a person’s sexual partner is not receiving the egg/sperm, the
54 donation is considered an anonymous donation, which is mostly done in private clinics
55 costing more¹⁴; and

56
57 **WHEREAS**, insurance companies do not consider LGBT+ infertility treatment
58 because by their definition, fertility treatment is only when a couple cannot conceive after
59 12 months of unprotected intercourse, which inherently excludes LGBT+ couples from
60 their definition¹⁵; and

61
62 **WHEREAS**, the American Society for Reproductive Medicine (ASRM) updated its
63 definition of “infertility” in 2023 to make it more inclusive of all people, including those in
64 the LGBTQ community, who seek fertility-related healthcare¹⁶; and

65
66 **WHEREAS**, fertility services are medically necessary for same-sex couples and
67 some couples in which one partner has a difference in sex development (DSD) or intersex
68 variation since each partner produces the same gametes; and

69
70 **WHEREAS**, our OSMA supports access to affordable health care insurance,
71 including coverage for diagnosing and treating male and female infertility (Policies 37-
72 1988, 5-2008); and

73
74 **WHEREAS**, our OSMA opposes limitations on access to evidence-based
75 reproductive health services, including fertility treatments (Policy 15-2023); and therefore
76 be it

77
78 **RESOLVED**, that the OSMA supports health insurance coverage for fertility-
79 related healthcare, including treatment for infertility and fertility preservation, regardless
80 of marital status, gender identity, or sexual orientation; and be it further

81
82 **RESOLVED**, that the OSMA rescind OSMA Policy 37 – 1988 – Infertility Insurance
83 Coverage.

84
85 **Fiscal Note:** \$ (Sponsor)
86 \$ 500+(Staff)

87
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145
146

147 **Relevant OSMA Policy:**

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149 **Policy 37-1988 – Infertility Insurance Coverage**

- 150 1. The OSMA supports health insurance coverage for the diagnosis and treatment
151 of recognized male and female infertility.
152

153 **Policy 6 – 2024 – Policy on Abortion**

- 154 1. The OSMA recognizes and supports each individual physician’s right to maintain
155 their own personal views. It is neither our duty nor our intent to alter personal views.
156 2. The OSMA shall take a position of opposition to any proposed Ohio legislation or
157 rule that would:
- 158 • Require or compel Ohio physicians to perform treatment actions, investigative
159 tests, or questioning and or education of a patient which are not consistent
160 with the medical standard of care; or,
 - 161 • Require or compel Ohio physicians to discuss treatment options that are not
162 within the standard of care and/or omit discussion of treatment options that
163 are within the standard of care.
- 164 3. The OSMA supports an individual’s right to decide whether to have children, the
165 number and spacing of children, as well as the right to have the information,
166 education, and access to evidence-based reproductive health care services to make
167 these decisions.
- 168 4. The OSMA opposes non-evidence based limitations on access to evidence-based
169 reproductive health care services, including fertility treatments, contraception, and
170 abortion.
- 171 5. The OSMA opposes the imposition of criminal and civil penalties or other retaliatory
172 efforts against patients, patient advocates, physicians, other healthcare workers, and
173 health systems for receiving, assisting in, referring patients to, or providing evidence-
174 based reproductive health care services within the medical standard of care.
- 175 6. The OSMA collaborates with relevant stakeholders to educate legislators and amend
176 existing state laws so that the term “fetal heartbeat” is not used to inaccurately
177 represent physiological electrical activity.
178
179
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181

182 **Policy 22-2016 – Lesbian Gay Bisexual Transgender Queer (LGBTQ) Protection**
183 **Laws**

- 184 1. The OSMA supports the protection of Lesbian Gay Bisexual Transgender Queer
185 (LGBTQ) individuals from discriminating practices and harassment.
186 2. The OSMA advocates for equal rights protections to all patient populations
187

188 **Policy 01-2017 – Supporting Changes in Health Care Policy that Increase**
189 **Coverage and Expand Benefits**

- 190 1. The OSMA supports the elimination of pre-existing condition exclusions from
191 health insurance contracts and supports providing all Ohio citizens with high
192 quality health care.
193 2. The OSMA opposes changes to healthcare policy that would decrease access to
194 health care coverage for the citizens of Ohio.
195 3. The OSMA supports the inclusion of young adults up to age 26 on their
196 parents'/guardians' health care plans.
197 4. The OSMA supports health care policies that allow states and institutions the
198 right to explore and develop individualized models for covering the uninsured.
199

200 **Policy 5-2008 – Health Insurance Coverage for All Ohioans**

- 201 1. The OSMA supports guaranteed access to individually owned, affordable and
202 sustainable health care insurance for all Ohio citizens.
203

204 **Relevant AMA and AMA-MSS Policy:**
205

206 **Reproductive Health Insurance Coverage H-185.926**

207 Our AMA supports: (1) insurance coverage for fertility treatments regardless of marital
208 status or sexual orientation when insurance provides coverage for fertility treatments;
209 and (2) local and state efforts to promote reproductive health insurance coverage
210 regardless of marital status or sexual orientation when insurance provides coverage for
211 fertility treatments.
212

213 **Preserving Access to Reproductive Health Services D-5.999**

- 214 1. Our American Medical Association recognizes that healthcare, including
215 reproductive health services like contraception and abortion, is a human right.
216 2. Our AMA opposes limitations on access to evidence-based reproductive health
217 services, including fertility treatments, contraception, and abortion.
218 3. Our AMA will work with interested state medical societies and medical specialty
219 societies to vigorously advocate for broad, equitable access to reproductive
220 health services, including fertility treatments, fertility preservation, contraception,
221 and abortion.
222 4. Our AMA supports shared decision-making between patients and their
223 physicians regarding reproductive healthcare.
224 5. Our AMA opposes any effort to undermine the basic medical principle that clinical
225 assessments, such as viability of the pregnancy and safety of the pregnant
226 person, are determinations to be made only by healthcare professionals with
227 their patients.

- 228 6. Our AMA opposes the imposition of criminal and civil penalties or other
229 retaliatory efforts, including adverse medical licensing actions and the termination
230 of medical liability coverage or clinical privileges against patients, patient
231 advocates, physicians, other healthcare workers, and health systems for
232 receiving, assisting in, referring patients to, or providing reproductive health
233 services.
- 234 7. Our AMA will advocate for legal protections for patients who cross state lines to
235 receive reproductive health services, including contraception and abortion, or
236 who receive medications for contraception and abortion from across state lines,
237 and legal protections for those that provide, support, or refer patients to these
238 services.
- 239 8. Our AMA will advocate for legal protections for medical students and physicians
240 who cross state lines to receive education in or deliver reproductive health
241 services, including contraception and abortion.

242

243 **Right for Gamete Preservation Therapies H-65.956**

- 244 1. Fertility preservation services are recognized by our AMA as an option for the
245 members of the transgender and non-binary community who wish to preserve
246 future fertility through gamete preservation prior to undergoing gender affirming
247 medical or surgical therapies.
- 248 2. Our AMA supports the right of transgender or non-binary individuals to seek
249 gamete preservation therapies.

250

251 **Right for Gamete Preservation Therapies H-185.922**

252 Our AMA supports insurance coverage for gamete preservation in any individual for
253 whom a medical diagnosis or treatment modality is expected to result in the loss of
254 fertility.

255

256 **Infertility and Fertility Preservation Insurance Coverage H-185.990**

- 257 1. Our American Medical Association advocates for third-party payer health
258 insurance carriers, as well as state and federal initiatives to make available
259 insurance benefits for the diagnosis and treatment of recognized infertility and for
260 reproductive and family planning purposes.
- 261 2. Our AMA supports payment for fertility preservation therapy services by all
262 payers including when infertility may be caused directly or indirectly by necessary
263 medical treatments.

46 **RESOLVED**, that our OSMA work with the Ohio Department of Health and
47 Human Services to educate the public about the availability of prescription drug take
48 back programs approved by the U.S. Drug Enforcement Agency's Office of Diversion
49 Control.

50
51 **Fiscal Note:** \$ (Sponsor)
52 \$ 100,000+(Staff)
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46 **WHEREAS**, one of the most common barriers to filling an epinephrine autoinjector
47 prescription is cost, and therefore providing them in schools would help mitigate this
48 barrier¹¹; and

49
50 **WHEREAS**, early administration of epinephrine for anaphylaxis results in better
51 outcomes including less need for hospitalizations and reduction in mortality rates¹²; and

52
53 **WHEREAS**, Ohio Revised Code 3313.7110 supports the procurement of
54 epinephrine autoinjectors¹³; and

55
56 **WHEREAS**, Ohio Revised Code 3728 supports required training for those schools
57 who choose to procure epinephrine autoinjectors, but does not mandate epinephrine
58 autoinjector stock in K-12 public schools^{14,15}; and

59
60 **WHEREAS**, AMA Policy D-60.976, supports increased legislation, research, and
61 education surrounding epinephrine autoinjector usage and procedures in schools with
62 preschool through 12th grade students¹⁶; and therefore be it

63
64 **RESOLVED**, that our OSMA supports mandatory stocking of epinephrine injection
65 autoinjectors in K-12 public schools; and be it further

66
67 **RESOLVED**, that our OSMA supports mandatory dispense training of epinephrine
68 injection autoinjectors for K-12 public school staff and administration.

69
70 **Fiscal Note:** \$ (Sponsor)
71 \$ 500+(Staff)

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127 **Relevant OSMA Policy:**

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No Relevant OSMA Policy

Relevant AMA and AMA-MSS Policy
Childhood Anaphylactic Reactions D-60.976

1. Our American Medical Association will urge all schools, from preschool through 12th grade, to:
 - a. develop Medical Emergency Response Plans (MERP);
 - b. practice these plans in order to identify potential barriers and strategies for improvement;
 - c. ensure that school campuses have a direct communication link with an emergency medical system (EMS);
 - d. identify students at risk for life-threatening emergencies and ensure these children have an individual emergency care plan that is formulated with input by a physician;
 - e. designate roles and responsibilities among school staff for handling potential life-threatening emergencies, including administering medications, working with EMS and local emergency departments, and contacting families;
 - f. train school personnel in cardiopulmonary resuscitation;
 - g. adopt the School Guidelines for Managing Students with Food Allergies distributed by FARE (Food Allergy Research & Education); and
 - h. ensure that appropriate emergency equipment to deal with anaphylaxis and acute asthmatic reactions is available and that assigned staff are familiar with using this equipment;
2. Our AMA will work to expand to all states laws permitting students to carry prescribed epinephrine or other medications prescribed by their physician for asthma or anaphylaxis.
3. Our AMA supports increased research to better understand the causes, epidemiology, and effective treatment of anaphylaxis.
4. Our AMA urges the Centers for Disease Control and Prevention to study the adequacy of school personnel and services to address asthma and anaphylactic emergencies.
5. Our AMA urges physicians to work with parents and schools to ensure that all their patients with a food allergy have an individualized emergency plan.
6. Our AMA will work to allow all first responders to carry and administer epinephrine in suspected cases of anaphylaxis.

Expansion of Epinephrine Entity Stocking Legislation H-115.966

167 Our American Medical Association supports the adoption of state laws that allow state-
168 authorized entities to permit the storage of auto-injectable epinephrine for use in case of
169 anaphylaxis.

170

171 **Improvement in US Airlines Aircraft Emergency Kits H-45.981**

172 Our American Medical Association urges federal action to require all US air carriers to
173 report data on in-flight medical emergencies, specific uses of in-flight medical kits and
174 emergency lifesaving devices, and unscheduled diversions due to in-flight medical
175 emergencies; this action should further require the Federal Aviation Administration to
176 work with the airline industry and appropriate medical specialty societies to periodically
177 review data on the incidence and outcomes of in-flight medical emergencies and issue
178 recommendations regarding the contents of in-flight medical kits and the use of
179 emergency lifesaving devices aboard commercial aircraft.

180 Our AMA will:

- 181 1. support the addition of naloxone, epinephrine auto injector and glucagon to the
182 airline medical kit.
 - 183 a. encourage airlines to voluntarily include naloxone, epinephrine auto
184 injector and glucagon in their airline medical kits.
 - 185 b. encourage the addition of naloxone, epinephrine auto injector and
186 glucagon to the emergency medical kits of all US airlines (14CFR
187 Appendix A to Part 121 - First Aid Kits and Emergency Medical Kits).
- 188 2. That our American Medical Association advocates for U.S. passenger airlines to
189 carry standard pulse oximeters, automated blood pressure cuffs and blood
190 glucose monitoring devices in their emergency medical kits.

191

192

45 **WHEREAS**, the Ohio Joint Study Committee on Drug Use Prevention Education
46 recommended that every Ohio student receive annual, age-appropriate prevention
47 education in grades kindergarten through 12 [47]; and
48

49 **WHEREAS**, the Ohio Department of Education offers youth substance use
50 prevention programs like "Start Talking!" and Generation Rx to teach students about the
51 risks of opioid misuse [49]; and
52

53 **WHEREAS**, RecoveryOhio seeks to expand access to substance misuse
54 prevention and treatment resources by promoting safe medication storage, proper
55 disposal, and distributing naloxone kits to schools and community organizations [48]; and
56

57 **WHEREAS**, Project DAWN (Deaths Avoided With Naloxone), educates and
58 collaborates with health departments, emergency departments, and community
59 organizations, providing vital overdose prevention and intervention tools across Ohio's 88
60 counties [45]; and
61

62 **WHEREAS**, annually, Project Dawn distributes more than 205,000 naloxone kits
63 which in turn prevents roughly 18,000 overdoses each year [46]; and
64

65 **WHEREAS**, the legalization of fentanyl testing strips in Ohio in 2023, combined
66 with overdose prevention education programs, has been shown to improve long-term
67 knowledge about opioid overdose and attitudes toward naloxone use, with naloxone
68 distribution programs linked to a 14% reduction in overdose fatalities in states where they
69 are legalized [29,53]; and
70

71 **WHEREAS**, similar Project DAWN overdose prevention initiatives in other states
72 have demonstrated success in strengthening their overdose prevention education, with
73 evidence showing that states with mandatory overdose education see reductions in
74 mortality rates [30]; and
75

76 **WHEREAS**, the incorporation of online educational modules and mandatory
77 annual training sessions for all healthcare providers and school systems in Ohio facilitates
78 broader access to critical overdose prevention information and readiness [19, 21]; and
79

80 **WHEREAS**, the Ohio Department of Health has provided millions of dollars
81 annually to local overdose prevention initiatives; expanding overdose prevention
82 education to include naloxone and fentanyl testing strips will enhance the effectiveness
83 of these investments [52]; and
84

85 **WHEREAS**, public education is proven to reduce fatalities through increased
86 awareness and informed decision-making [50], and therefore be it
87

88 **RESOLVED**, our OSMA supports policies promoting education on overdose
89 prevention and naloxone administration.
90

91 **Fiscal Note:** \$ (Sponsor)
92 \$ 500+(Staff)
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230

231 **Relevant OSMA Policy:**

232 **Policy 13-2022 - Curbing Opioid-Related Deaths in Ohio Through Medication-**

233 **Assisted Treatment and Harm Reduction Services**

234 1. The Ohio State Medical Association (OSMA) advocates for the use of
235 medication-assisted treatment, including but not limited to methadone or buprenorphine,
236 and harm reduction methods without penalty when clinically appropriate.

237 2. The OSMA supports public awareness campaigns to increase education of
238 evidence-based services for opioid addiction, including but not limited to
239 medication-assisted treatment, harm reduction, and recovery services.

240 3. The OSMA supports existing and pilot programs for the distribution of fentanyl test
241 strips in at risk communities in Ohio.

242 4. The OSMA supports legislation prohibiting prior authorization requirements and other
243 restrictions on use of evidence-based medications for opioid use disorder.

244 5. The OSMA supports research, policy, and education concerning the impacts of
245 racism and classism on patient awareness of and access to substance use disorder
246 treatment.

247 6. The OSMA supports legislation directing residential treatment providers to offer
248 opioid agonist or partial agonist therapies, with associated trained medical personnel,
249 on-site, or to facilitate access off-site.

250

251 **Policy 8 – 2023 -- Reducing Barriers and Eliminating Disparities Surrounding Use**
252 **of Medications for Opioid Use Disorder in Ohio**

253 1. OSMA Policy 13-2022 - curbing opioid-related deaths in Ohio through
254 medication-assisted treatment and harm reduction services be amended to read as
255 follows:

256 1. The Ohio State Medical Association (OSMA) advocates for the use of
257 medication-assisted treatment, including but not limited to methadone or buprenorphine,
258 and harm reduction methods without penalty when clinically appropriate.

259 2. The OSMA supports public awareness campaigns to increase education of
260 evidence-based services for opioid addiction, including but not limited to
261 medication-assisted treatment, harm reduction, and recovery services.

262 3. The OSMA supports existing and pilot programs for the distribution of fentanyl test
263 strips in at-risk communities in Ohio.

264 4. THE OSMA SUPPORTS LEGISLATION PROHIBITING PRIOR AUTHORIZATION
265 REQUIREMENTS AND OTHER RESTRICTIONS ON USE OF EVIDENCE-BASED
266 MEDICATIONS FOR OPIOID USE DISORDER.

267 5. THE OSMA SUPPORTS RESEARCH, POLICY, AND EDUCATION CONCERNING
268 THE IMPACTS OF RACISM AND CLASSISM ON PATIENT AWARENESS OF AND
269 ACCESS TO SUBSTANCE USE DISORDER TREATMENT.

270

46 **WHEREAS**, a study examining the potential utilization of fentanyl test strips found
47 that 98% of participants expressed confidence in their ability to use the test strips, and
48 95% expressed a desire to use them in the future, highlighting the public's willingness to
49 adopt harm reduction measures⁶; and therefore be it

50
51 **RESOLVED**, that the OSMA amend Policy 13-2022 as follows;

52
53 Policy 13-2022 - Curbing Opioid-Related Deaths in Ohio Through Medication-
54 Assisted Treatment and Harm Reduction Services

55
56 1.The Ohio State Medical Association (OSMA) advocates for the use of
57 medication-assisted treatment, including but not limited to methadone or
58 buprenorphine, and harm reduction methods without penalty when clinically
59 appropriate.

60 2. The OSMA supports public awareness campaigns to increase education of
61 evidence-based services for opioid addiction, including but not limited to
62 medication-assisted treatment, harm reduction, and recovery services.

63 3. The OSMA supports existing and pilot programs for the distribution of fentanyl
64 AND XYLAZINE test strips in at-risk communities in Ohio.

65 4. The OSMA supports legislation prohibiting prior authorization requirements and
66 other restrictions on use of evidence-based medications for opioid use disorder.

67 5. The OSMA supports research, policy, and education concerning the impacts of
68 racism and classism on patient awareness of and access to substance use
69 disorder treatment.

70 6. The OSMA supports legislation directing residential treatment providers to offer
71 opioid agonist or partial agonist therapies, with associated trained medical
72 personnel, on-site, or to facilitate access off-site.

73 7. THE OSMA SUPPORTS THE IMPLEMENTATION AND WIDESPREAD
74 EDUCATION ABOUT THE DANGERS OF CONTAMINANTS IN ILLICIT DRUG
75 SUPPLIES.

76
77 **Fiscal Note:** \$ (Sponsor)
78 \$ 500+(Staff)

79
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- 100

46 **RESOLVED**, that our OSMA work with the Ohio Department of Insurance to
47 evaluate differences in reimbursement for pharmaceuticals between Medicaid and private
48 insurances, and rectify those differences; and be it further

49
50 **RESOLVED**, that our OSMA ask for review of preferred pharmacy networks,
51 especially in view of multiple pharmacy deserts in Ohio, resulting in lack of patient access
52 to pharmacies; and be it further

53
54 **RESOLVED**, that our OSMA AMA Delegation take the issue of pharmacy deserts
55 to our AMA for further study and discussion of possible solutions to this issue including
56 telepharmacy, better reimbursement by Medicare, Pharmacy Benefit Managers
57 limitations on preferred pharmacies and reimbursement, especially for independent
58 pharmacies, and other policies to improve access for patients to their prescribed
59 medications.

60
61 **Fiscal Note:** \$ (Sponsor)
62 \$ 500+(Staff)

63
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47
48 **WHEREAS**, in a 2020 survey of resident physicians, 73% of participants reported
49 that residency significantly interfered with their ability to lactate, 60% had no place to store
50 expressed breast milk, and 48% were made to feel guilty for pumping by colleagues, and
51 only 21% had access to usable lactation rooms in their hospital⁹; and

52
53 **WHEREAS**, in a 2020 survey of resident physicians, 37% of participants stopped
54 breastfeeding before they intended to and 56% of participants experienced mental health
55 problems due to their inability to breastfeed in residency⁹; and

56
57 **WHEREAS**, a 2015 survey from the American Academy of Pediatrics found that 1
58 in 4 respondents did not have access to or were unaware of a private room for lactation,
59 40% needed to extend their training duration to accommodate a longer maternity leave
60 with breastfeeding being a deciding factor among 44%, and 1 in 3 respondents did not
61 meet their goals for exclusive breastfeeding¹⁰; and

62
63 **WHEREAS**, a 2023 cohort study at the University of California San Francisco
64 (UCSF) School of Medicine demonstrated that a multifaceted approach to improving
65 lactation accommodations (i.e. creation of functional lactation spaces, improving
66 communication regarding lactation resources, establishment of physician-specific
67 lactation policies, development of a program to reimburse faculty for time spent during
68 lactation in the ambulatory setting) in an academic health system can remove barriers to
69 physician lactation, address the impact of lactation time on productivity, and offer a culture
70 of support for lactating trainees¹¹; and therefore be it

71
72 **RESOLVED**, the OSMA encourages healthcare organizations to implement
73 policies that allow lactating health care workers and trainees sufficient time to breastfeed
74 and/or pump breast milk, and appropriate resources for them to maintain their work and
75 study responsibilities, including but not limited to:

- 76
77 i. Installation of computer workstations and phones in private lactation
78 rooms
79 ii. Accommodations for lactation in faculty schedules
80 iii. Creation and maintenance of facilities for storing expressed breast milk.

81
82 **Fiscal Note:** \$ (Sponsor)
83 \$ 100,000+(Staff)
84

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129 health-ambulatory-clinicians)

129 **Relevant AMA Policy:**

131 **AMA Support for Breastfeeding H-245.982**

132 1. Our AMA: (a) recognizes that breastfeeding is the optimal form of nutrition for most
133 infants; (b) endorses the 2012 policy statement of American Academy of Pediatrics on
134 Breastfeeding and the use of Human Milk, which delineates various ways in which
135 physicians and hospitals can promote, protect, and support breastfeeding practices; (c)
136 supports working with other interested organizations in actively seeking to promote
137 increased breastfeeding by Supplemental Nutrition Program for Women, Infants, and
138 Children (WIC Program) recipients, without reduction in other benefits; (d) supports the
139 availability and appropriate use of breast pumps as a cost-effective tool to promote
140 breast feeding; and (e) encourages public facilities to provide designated areas for
141 breastfeeding and breast pumping; mothers nursing babies should not be singled out
142 and discouraged from nursing their infants in public places.

143 2. Our AMA: (a) promotes education on breastfeeding in undergraduate, graduate, and
144 continuing medical education curricula; (b) encourages all medical schools and
145 graduate medical education programs to support all residents, medical students and
146 faculty who provide breast milk for their infants, including appropriate time and facilities
147 to express and store breast milk during the working day; (c) encourages the education
148 of patients during prenatal care on the benefits of breastfeeding; (d) supports
149 breastfeeding in the health care system by encouraging hospitals to provide written
150 breastfeeding policy that is communicated to health care staff; (e) encourages hospitals
151 to train staff in the skills needed to implement written breastfeeding policy, to educate
152 pregnant women about the benefits and management of breastfeeding, to attempt early
153 initiation of breastfeeding, to practice "rooming-in," to educate mothers on how to
154 breastfeed and maintain lactation, and to foster breastfeeding support groups and
155 services; (f) supports curtailing formula promotional practices by encouraging perinatal
156 care providers and hospitals to ensure that physicians or other appropriately trained
157 medical personnel authorize distribution of infant formula as a medical sample only after
158 appropriate infant feeding education, to specifically include education of parents about
159 the medical benefits of breastfeeding and encouragement of its practice, and education
160 of parents about formula and bottle-feeding options; and (g) supports the concept that
161 the parent's decision to use infant formula, as well as the choice of which formula,
162 should be preceded by consultation with a physician.

163 3. Our AMA: (a) supports the implementation of the WHO/UNICEF Ten Steps to
164 Successful Breastfeeding at all birthing facilities; (b) endorses implementation of the
165 Joint Commission Perinatal Care Core Measures Set for Exclusive Breast Milk Feeding
166 for all maternity care facilities in the US as measures of breastfeeding initiation,
167 exclusivity and continuation which should be continuously tracked by the nation, and
168 social and demographic disparities should be addressed and eliminated; (c)
169 recommends exclusive breastfeeding for about six months, followed by continued
170 breastfeeding as complementary food are introduced, with continuation of breastfeeding
171 for 1 year or longer as mutually desired by mother and infant; (d) recommends the

172 adoption of employer programs which support breastfeeding mothers so that they may
173 safely and privately express breast milk at work or take time to feed their infants; and (e)
174 encourages employers in all fields of healthcare to serve as role models to improve the
175 public health by supporting mothers providing breast milk to their infants beyond the
176 postpartum period.

177 4. Our AMA supports the evaluation and grading of primary care interventions to
178 support breastfeeding, as developed by the United States Preventive Services Task
179 Force (USPSTF).

180 5. Our AMA's Opioid Task Force promotes educational resources for mothers who are
181 breastfeeding on the benefits and risks of using opioids or medication-assisted therapy
182 for opioid use disorder, based on the most recent guidelines.

183

184 **Burdensome Paperwork for Breast Pumps H-185.928**

185 Our AMA will vigorously oppose unnecessary and burdensome paperwork which
186 presents barriers to lactation support, such as prescriptions to support physiologic
187 functions; and further, to ensure that The Joint Commission and Healthy People 2020
188 breastfeeding goals are met.

189

190 **Improving and Standardizing Pregnancy and Lactation Accommodations for** 191 **Medical Board Examinations H-275.915**

192 1. Our American Medical Association supports and will advocate for the implementation
193 of a minimum of 60 minutes of additional, scheduled break time for all test takers who
194 are pregnant and/or lactating during all medical licensure and certification examinations.

195 2. Our AMA supports the addition of pregnancy comfort aids, including but not limited to
196 ginger teas, saltines, wastebaskets, and antiemetics, to any medical licensure or
197 certification examination's pre-approved list of Personal Item Exemptions (PIEs)
198 permitted in the secure testing area for all test takers who are pregnant and/or lactating.

199

200

44 **WHEREAS**, in a study on healthcare utilization, the elderly comprise 13.5% of the
45 population, however their healthcare utilization comprises 42.5% percent of healthcare
46 costs¹⁰; and

47
48 **WHEREAS**, previous studies have found that elder abuse is associated with
49 increased healthcare utilization, particularly in the emergency department where
50 physicians are 3x more likely to encounter a victim of elder abuse^{5,11}; and

51
52 **WHEREAS**, a survey conducted with emergency department physicians in the
53 United States reported that approximately 58% of physicians lacked confidence in
54 correctly identifying elder abuse which highlights gaps in education¹²; and

55
56 **WHEREAS**, a cross-sectional study reported that guidelines are supported for
57 geriatric screening in the ED, however close to 0% of elderly patients are consistently
58 screened¹²; and

59
60 **WHEREAS**, a study looking at the effects of the screening tool DETECT in ED's
61 found that there was increased reporting of elder abuse¹³; and

62
63 **WHEREAS**, a study investigating simulations as a means to enhance medical
64 student knowledge and recognition of elder abuse found there was a significant difference
65 between pre-training and post-training awareness¹⁴; and

66
67 **WHEREAS**, medical school curriculums cover elder abuse and mistreatment, but
68 students are often left unsure of the protocol for reporting¹⁵; and

69
70 **WHEREAS**, a systematic review looking at residency programs who used an
71 integrative elderly abuse detection program found that residents had an improved
72 recognition of elder abuse and felt more confident in reporting¹⁵; and

73
74 **WHEREAS**, elder abuse screening is not currently recommended under the United
75 States Preventative Task Force guidelines, however, the elder abuse suspicion index has
76 been approved for primary care settings¹⁶; and

77
78 **WHEREAS**, the American Association of Family Physicians (AAFP) recommends
79 that family physicians should be aware of risk factors for elder abuse and mistreatment,
80 and be trained in educating their communities on caregiver stress and conflict resolution
81 skills^{17,18}; and

82

83 **WHEREAS**, there have been efforts to prevent elder abuse through advocacy,
84 safe havens, screening, and legislation, the effectiveness of such methods are unclear
85 and require more rigorous research²⁰; and

86
87 **WHEREAS**, the Elder Justice Act addresses abuse, neglect, and exploitation,
88 while providing reporting requirements and funding to decrease rates of abuse and
89 support victims⁸; and

90
91 **WHEREAS**, the limited data on elder abuse prevention, treatments, and
92 interventions highlights the need for more effective evidence-based strategies^{21, 22}; and

93
94 **WHEREAS**, conducting randomized controlled trials could provide valuable
95 insights to enhance protocols for addressing elder abuse^{21, 22}; and

96
97 **WHEREAS**, AMA Policy H-515.949 supports improved recognition and treatment
98 for elderly experiencing abuse, as well as the adoption of the Elder Justice Act²³; and

99
100 **WHEREAS**, AMA Policy H-515.961 supports interdisciplinary management of
101 elder mistreatment and recognizes elder mistreatment as a public health crisis²⁴; and

102
103 **WHEREAS**, AMA Policy reaffirms the implementation of Geriatric Medicine and
104 pharmacotherapy in medical curriculums, including both medical schools and residency
105 programs²⁵; and therefore be it

106
107 **RESOLVED**, that our OSMA encourages training for physicians to screen for elder
108 injustice, including neglect, abuse, and exploitation, and policy for mitigation of elder
109 inequities.

110
111 **Fiscal Note:** \$ (Sponsor)
112 \$ 500+(Staff)

113
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194

195 **Relevant OSMA Policy**

196 No Relevant OSMA Policy

197

198 **Relevant AMA and AMA-MSS Policy**

199 **Elder Mistreatment H-515.949**

200 Our American Medical Association encourages all physicians caring for the elderly to
201 become more proactive in recognizing and treating vulnerable elders who may be
202 victims of mistreatment through prevention and early identification of risk factors in all
203 care settings. Encourage physicians to participate in medical case management and
204 APS teams and assume greater roles as medical advisors to APS services.

205 Our AMA promotes collaboration with the Liaison Committee on Medical Education and
206 the Association of American Medical Colleges, as well as the Commission on
207 Osteopathic College Accreditation and American Association of Colleges of Osteopathic
208 Medicine, in establishing training in elder mistreatment for all medical students; such
209 training could be accomplished by local arrangements with the state APS teams to
210 provide student rotations on their teams. Physician responsibility in cases of elder
211 mistreatment could be part of the educational curriculum on professionalism and
212 incorporated into questions on the US Medical Licensing Examination and
213 Comprehensive Osteopathic Medical Licensing Examination.

214
215 Our AMA encourages the development of curricula at the residency level and
216 collaboration with residency review committees, the Accreditation Council for Graduate
217 Medical Education, specialty boards, and Maintenance of Certification programs on the
218 recognition of elder mistreatment and appropriate referrals and treatment.

219
220 Our AMA encourages substantially more research in the area of elder mistreatment.

221
222 Our AMA encourages the US Department of Health and Human Services, Office of
223 Human Research Protections, which provides oversight for institutional review boards,
224 and the Association for the Accreditation of Human Research Protection Programs to
225 collaborate on establishing guidelines and protocols to address the issue of vulnerable
226 subjects and research subject surrogates, so that research in the area of elder
227 mistreatment can proceed.

228
229 Our AMA encourages a national effort to reach consensus on elder mistreatment
230 definitions and rigorous objective measurements so that interventions and outcomes of
231 treatment can be evaluated.

232
233 Our AMA encourages adoption of legislation, such as the Elder Justice Act, that
234 promotes clinical, research, and educational programs in the prevention, detection,
235 treatment, and intervention of elder abuse, neglect, and exploitation.

236
237 **Health Care for Older Patients H-25.999**

238 Our American Medical Association endorses and encourages further experimentation
239 and application of home-centered programs of care for older patients and recommends
240 further application of other new experiments in providing better health care, such as
241 rehabilitation education services in nursing homes, chronic illness referral centers, and
242 progressive patient care in hospitals.

243
244 Our AMA recommends that there be increased emphasis at all levels of medical
245 education on the new challenges being presented to physicians in health care of the
246 older person, on the growing opportunities for effective use of health maintenance
247 programs and restorative services with this age group, and on the importance of a total
248 view of health, embracing social, psychological, economic, and vocational aspects.

249 Our AMA encourages continued leadership and participation by the medical profession
250 in community programs for seniors.

251
252 Our AMA will explore and advocate for policies that best improve access to, and the
253 availability of, high quality geriatric care for older adults in the post-acute and long term
254 care continuum.

255
256 **Elder Mistreatment H-515.961**

257 Our American Medical Association recognizes elder mistreatment as a serious and
258 pervasive public health problem that requires an organized effort from physicians and all
259 medical professionals to improve the timely recognition and provision of clinical care in
260 vulnerable elders who experience mistreatment.

261
262 Our AMA recognizes the importance of an interdisciplinary and collaborative approach
263 to this issue, and encourage states to bring together teams with representatives from
264 medicine, nursing, social work, adult protective services (APS), criminal and civil law,
265 and law enforcement to develop appropriate interventions and evaluate their
266 effectiveness.

267
268 Promoting and Ensuring Safe, High Quality, and Affordable Elder Care Through
269 Examining and Advocating for Better Regulation of and Alternatives to the Current,
270 Growing For-Profit Long Term Care Options D-280.982

271
272 Our American Medical Association will advocate for business models in long term care
273 for the elderly which incentivize and promote the ethical and equitable use of resources
274 to maximize care quality, staff and resident safety, and resident quality of life, and which
275 hold patients' interests as paramount over maximizing profit.

276
277 Our AMA will, in collaboration with other stakeholders, including major payers, advocate
278 for further research into alternatives to current options for long term care to promote the
279 highest quality and value long term care services and supports (LTSS) models as well
280 as functions and structures which best support these models for care.

281

45 **WHEREAS**, the AMA supports the safety of healthcare and humanitarian aid
46 workers along with safe access to healthcare, healthcare facilities, and humanitarian aid
47 for all civilians in areas of armed conflict⁵; and therefore be it
48

49 **RESOLVED**, that our OSMA opposes any attacks on healthcare workers and
50 facilities in conflict zones and calls for international measures to protect them; and be it
51 further
52

53 **RESOLVED**, that our OSMA advocates for global accountability for targeting
54 medical personnel and facilities and supports strengthening enforcement of international
55 humanitarian law; and be it further
56

57 **RESOLVED**, that our OSMA advocates adherence to international conventions
58 protecting healthcare workers and facilities in conflict zones to ensure that essential care
59 continues during times of war and unrest.
60

61 **Fiscal Note:** \$ (Sponsor)
62 \$ 50,000+ (Staff)
63

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102

103 **Relevant OSMA Policy**

104 N/A

105
106 **Relevant AMA and AMA-MSS Policy**

107 **H-520.985- Protection of Healthcare and Humanitarian Aid Workers in all Areas of**
108 **Armed Conflict**

- 109 1. Our American Medical Association supports peace in Israel and Palestine in
110 order to protect civilian lives and healthcare personnel.
111 2. Our AMA supports the safety of healthcare and humanitarian aid workers along
112 with safe access to healthcare, healthcare facilities, and humanitarian aid for all
113 civilians in areas of armed conflict.
114

47 **WHEREAS**, Ohio currently lacks legislation mandating paid sick leave for private
48 employers, despite prior interest highlighted in a 2007 study that that highlighted the
49 significant benefits of paid sick leave policies for employees and their families; however,
50 no legislative action followed this research.¹¹; and

51
52 **WHEREAS**, employees without access to paid leave were more than twice as
53 likely to go without medical care because they could not afford to take unpaid time off (12
54 percent versus 5 percent of those with access to paid leave) or because they worried
55 losing their job if they took paid or unpaid leave (7 percent against 3 percent of those with
56 access to paid leave).¹²; and

57
58 **WHEREAS**, approximately half of working parents report that they are not paid
59 when they take time off to care for ill children. Three-quarters (76%) of working mothers
60 with low incomes (less than 200% of the federal poverty threshold) report losing pay when
61 they miss work to care for sick children, more than twice as many as those with higher
62 incomes (38%).¹³; and

63
64 **WHEREAS**, while 72 percent of white workers reported having access to at least
65 one type of paid leave, only 58 percent of Hispanic/Latinx adults and 67 percent of Black
66 adults reported having such access.¹⁴; and

67
68 **WHEREAS**, part-time and low-income workers are disproportionately affected by
69 a lack of workplace support, such as paid sick leave, which makes it difficult for them to
70 balance their healthcare needs with job security.¹³; and

71
72 **WHEREAS**, employees without paid leave are more likely to have material and
73 financial difficulties than those with paid leave, such as being twice as likely to face food
74 insecurity and more than twice as likely to be unable to pay for utilities or rent.¹⁴; and

75
76 **WHEREAS**, approximately 80.5 percent of workers in families with incomes four
77 times or greater than the federal poverty level receive paid leave, whereas only 31.5
78 percent of workers in households below the poverty line have access, with workers'
79 access rates progressively declining as family income drops.¹⁴; and therefore be it

80
81 **RESOLVED**, our OSMA supports paid sick leave for Ohio workers.

82
83 **Fiscal Note:** \$ (Sponsor)
84 \$ 500+(Staff)

85
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140
141 **Relevant OSMA Policy:**
142 **Policy 12 – 2024 Support for Paid Parental Leave**
143 1. OSMA supports paid parental leave following the birth, adoption, or foster placement
144 of a new child and following loss of pregnancy.

145
146 **Relevant AMA Policy:**
147 **Paid Sick Leave H-440.823**
148 1. Our American Medical Association recognizes the public health benefits of paid sick
149 leave and other discretionary paid time off.
150 2. Our AMA supports employer policies that allow employees to accrue paid time off
151 and to use such time to care for themselves or a family member.
152 3. Our AMA supports employer policies that provide employees with unpaid sick days to
153 use to care for themselves or a family member where providing paid leave is overly
154 burdensome.
155 4. Our AMA advocates for federal and state policies that guarantee employee access to
156 protected paid sick leave without unduly burdening small businesses.
157

42 **WHEREAS**, Ohio House Bill 49, which aimed to prohibit medical debt collectors
43 from sharing or reporting any patient medical debt to a consumer reporting agency for
44 one year after the patient’s first bill, failed in the 2023-2024 legislative session¹⁴; and
45

46 **WHEREAS**, the Consumer Federal Protection Bureau finalized rules in January
47 2025 banning medical debt bills on credit reports¹⁵; and
48

49 **WHEREAS**, the AMA “opposes wage garnishments and property liens being
50 placed on low-wage patients due to outstanding medical debt at levels that would
51 preclude payments for essential food and housing” and supports other interventions
52 addressing medical debt (Policy H-373.990); and therefore be it
53

54 **RESOLVED**, that the OSMA support policies that protect patients from negative
55 consequences of medical debt, including, but not limited to, policies that:

- 56 a. Limit medical debt interest,
- 57 b. Limit wage garnishment due to medical debt,
- 58 c. Prohibit placing liens on homes due to medical debt,
- 59 d. Set minimum standards for hospital payment plans for patients,
- 60 e. Mandate instructions be given to every patient on how to pursue a
61 healthcare facility’s payment plan, payment forgiveness, and loan
62 services, and
- 63 f. Establish conditions before a hospital can send a bill to collections.

64
65 **Fiscal Note:** \$ (Sponsor)
66 \$ 500+(Staff)
67

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- 124

125 **Relevant OSMA Policy:**

126

127 **Policy 19 – 2020 – Out-of-Network Billing**

128 1. The OSMA rescinds Policy 19 – 2010 (Lifting the Restrictions on Balance Billing).

129 2. The OSMA supports repeal of regulations currently in place that prohibit balance
130 billing for physicians.

131 3. The OSMA adopts its own policy similar to AMA policy H-285.904, to read as follows:

132 1. The OSMA adopts the following principles related to unanticipated out-of-network
133 care:

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

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

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

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

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

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

150 G. Minimum coverage standards for unanticipated out-of-network services should be
151 identified. Minimum coverage standards should pay out-of-network providers at the
152 usual and customary out-of-network charges for services, with the definition of usual
153 and customary based upon a percentile of all out-of-network charges for the particular
154 health care service performed by a provider in the same or similar specialty and
155 provided in the same geographical area as reported by a benchmarking database. Such
156 a benchmarking database must be independently recognized and verifiable, completely
157 transparent, independent of the control of either payers or providers and maintained by
158 a non-profit organization. The non-profit organization shall not be affiliated with an
159 insurer, a municipal cooperative health benefit plan or health management organization.
160 H. Mediation and/or Independent Dispute Resolution (IDR) should be permitted in all
161 circumstances as an option or alternative to come to payment resolution between
162 insurers and providers.

163 2. The OSMA will advocate for the principles delineated in this policy for all health
164 plans, including ERISA plans.

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

167 4. The OSMA’s delegation to the AMA submit a resolution at A-20 asking for this
168 amendment to Item H in their policy.

169

170 **Policy 12 – 2017 – Medical Price Transparency**

171 1. The OSMA supports legislative efforts to develop medical price transparency which
172 are congruent with the principles of price transparency found in AMA policies such as D-
173 155.987 and CMS Report 4-A-15 on price transparency.

174
175 **Relevant AMA Policy:**

176
177 **Exclusion of Medical Debt That Has Been Fully Paid or Settled H-373.996**
178 Our AMA supports the principles contained in The Medical Debt Relief Act as drafted
179 and passed by the US House of Representatives to provide relief to the American
180 consumer from a complicated collections process and supports medical debt resolution
181 being portrayed in a positive and productive manner.

182
183 **Health Plan Payment of Patient Cost-Sharing D-180.979**
184 Our AMA will: (1) support the development of sophisticated information technology
185 systems to help enable physicians and patients to better understand financial
186 obligations; (2) encourage states and other stakeholders to monitor the growth of high
187 deductible health plans and other forms of cost-sharing in health plans to assess the
188 impact of such plans on access to care, health outcomes, medical debt, and provider
189 practice sustainability; (3) advocate for the inclusion of health insurance contract
190 provisions that permit network physicians to collect patient cost-sharing financial
191 obligations (eg, deductibles, co-payments, and co-insurance) at the time of service; and
192 (4) monitor programs wherein health plans and insurers bear the responsibility of
193 collecting patient co-payments and deductibles.

194
195 **Patient Medical Debt H-373.990**
196 Our American Medical Association encourages health care organizations to manage
197 medical debt with patients directly, considering several options including but not limited
198 to discounts, payment plans with flexibility and extensions as needed, or forgiveness of
199 debt altogether, before resorting to third-party debt collectors or any punitive actions.
200 Our AMA supports innovative efforts to address medical debt for patients, including
201 sliding-scale, interest-free payment plans before collection or litigation activities and
202 public and private efforts to eliminate medical debt, such as purchasing debt with the
203 intent of cancellation.

204 Our AMA supports amending the Fair Debt Collection Practices Act to include hospitals
205 and strengthen standards within the Act to provide clarity to patients about whether their
206 insurance has been or will be billed, which would require itemized debt statements to be
207 provided to patients, thereby increasing transparency, and prohibiting misleading
208 representation in connection with debt collection.

209 Our AMA opposes wage garnishments and property liens being placed on low-wage
210 patients due to outstanding medical debt at levels that would preclude payments for
211 essential food and housing.

212 Our AMA supports patient education on medical debt that addresses dimensions such
213 as:

- 214 a. patient financing programs that may be offered by hospitals, physicians offices,
215 and other non-physician provider offices;

- 216 b. the ramifications of high interest rates associated with financing programs that
- 217 may be offered by a hospital, physician's office, or other non-physician provider's
- 218 office;
- 219 c. potential financial aid available from a patient's hospital and/or physician's office;
- 220 and
- 221 d. methods to reduce high deductibles and cost-sharing.
- 222
- 223

46 **WHEREAS**, one-time large purchases of PPE are often not sufficient to address
47 demand in future times of crisis, due to short expiration windows of millions of units⁷; and
48

49 **WHEREAS**, a survey conducted by Premier Inc. showed that 86% of providers
50 experienced shortages with approximately 54% of respondents having less than a 10 day
51 supply⁸; and
52

53 **WHEREAS**, a Premier Inc. survey confirmed that Center for Strategic National
54 Stockpile does not stock the IV fluids that Baxter produced⁸; and
55

56 **WHEREAS**, approximately 24% of healthcare workers acknowledge that drug
57 shortages contributed to dosing errors and also reported that healthcare workers were
58 concerned about additional shortages^{8, 9}; and
59

60 **WHEREAS**, supply rotation strategies have been devised at national and regional
61 levels to facilitate coordination between hospitals, manufacturers, and storage
62 warehouses to increase crisis preparedness, reduce waste, and lower material costs¹⁰;
63 and
64

65 **WHEREAS**, supply shortages cause delays in treatments leading to decreased
66 quality of care due to lack of access to medications or having to resort to less-effective
67 treatments⁹; and
68

69 **WHEREAS**, AMA Policy H-440.847 supports adequate resourcing, funding,
70 protocols, and collaboration to ensure pandemic preparedness¹¹; and therefore be it
71

72 **RESOLVED**, that our OSMA amend Policy 09-2021 as follows:
73

74 **Policy 09-2021 – Pandemic DISASTER Preparedness**

75 The OSMA recommends that The State of Ohio establish a standing board to
76 continuously review pandemic DISASTER preparedness including, but not limited to,
77 stockpiles of personal protective equipment, plans for isolation protocols,
78 mobilization of testing, and immunization procedures, and ensure that physicians
79 (MD/DO) are central to the administration of vaccinations to the citizens of Ohio.
80 This board should include the Ohio State Medical Association, Ohio State Board
81 of Pharmacy, the Ohio Hospital Association, and the Ohio Department of Health,
82 and other interested parties; and be it further
83

84 **RESOLVED**, that our OSMA select a strategic stockpiling board for all disasters,
85 including, but not limited to, pandemics, wildfires, hurricanes, tsunamis, tornados,
86 earthquakes, landslides, snow storms, drought, flood, migration, mass shootings, terrorist
87 attacks, nuclear events, and wars, which includes physicians, healthcare product
88 manufacturers, health officials, emergency management specialists, and hospital
89 administration.
90

91 **Fiscal Note:** \$ (Sponsor)

\$ 500+(Staff)

92
93
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134

135 **Relevant OSMA Policy:**

136 **Policy 09-2021 – Pandemic Preparedness**

137 The OSMA recommends that The State of Ohio establish a standing board to
138 continuously review pandemic preparedness including, but not limited to, stockpiles of
139 personal protective equipment, plans for isolation protocols, mobilization of testing, and
140 immunization procedures, and ensure that physicians (MD/DO) are central to the
141 administration of vaccinations to the citizens of Ohio. This board should include the
142 Ohio State Medical Association, Ohio State Board of Pharmacy, the Ohio Hospital
143 Association, and the Ohio Department of Health, and other interested parties.

144

145 **Relevant AMA and AMA-MSS Policy:**

146 **H-440.847- Pandemic Preparedness**

147 In order to prepare for a pandemic, our American Medical Association:

- 148 1. urges the Department of Health and Human Services Emergency Care
149 Coordination Center, in collaboration with the leadership of the Centers for
150 Disease Control and Prevention (CDC), state and local health
151 departments, and the national organizations representing them, to
152 urgently assess the shortfall in funding, staffing, supplies, vaccine, drug,
153 and data management capacity to prepare for and respond to a pandemic
154 or other serious public health emergency.
- 155 2. urges Congress and the Administration to work to ensure adequate
156 funding and other resources: (a) for the CDC, the National Institutes of
157 Health (NIH), the Strategic National Stockpile and other appropriate
158 federal agencies, to support the maintenance of and the implementation of
159 an expanded capacity to produce the necessary vaccines, anti- microbial
160 drugs, medical supplies, and personal protective equipment, and to
161 continue development of the nation's capacity to rapidly manufacture the
162 necessary supplies needed to protect, treat, test and vaccinate the entire
163 population and care for large numbers of seriously ill people, without
164 overreliance on unreliable international sources of production; and (b) to
165 bolster the infrastructure and capacity of state and local health
166 departments to effectively prepare for and respond to a pandemic or other
167 serious public health emergency.
- 168 3. encourages states to maintain medical and personal protective equipment
169 stockpiles sufficient for effective preparedness and to respond to a
170 pandemic or other major public health emergency.
- 171 4. urges the federal government to meet treaty and trust obligations by
172 adequately sourcing medical and personal protective equipment directly to
173 tribal communities and the Indian Health Service for effective
174 preparedness and to respond to a pandemic or other major public
175 emergency.

- 176 5. urges the CDC to develop and disseminate electronic instructional
177 resources on procedures to follow in an epidemic, pandemic, or other
178 serious public health emergency, which are tailored to the needs of health
179 care personnel in direct patient care settings;
- 180 6. supports the position that:
- 181 a. relevant national and state agencies (such as the CDC, NIH, and
182 the state departments of health) continue to plan and test
183 distribution activities in advance of a public health emergency, to
184 assure that physicians, nurses, other health care personnel, and
185 first responders having direct patient contact, receive any
186 appropriate vaccination or medical countermeasure in a timely and
187 efficient manner, in order to reassure them that they will have first
188 priority in the event of such a pandemic.
- 189 b. such agencies should publicize now, in advance of any such
190 pandemic, what the plan will be to provide immunization to health
191 care provider.
- 192 7. will monitor progress in developing a contingency plan that addresses
193 future vaccine production or distribution problems and in developing a plan
194 to respond to a pandemic in the United States.
- 195 8. will encourage state and federal efforts to locate the manufacturing of
196 goods used in healthcare and healthcare facilities in the United States.
- 197 9. will support federal efforts to encourage the purchase of domestically
198 produced personal protective equipment.
- 199

D-120.961- Personal Medication and Medical Supplies in Times of Disaster

200 Our AMA urges continued dialogue with appropriate federal agencies, medical
201 societies, health care organizations, and other appropriate stakeholders to: (a) ensure
202 timely distribution of and access to medications for acute and chronic medical
203 conditions in a disaster; (b) issue guidance to health professionals and the public on the
204 appropriate stockpiling of medications for acute and chronic medical conditions in a
205 disaster or other serious emergency; and (c) deliberate the design, feasibility, and utility
206 of a universal mechanism, that provides the essential health and medical supplies and
207 information that can assist emergency medical responders and other health care
208 personnel with the provision of medical care and assistance in a disaster or other
209 serious emergency.

210

H-440.810- Availability of Personal Protective Equipment (PPE)

211
212 Our American Medical Association affirms that the medical staff of each health care
213 institution should be integrally involved in disaster planning, strategy and tactical
214 management of ongoing crises.

215

216
217 Our AMA supports evidence-based standards and national guidelines for PPE use,
218 reuse, and appropriate cleaning/decontamination during surge conditions.

219

220 Our AMA will advocate that it is the responsibility of health care facilities to provide
221 sufficient personal protective equipment (PPE) for all employees and staff, as well as

222 trainees and contractors working in such facilities, in the event of a pandemic, natural
223 disaster, or other surge in patient volume or PPE need.

224
225 Our AMA supports physicians and health care professionals and other workers in health
226 care facilities in being permitted to use their professional judgement and augment
227 institution-provided PPE with additional, appropriately decontaminated, personally-
228 provided personal protective equipment (PPE) without penalty.

229
230 Our AMA supports the rights of physicians and trainees to participate in public
231 commentary addressing the adequacy of clinical resources and/or health and
232 environmental safety conditions necessary to provide appropriate and safe care of
233 patients and physicians during a pandemic or natural disaster.

234
235 Our AMA will work with the HHS Office of the Assistant Secretary for Preparedness and
236 Response to gain an understanding of the PPE supply chain and ensure the adequacy
237 of the Strategic National Stockpile for public health emergencies.

238
239 Our AMA encourages the diversification of personal protective equipment design to
240 better fit all body types, cultural expressions and practices among healthcare personnel.

241

242

46 **RESOLVED**, that OSMA hereby reaffirms OSMA Policy 06-2013, stating that our
47 OSMA supports legislation to convene a state based task force of key stakeholders to
48 include representatives from private business enterprises such as health insurance
49 companies, private practice physicians, members of the general public, and academic
50 medical center employees to study current graduate medical education (GME) financing
51 in Ohio and investigate creative alternatives for GME funding that rely less on federal
52 resources; and be it further

53
54 **RESOLVED**, that our OSMA advocate for increased state and federal funding for
55 Graduate Medical Education (GME) programs, with specific attention to underserved
56 specialties and regions within Ohio; and be it further

57
58 **RESOLVED**, that our OSMA work with legislative bodies to support and advocate
59 for policies aimed at expanding GME funding and resources, especially to increase
60 physician numbers in primary care and rural Ohio.

61
62 Fiscal Note: \$50,000+ (Sponsor)
63 \$50,000+ (Staff)
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- 46 1. The establishment and expansion of residency programs in rural and
47 underserved communities.
48 2. Training programs in primary care, mental health, and other specialties facing
49 critical shortages.
50 3. Collaboration with medical schools, teaching hospitals, and community health
51 systems to maximize the impact of GME funding.
52

53 **RESOLVED**, that the state explore innovative funding mechanisms, including
54 public-private partnerships and matching funds, to amplify the impact of its investment in
55 GME; and be it further
56

57 **RESOLVED**, that the Ohio State Medical Association commit to annual advocacy
58 efforts and collaboration with stakeholders to monitor and evaluate GME funding levels
59 and workforce outcomes, ensuring accountability, transparency, and alignment with
60 Ohio's healthcare workforce needs.
61

62 **Fiscal Note:** \$ (Sponsor)
63 \$ 50,000 (Staff)
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WHEREAS, efforts to improve healthcare coverage and reduce medical debt, such as the Affordable Care Act, have had minimal effect on rates of debt, with 41% of families reporting a significant medical debt in 2022 and medical debt attributable 66% of bankruptcies attributable to medical debt¹⁸⁻¹⁹; and

WHEREAS, the administrative overhead of private insurance operations averages 20-25% of total medical expenses, much greater than the administrative overhead of Medicare which was just 1.16% of medical costs of 2021²⁰⁻²¹; and

WHEREAS, expansion of public options like Medicaid through the ACA improved access to health care for disenfranchised groups such as Black Americans, Hispanics and those in poverty, both nationally and in Ohio^{13,21}; and

WHEREAS, public insurance systems such as Medicare and Medicaid spent \$89.12 billion less in administrative costs in 2022 than private health insurance entities²; and

WHEREAS, the U.S. could save over \$600 billion annually on administrative costs with a single-payer system and over \$14 billion annually if it were paying government negotiated prescription drug prices²³⁻²⁴; and

WHEREAS, overbilling by Medicare Advantage organizations and outside agencies costs the US government upwards of \$25 billion in excess each year²⁵; and

WHEREAS, a single-payer system would reduce fraudulent, wasteful spending through a singular billing system which would log all interactions and services²⁶; and

WHEREAS, an increased emphasis on financing and complex incentives requires physicians to spend two thirds of clinic time on administrative tasks, significantly contributing to rising rates of burnout, which would be alleviated under single payer²⁸⁻²⁹; and

WHEREAS, the Congressional Budget Office (CBO) estimates that a public option with universal healthcare coverage such as single-payer would increase physician income by as much as 9% through increased health care utilization with secured reimbursement and reduced administrative costs for health care delivery²⁹⁻³⁰; and

WHEREAS, through a single payer system, a single healthcare EMR would be created, providing a secure, centralized database of health records, reducing medical errors due to incomplete or inaccurate histories, eliminating care redundancies and delays for medical record requests, and expanding opportunities for retrospective chart reviews³¹⁻³³; and

WHEREAS, several medical societies including the American College of Physicians, Hawaii Medical Association, New Hampshire Medical Society, Vermont

93 Medical Society, and Washington State Medical Association have passed resolutions
94 endorsing single payer health care³⁴; and

95
96 **WHEREAS**, local governments in Ohio such as Toledo, Lucas County, Lakewood,
97 Newburgh Heights, Cleveland Heights, Kent, Cincinnati, and Dayton have passed
98 resolutions calling upon Congress to enact a single payer system³⁵; and

99
100 **WHEREAS**, single-payer systems, such as those implemented in Canada, have
101 demonstrated cost efficiency, reducing administrative overhead to less than 2%³⁶⁻³⁷; and

102
103 **WHEREAS**, public option systems, like those seen in Australia, provide a
104 government-managed insurance plan competing alongside private insurance, increasing
105 accessibility and affordability for underserved populations³⁸; and

106
107 **WHEREAS**, direct primary care models have gained traction in the U.S., offering
108 affordable flat-fee subscription plans for patients, resulting in improved patient satisfaction
109 and reduced emergency department visits³⁸; and

110
111 **WHEREAS**, the Bismarck model, implemented in Germany, successfully uses
112 employer-funded insurance schemes combined with government oversight to achieve
113 universal coverage and lower healthcare costs³⁹; and

114
115 **WHEREAS**, combining aspects of these models, such as single-payer's
116 administrative efficiency, public option's competitive structure, direct primary care's
117 affordability, and the Bismarck model's universal employer-funded approach, offers a
118 viable path toward comprehensive reform⁴⁰⁻⁴¹; and

119
120 **WHEREAS**, universal health coverage systems can leverage economies of scale
121 to negotiate lower prescription drug prices, as evidenced by the Veterans Affairs system
122 in the United States⁴²; and

123
124 **WHEREAS**, integrated healthcare delivery models, such as those in the
125 Netherlands, combine public and private insurance with comprehensive primary care
126 networks to achieve high patient satisfaction and cost efficiency⁴³; and

127
128 **WHEREAS**, innovative pilot programs within the U.S., such as Accountable Care
129 Organizations (ACOs), demonstrate the feasibility of aligning incentives to improve health
130 outcomes and reduce costs, providing a framework that could complement broader
131 healthcare reforms⁴⁴; and therefore be it

132
133 **RESOLVED**, that the Ohio State Medical Association supports universal
134 healthcare reform that explores elements of single-payer efficiency, public option
135 accessibility, and direct primary care affordability to maximize healthcare equity and cost-
136 effectiveness; and be it further

137

138 **RESOLVED**, that the Ohio State Medical Association supports existing and pilot
139 programs integrating these elements to evaluate their feasibility and scalability in
140 addressing healthcare disparities within the United States.

141
142 **Fiscal Note:** \$ (Sponsor)
143 \$ 500+(Staff)
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276

277 **Relevant OSMA Policy:**

278

279 **Policy 11 – 2010 - Promoting Free Market-Based Solutions to Health Care Reform**

- 280 1. The OSMA promotes free market based solutions to improve access and cost
281 effectiveness of health care delivery in the United States.

282

283 **Policy 05 – 2011 - Universal Health Insurance Coverage**

- 284 1. The OSMA reaffirms support for universal health insurance access for all
285 Americans through market based initiatives to create incentives for the purchase
286 of coverage.
287 2. OSMA and AMA will pursue legislative and regulatory reform to achieve universal
288 health insurance access through free market solutions.

289

290 **Relevant AMA Policy:**

291 N/A

292

47 **WHEREAS**, higher blood pressure variability was associated with increased risk
48 of recurrent ischemic stroke, major cardiovascular events, and all cause death, and that
49 increased systolic BPV after hemorrhagic stroke was associated with worse functional
50 outcomes⁹; and

51
52 **WHEREAS**, diastolic blood pressure variability (DBPV) independently predicted
53 worse clinical outcomes in regards to death from cardiovascular causes, acute coronary
54 syndrome (ACS), acute decompensated heart failure, coronary revascularization, atrial
55 fibrillation, and stroke¹⁰; and

56
57 **WHEREAS**, DBPV is associated with increased risk for readmission and wound
58 infection and should, therefore, be factored into pre surgical risk assessment¹¹; and

59
60 **WHEREAS**, although an effective medical treatment for BPV has not yet been
61 established, patients can reduce their risk of BPV-related complications by making
62 lifestyle modifications, including adopting a healthy diet to reduce obesity, smoking
63 cessation, engaging in aerobic and resistance training, and getting an adequate amount
64 of quality sleep¹²⁻¹⁴; and

65
66 **WHEREAS**, BPV can be manually estimated by taking the greatest change
67 between two consecutive blood pressure measurements making it a reasonable and
68 immediate tool for incorporation into clinical practice until automated solutions become
69 available¹¹; and

70
71 **WHEREAS**, other studies have demonstrated that BPV can feasibly be determined
72 through automatic calculations within an EMR and that these visit-to-visit variations are
73 associated with mortality in diverse populations at high risk of developing coronary artery
74 disease ¹⁵; and therefore be it

75
76 **RESOLVED**, that our OSMA support the integration of blood pressure variability
77 data into electronic medical records, with a focus on automated calculation capabilities
78 similar to those established for body mass index; and be it further

79
80 **RESOLVED**, that our OSMA support research efforts to establish a pathological
81 BPV threshold that could guide dietary and exercise recommendations, sleep evaluation,
82 risk stratification, and other evidence-based interventions by healthcare providers; and
83 be it further

84
85 **RESOLVED**, that our OSMA encourages healthcare providers to incorporate
86 blood pressure variability into their clinical decision making.

87
88 **Fiscal Note:** \$ (Sponsor)
89 \$ 500+(Staff)

90
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146

147 **Relevant OSMA Policy:**

148 None

149 <https://osma.org/aws/OSMA/pt/sp/policy-compendium>

151 **Relevant AMA and AMA-MSS Policy:**

152 None

153

154

- 47 - "The ASRM is strongly opposed to measures granting constitutional rights or
48 protections and "personhood" status to fertilized reproductive tissues.
49 - In a growing number of states, vaguely worded and often misleading measures
50 are... defining when life begins and granting legal "personhood" status to embryos
51 at varying stages of development.
52 - ..., these broadly worded measures will have significant effects on a number of
53 medical treatments available to women of reproductive age.
54 o Personhood measures would make illegal some commonly used birth
55 control methods.
56 o Personhood measures would make illegal a physician's ability to provide
57 medically appropriate care to women experiencing life-threatening
58 complications due to a tubal pregnancy.
59 o Personhood measures would consign infertility patients to less effective,
60 less safe treatments for their disease.
61 o Personhood measures would unduly restrict infertile patients' right to make
62 decisions about their own medical treatments, including determining the
63 fate of any embryos created as part of the IVF process.
64 - ASRM will oppose any personhood measure"; and
65

66 **WHEREAS**, partly to respond to a movement to allow establishment of college
67 savings accounts for undelivered pregnancies; the American Medical Association (AMA)
68 established policy H-140.835 ("Political Interference in the Patient-Physician
69 Relationship") which states that:
70

71 our AMA opposes any policies that interfere with the patient-physician relationship
72 by giving probate, inheritance, a social security number, or other legal rights to
73 an undelivered pregnancy, or imposing legislative barriers to medical decision-
74 making by changes in tax codes or in definitions of beneficiaries; and
75

76 **WHEREAS**, the AMA also passed a resolution^{13, 14} in June 2024 (Resolutions
77 217/226 on "Protecting Access to IVF Treatment"), which stated that:

- 78 - "RESOLVED, that our American Medical Association oppose any legislation or
79 ballot measures that could criminalize in-vitro fertilization (New HOD Policy); and
80 be it further
81 - RESOLVED, that our AMA work with other interested organizations to oppose any
82 civil or criminal legislation or ballot measures or court rulings that (a) would equate
83 gametes (oocytes and sperm) or embryos with children and/or (b) would otherwise
84 restrict or interfere with evidence-based care for Assisted Reproductive
85 Technology (ART) (New HOD Policy); and be it further
86 - RESOLVED, that our AMA, through the AMA Task Force to Preserve the Patient-
87 Physician Relationship, report back at I-24 on the status of, and AMA's activities
88 surrounding, proposed ballot measures or legislation and pending court rulings that
89 (a) would equate gametes or embryos with children and/or (b) would otherwise
90 restrict or interfere with evidence-based care for Assisted Reproductive
91 Technology (ART). (Directive to Take Action)"; and therefore be it
92

93 **RESOLVED**, that our Ohio State Medical Association oppose any legislation or
94 ballot measures that could criminalize in-vitro fertilization.

95
96 **Fiscal Note:** \$500+ (Sponsor)
97 \$50,000 (Staff)
98

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148

149 **Relevant AMA Policy:**

150 **D-5.999 "Preserving Access to Reproductive Health Services"**

151 Our AMA: (1) recognizes that healthcare, including reproductive health services like
152 contraception and abortion, is a human right; (2) opposes limitations on access to
153 evidence-based reproductive health services, including fertility treatments,
154 contraception, and abortion; (3) will work with interested state medical societies and
155 medical specialty societies to vigorously advocate for broad, equitable access to
156 reproductive health services, including fertility treatments, fertility preservation,
157 contraception, and abortion; (4) supports shared decision-making between patients and
158 their physicians regarding reproductive healthcare; (5) opposes any effort to undermine
159 the basic medical principle that clinical assessments, such as viability of the pregnancy
160 and safety of the pregnant person, are determinations to be made only by healthcare
161 professionals with their patients; (6) opposes the imposition of criminal and civil
162 penalties or other retaliatory efforts, including adverse medical licensing actions and the
163 termination of medical liability coverage or clinical privileges against patients, patient
164 advocates, physicians, other healthcare workers, and health systems for receiving,
165 assisting in, referring patients to, or providing reproductive health services; (7) will
166 advocate for legal protections for patients who cross state lines to receive reproductive
167 health services, including contraception and abortion, or who receive medications for
168 contraception and abortion from across state lines, and legal protections for those that
169 provide, support, or refer patients to these services; and (8) will advocate for legal
170 protections for medical students and physicians who cross state lines to receive
171 education in or deliver reproductive health services, including contraception and
172 abortion.

173 (Res 028, A-22; Reaffirmed: Res 224, I-22; Modified: BOT Rep. 4, I-22; Appended: Res
174 317, I-22; Reaffirmation: A-23, Appended: Res 711, A-23)
175

176 **G-605.009 "Establishing a Task Force to Preserve the Patient-Physician 177 Relationship when Evidence-Based Appropriate Care is Banned or Restricted"**

178 1. Our AMA will convene a task force of appropriate AMA councils and interested state
179 and medical specialty societies, in conjunction with the AMA Center for Health Equity,
180 and in consultation with relevant organizations, practices, government bodies, and
181 impacted communities for the purpose of preserving the patient-physician relationship.

182 2. This task force, which will serve at the direction of our AMA Board of Trustees, will
183 inform the Board to help guide organized medicine's response to bans and restrictions

184 on abortion, prepare for widespread criminalization of other evidence-based care,
185 implement relevant AMA policies, and identify and create implementation-focused
186 practice and advocacy resources on issues including but not limited to:
187 a. Health equity impact, including monitoring and evaluating the consequences of
188 abortion bans and restrictions for public health and the physician workforce and
189 including making actionable recommendations to mitigate harm, with a focus
190 on the disproportionate impact on under-resourced, marginalized, and minoritized
191 communities;
192 b. Practice management, including developing recommendations and educational
193 materials for addressing reimbursement, uncompensated care, interstate licensure, and
194 provision of care, including telehealth and care provided across state lines;
195 c. Training, including collaborating with interested medical schools, residency and
196 fellowship programs, academic centers, and clinicians to mitigate radically diminished
197 training opportunities;
198 d. Privacy protections, including best practice support for maintaining medical records
199 privacy and confidentiality, including under HIPAA, for strengthening physician, patient,
200 and clinic security measures, and countering law enforcement reporting requirements;
201 e. Patient triage and care coordination, including identifying and publicizing resources
202 for physicians and patients to connect with referrals, practical support, and legal
203 assistance;
204 f. Coordinating implementation of pertinent AMA policies, including any
205 actions to protect against civil, criminal, and professional liability and retaliation,
206 including criminalizing and penalizing physicians for referring patients to the care they
207 need; and
208 g. Anticipation and preparation, including assessing information and resource gaps and
209 creating a blueprint for preventing or mitigating bans on other appropriate health care,
210 such as gender affirming care, contraceptive care, sterilization, infertility care, and
211 management of ectopic pregnancy and spontaneous pregnancy loss and pregnancy
212 complications.
213 3. Our American Medical Association will appoint an ad hoc committee or task force,
214 composed of physicians from specialties who routinely provide gender-affirming care,
215 payers, community advocates, and state Medicaid directors and/or insurance
216 commissioners, to identify issues with physician payment and reimbursement for
217 gender-affirming care and recommend solutions to address these barriers to care.
218 (Res 621, A-22; Appended: Res 816, I-23)

219

H-160.954 Criminalization of Medical Judgment

221 (1) Our AMA continues to take all reasonable and necessary steps to insure that
222 medical decision-making exercised in good faith, does not become a violation of
223 criminal law. (2) Henceforth our AMA opposes any future legislation which gives the
224 federal government the responsibility to define appropriate medical practice and
225 regulate such practice through the use of criminal penalties.
226 (Sub. Res. 223, I-93; Reaffirmed: Res. 227, I-98; Reaffirmed: Res. 237, A-99;
227 Reaffirmed and Appended: Sub. Res. 215, I-99; Reaffirmation A-09; Reaffirmed: CEJA
228 Rep. 8, A-09)

229

230 **H-160.946 The Criminalization of Health Care Decision-making**

231 The AMA opposes the attempted criminalization of health care decision-making
232 especially as represented by the current trend toward criminalization of malpractice; it
233 interferes with appropriate decision making and is a disservice to the American public;
234 and will develop model state legislation properly defining criminal conduct and
235 prohibiting the criminalization of health care decision-making, including cases involving
236 allegations of medical malpractice, and implement an appropriate action plan for all
237 components of the Federation to educate opinion leaders, elected officials and the
238 media regarding the detrimental effects on health care resulting from the criminalization
239 of health care decision-making.

240 (Sub. Res. 202, A-95; Reaffirmed: Res. 227, I-98; Reaffirmed: BOT Rep. 2, A-07;
241 Reaffirmation A-09)

242

243 **D-160.999 Opposition to Criminalizing Health Care Decisions**

244 Our AMA will educate physicians regarding the continuing threat posed by the
245 criminalization of healthcare decision-making and the existence of our model legislation
246 "An Act to Prohibit the Criminalization of Healthcare Decision-Making."

247 (Res. 228, I-98; Reaffirmed: BOT Rep. 5, A-08)

248

249 **H-140.835 Political Interference in the Patient-Physician Relationship**

250 Our AMA opposes any policies that interfere with the patient-physician relationship by
251 giving probate, inheritance, a social security number, or other legal rights to an
252 undelivered pregnancy, or imposing legislative barriers to medical decision-making by
253 changes in tax codes or in definitions of beneficiaries.

254 (Alt Res 007, I-17)

255

1 **OHIO STATE MEDICAL ASSOCIATION HOUSE OF DELEGATES**

2
3 **Resolution No. 54 – 2025**

4
5 **Introduced by:** OSMA District 2

6
7 **Subject:** Third Party Payer Denials Without Review of the Medical Record

8
9 **Referred to:** Resolutions Committee No. 2

10
11 -----
12
13 **WHEREAS**, providers are required to document appropriate medical decision
14 making to support Evaluation and Management claim submission to third party payers;
15 and

16
17 **WHEREAS**, some payers, including Medicare Advantage companies, have
18 implemented Evaluation and Management downcoding programs that inappropriately
19 reduce payment for claims billed; and

20
21 **WHEREAS**, some payer downcoding processes include denial or downcoding of
22 claims without request and review of the medical record; and therefore be it

23
24 **RESOLVED**, that our Ohio State Medical Association (OSMA) work with all
25 relevant stakeholders to ensure that all payers be required to review the medical record
26 prior to any denial or downcode, and be it further

27
28 **RESOLVED**, that our OSMA work with all relevant stakeholders to require that all
29 payer denials and downcodes include clearly communicated rationale for such decisions;
30 and be it further

31
32 **RESOLVED**, that our OSMA advocate for a universally accessible reporting
33 mechanism and enforceable penalties for payers who do not abide by the above
34 requirements.

35
36 **Fiscal Note:** \$ (Sponsor)
37 \$50,000 (Staff)

38
39 **References**

40
41 **Relevant OSMA Policy:**
42 OSMA Policy 19 – 1992 – Third Party Payor Denials

43
44 **Relevant AMA Materials:**
45 “Payer Evaluation and Management (E/M) Downcoding programs – What you Need to
46 Know” - American Medical Association

45 **WHEREAS**, Mobile Medical Units can facilitate effective treatment of substance
46 use disorders, provision of primary care, and services for severe mental illness among
47 people experiencing homelessness; and

48
49 **WHEREAS**, the Maximizing Outcomes through Better Investments in Lifesaving
50 Equipment for (MOBILE) Health Care Act in 2022 enabled health centers to receive
51 funding for Mobile Medical Units¹²; and

52
53 **WHEREAS**, the integration of street medicine programs into the broader
54 healthcare system has the potential to reduce healthcare costs and improve overall health
55 equity in Ohio²; and

56
57 **WHEREAS**, legislative approaches integrating healthcare, housing, and social
58 services have reduced homelessness in states like Utah and Massachusetts; and

59
60 **WHEREAS**, legislation such as HR 773 Homelessness and Behavioral Health
61 Care Coordination Act of 2023 seeks to protect healthcare coverage and housing
62 resources for individuals who are homeless⁸; and

63
64 **WHEREAS**, the American Medical Association supports the development of street
65 medicine programs to increase access to care for populations experiencing
66 homelessness and reduce long-term costs; and

67
68 **WHEREAS**, Ohio has yet to integrate Mobile Medical Units and Street Medicine
69 into the statewide response system for homelessness akin to models seen in other states
70 like California¹³; and therefore be it

71
72 **RESOLVED**, that our OSMA support wraparound services for the unhoused,
73 including mental health care, substance use treatment, job training, and transportation
74 assistance; and be it further

75
76 **RESOLVED**, That the OSMA support state or local government funding for mobile
77 health units and street medicine programs that expand care access for the unhoused.

78
79 **Fiscal Note:** \$ 500 (Sponsor)
80 \$ 500 (Staff)

81
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132 Relevant AMA/OSMA policies:
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134 Policy 29 - 2022 "The OSMA supports the development of state and local policies that
135 protect the health of low income and homeless individuals by promoting and funding
136 housing initiatives."

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[H-160.886 - 2023 "Payment for Physicians who Practice Street Medicine"](#)

- Our American Medical Association supports the development of street medicine programs to increase access to care for populations experiencing homelessness and reduce long- term costs.
- Our AMA supports the implementation of Medicare and Medicaid payment for street medicine initiatives by advocating for necessary legislative and/or regulatory changes, including submission of a recommendation to the Centers for Medicaid & Medicaid Services asking that it establish a new place-of-service code to support street medicine practices for people eligible for Medicare and/or Medicaid, with "street medicine" defined, in keeping with the Street Medicine Institute, as "the provision of health care directly to people where they are living and sleeping on the streets."

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