OSMA and AMA Policies Relevant to 2025 Proposed Resolutions
Resolution Committee Two
Resolutions 29-57

Resolution 29-2025: Removing Ambiguous Language about Fetal Heartbeat

OSMA Policy

Policy 6-2024 - Policy on Abortion

1. The OSMA recognizes and supports each individual physician's right to maintain their own personal views. It is neither our duty nor our intent to alter personal views.

2. The OSMA shall take a position of opposition to any proposed Ohio legislation or rule that would:

   - Require or compel Ohio physicians to perform treatment actions, investigative tests, or questioning and or education of a patient which are not consistent with the medical standard of care; or,
   - Require or compel Ohio physicians to discuss treatment options that are not within the standard of care and/or omit discussion of treatment options that are within the standard of care.

3. The OSMA supports an individual's right to decide whether to have children, the number and spacing of children, as well as the right to have the information, education, and access to evidence-based reproductive health care services to make these decisions.

4. The OSMA opposes non-evidence based limitations on access to evidence-based reproductive health care services, including fertility treatments, contraception, and abortion.

5. The OSMA opposes the imposition of criminal and civil penalties or other retaliatory efforts against patients, patient advocates, physicians, other healthcare workers, and health systems for receiving, assisting in, referring patients to, or providing evidence-based reproductive health care services within the medical standard of care.

6. The OSMA collaborates with relevant stakeholders to educate legislators and amend existing state laws so that the term "fetal heartbeat" is not used to inaccurately represent physiological electrical activity.

Policy 10-1990 - Policy on Abortion

*AMENDED in 2023 by Policy 15 - 2023- Strengthening the OSMA Stance on Abortion in Ohio, and in 2024 by Policy 6 - 2024 - Policy on Abortion

Policy 15-2023 - Strengthening the OSMA Stance on Abortion Policy in Ohio

*AMENDED in 2024 by Policy 6 - 2024 - OSMA Policy on Abortion

AMA Policy

N/A

Resolution 30-2025: Vaccines

OSMA Policy

Policy 08-2019 - HPV Immunization

1. The OSMA supports increased access to the HPV vaccine.
2. The OSMA supports adding the HPV vaccine to the current schedule of require vaccines for attendance at public and private schools, subject to existing exemption policies.

Policy 16-2022 - Allowing Mature Minors to Consent for Vaccination

The OSMA supports allowing the mature minor, as defined in Ohio statute or legal precedent, the ability to self-consent for vaccination.

Policy 17-2022 - Supporting Vaccination in Ohio

The OSMA supports the right of public and private entities in Ohio to require vaccines for employees, staff, and students for highly communicable diseases while allowing for medical exemptions.

AMA Policy

N/A

Resolution 31-2025: No Surprises Act - Provider Protections

OSMA Policy

Policy 19-2020 - Out-of-Network Billing

1. The OSMA rescinds Policy 19 – 2010 (Lifting the Restrictions on Balance Billing).
2. The OSMA supports repeal of regulations currently in place that prohibit balance billing for physicians.
3. The OSMA adopts its own policy similar to AMA policy H-285.904, to read as follows:
    1. The OSMA adopts the following principles related to unanticipated out-of-network care:
        A. Patients must not be financially penalized for receiving unanticipated care from an out-of-network provider.
        B. Insurers must meet appropriate network adequacy standards that include adequate patient access to care, including access to hospital-based physician specialties. Ohio regulators should enforce such standards through active regulation of health insurance company plans.
        C. Insurers must be transparent and proactive in informing enrollees about all deductibles, copayments and other out-of-pocket costs that enrollees may incur.
        D. Prior to scheduled procedures, insurers must provide enrollees with reasonable and timely access to in-network physicians.
        E. Patients who are seeking emergency care should be protected under the “prudent layperson” legal standard as established in state and federal law, without regard to prior authorization or retrospective denial for services after emergency care is rendered.
        F. Out-of-network payments must not be based on a contrived percentage of the Medicare rate or rates determined by the insurance company.
        G. Minimum coverage standards for unanticipated out-of-network services should be identified. Minimum coverage standards should pay out-of-network providers at the usual and customary out-of-network charges for services, with the definition of usual and customary based upon a percentile of all out-of-network charges for the particular health care service performed by a provider in the same or similar specialty and provided in the same geographical area as reported by a benchmarking database. Such a benchmarking database must be independently recognized and verifiable, completely transparent, independent of the control of either payers or providers and maintained by a non-profit organization. The non-profit organization shall not be affiliated with an insurer, a municipal cooperative health benefit plan or health management organization.
        H. Mediation and/or Independent Dispute Resolution (IDR) should be permitted in all circumstances as an option or alternative to come to payment resolution between insurers and providers.
    2. The OSMA will advocate for the principles delineated in this policy for all health plans, including ERISA plans.

3. The OSMA will advocate that any legislation addressing surprise out of network medical bills use an independent, non-conflicted database of commercial charges.
4. The OSMA's delegation to the AMA submit a resolution at A-20 asking for this amendment to Item H in their policy.

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

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

Policy 17-2018 - OSMA to Seek Time Parity for Physician Claims Filing and Insurance Take Back

1. The OSMA again make every effort to limit the allowed time for insurance companies "look back/take back" payments to be commensurate to the time frame allowed for physicians to file claims.

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

1. The OSMA reaffirms policy 19-2020 out-of-network billing.
2. The OSMA will work through the regulatory bodies on both the state and federal levels on implementation of out-of-network policies, and when appropriate advocate to align the policies to the extent possible with OSMA Policy 19-2020.
3. The OSMA will actively monitor implementation of out-of-network policies by the Ohio Department of Insurance and other regulatory bodies for their impact, with particular focus on potential deleterious effects they may have on Ohio physicians, by creating a working group comprised of OSMA staff and physician members from appropriate specialties that will perform no less than semi-annual reviews and analysis of the effects of the outcomes of the Ohio out-of-network law and recommend to OSMA Council if any legislative advocacy needs to be undertaken. In addition, the working group will evaluate the text of existing federal and state laws and make recommendations for further legislative advocacy.

AMA Policy

Out-of-Network Care H-285.904

1. Our American Medical Association adopts the following principles related to unanticipated out-of-network care:
   a. Patients must not be financially penalized for receiving unanticipated care from an out-of-network provider.
   b. Insurers must meet appropriate network adequacy standards that include adequate patient access to care, including access to hospital-based physician specialties. State regulators should enforce such standards through active regulation of health insurance company plans.
   c. Insurers must be transparent and proactive in informing enrollees about all deductibles, copayments and other out-of-pocket costs that enrollees may incur.
   d. Prior to scheduled procedures, insurers must provide enrollees with reasonable and timely access to in-network physicians.
   e. Patients who are seeking emergency care should be protected under the "prudent layperson" legal standard as established in state and federal law, without regard to prior authorization or retrospective denial for services after emergency care is rendered.
   f. Out-of-network payments must not be based on a contrived percentage of the Medicare rate or rates determined by the insurance company.
   g. Minimum coverage standards for unanticipated out-of-network services should be identified. Minimum coverage standards should pay out-of-network providers at the usual and customary out-of-network charges for services, with the definition of usual and customary based upon a percentile of all out-of-network charges for the particular health care service performed by a provider in the same or similar specialty and provided in the same geographical area as reported by a benchmarking database. Such a benchmarking database must be independently recognized and verifiable, completely transparent,

independent of the control of either payers or providers and maintained by a non-profit organization. The non-profit organization shall not be affiliated with an insurer, a municipal cooperative health benefit plan or health management organization.

h. Independent Dispute Resolution (IDR) should be allowed in all circumstances as an option or alternative to come to payment resolution between insurers and physicians.

2. Our AMA will advocate for the principles delineated in Policy H-285.904 for all health plans, including ERISA plans.
3. Our AMA will advocate that any legislation addressing surprise out of network medical bills use an independent, non-conflicted database of commercial charges.

Resolution 32-2025: Prohibit Fees by Health Plans for Physician Standard Electronic Funds (EFT) Payment Transactions

OSMA Policy
N/A

AMA Policy
Amend Virtual Credit Card and Electronic Funds Transfer Fee Policy D-190.968

1. Our American Medical Association will advocate for legislation or regulation that would prohibit the use of virtual credit cards (VCCs) for electronic health care payments.
2. Our AMA will advocate on behalf of physicians and plainly state that it is not advisable or beneficial for medical practices to get paid by VCCs.
3. Our AMA will engage in legislative and regulatory advocacy efforts to address the growing and excessive electronic funds transfer (EFT) add-on service fees charged by payers when paying physicians, including advocacy efforts directed at:
   a. The issuance of Centers for Medicare & Medicaid Services (CMS) regulatory guidance affirming physicians' right to choose and receive timely basic EFT payments without paying for additional services.
   b. CMS enforcement activities related to this issue.
   c. Physician access to a timely no fee EFT option as an alternative to VCCs.

Resolution 33-2025: Opposing Co-Pay Maximizer Programs

OSMA Policy
Policy 25-2020 - Co-Pay Accumulators

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

AMA Policy
Co-Pay Accumulators D-110.986

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

Resolution 34-2025: Oversight of Medicare Advantage Plans

OSMA Policy
Policy 21-2024 - Oversight of Health Insurance Companies

1. OSMA supports proactive oversight of health insurance carrier policies and practices by the ODI by encouraging the ODI to develop a panel, with physician participation, to provide oversight of health insurance carrier policies and practices.
2. OSMA actively encourages, educates and supports physicians, patients, and hospitals regarding the process for reporting inappropriate and unfair practices by health insurance carriers directly to the Department of Insurance.

3. OSMA will create a structure to which physicians can report concerns and submit gathered information, regarding inappropriate, unsafe, or unfair health insurance carrier policies to be compiled, evaluated for merit, and, if validated, reported to the ODI, with appropriate supporting information from the OSMA.

Policy 18-2024 - "Guarantee Issue" Protections for Traditional Medicare

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

Policy 20-2019 - Establishing Fair Medicare Payor Rates

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

Policy 20-2018 - Compensation for Pre-Authorization Requests

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

AMA Policy

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

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

AMA Policy H-330.867 - Medicare Advantage Plans

1. Our American Medical Association encourages that Medicare Advantage risk adjustment formulas be revised so that claims data is based on the actual cost of providing care.
2. Our AMA will provide or create educational materials such as an infographic to compare Traditional Medicare and Medicare Advantage plans so that patients are able to make informed choices that best meet their health care needs."; and be it further

Resolution 35-2025: Insurance Subsidies for Undocumented Immigrants

OSMA Policy

Policy 5-2008 - Health Insurance Coverage for All Ohioans

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

Policy 01-2017 - Supporting Changes in Health Care Policy that Increase Coverage and Expand Benefits

1. The OSMA supports the elimination of pre-existing condition exclusions from health insurance contracts and supports providing all Ohio citizens with high quality health care.
2. The OSMA opposes changes to healthcare policy that would decrease access to health care coverage for the citizens of Ohio.
3. The OSMA supports the inclusion of young adults up to age 26 on their parents'/guardians' health care plans.

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

AMA Policy

Policy Number Pending: ACA Subsidies for Undocumented Immigrants

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

Resolution 36-2025: Inclusive Insurance Coverage for Fertility-Related Healthcare

OSMA Policy

Policy 37-1988 - Infertility Insurance Coverage

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

Policy 15-2023 - Strengthening the OSMA Stance on Abortion Policy in Ohio

1. The OSMA amend OSMA Policy 10-1990- Policy on Abortion by addition and deletion as follows:

Policy 10 – 1990 – Policy on Abortion

~~1. It is the position of the OSMA that the issue of support of or opposition to abortion is a matter for members of the OSMA to decide individually, based on personal values or beliefs.~~

~~2.~~ 1. The OSMA shall take no action which may be construed as an attempt to alter or influence the personal views of individual physicians regarding abortion procedures.

~~3.~~ 2. Item~~s~~ 1 ~~and 2~~ notwithstanding, the OSMA shall take a position of opposition to any proposed ~~OSMA~~Ohio legislation or rule that would:

- Require or compel Ohio physicians to perform treatment actions, investigative tests, or questioning and OR education of a patient which are not consistent with the medical standard of care; or,
- Require or compel Ohio physicians to discuss treatment options that are not within the standard of care and/or omit discussion of treatment options that are within the standard of care; and be it further

2. The OSMA supports an individual's right to decide whether to have children, the number and spacing of children, as well as the right to have the information, education, and access to evidence-based reproductive health care services to make these decisions.
3. The OSMA opposes non-evidence based limitations on access to evidence-based reproductive health care services, including fertility treatments, contraception, and abortion.
4. The OSMA opposes the imposition of criminal and civil penalties or other retaliatory efforts against patients, patient advocates, physicians, other healthcare workers, and health systems for receiving, assisting in, referring patients to, or providing evidence-based reproductive health care services within the medical standard of care.
5. The OSMA collaborates with relevant stakeholders to educate legislators and amend existing state laws so that the term "fetal heartbeat" is not used to inaccurately represent physiological electrical activity.

Policy 22-2016 - Lesbian Gay Bisexual Transgender Queer (LGBTQ) Protection Laws

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

Policy 01-2017 - Supporting Changes in Health Care Policy that Increase Coverage and Expand Benefits

1. The OSMA supports the elimination of pre-existing condition exclusions from health insurance contracts and supports providing all Ohio citizens with high quality health care.
2. The OSMA opposes changes to healthcare policy that would decrease access to health care coverage for the citizens of Ohio.
3. The OSMA supports the inclusion of young adults up to age 26 on their parents'/guardians' health care plans.

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

Policy 5-2008 - Health Insurance Coverage for All Ohioans

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

AMA Policy

Reproductive Health Insurance Coverage H-185.926

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

Preserving Access to Reproductive Health Services D-5.999

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

Right for Gamete Preservation Therapies H-65.956

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

Right for Gamete Preservation Therapies H-185.922

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

Infertility and Fertility Preservation Insurance Coverage H-185.990

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

Resolution 37-2025: Increasing Awareness of DEA Prescription Drug Take Back Programs

OSMA Policy
N/A

AMA Policy
Safe Use, Storage and Disposal of Leftover Opioids and Other Controlled Substances D-95.971
Our AMA and its Opioid Task Force: (1) will continue to adapt current educational materials to distribute to prescribers and patients, emphasizing the importance of safe storage and disposal of opioids, and encouraging prescribers and patients to investigate and advocate for more local drug take back programs; (2) encourages all prescribers to work with local organizations and pharmacists to develop and disseminate the most up-to-date information on local Take Back resources; and (3) will continue to educate all prescribers on the importance of optimal use of opioids, including appropriately limiting the quantities of opioid prescriptions and advocating for e-prescription capabilities for controlled substances.

Resolution 38-2025: Support for Mandatory Stock of Epinephrine Autoinjectors and Dispense Training for K-12 School Administrators and Staff

OSMA Policy
N/A

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

Improvement in US Airlines Aircraft Emergency Kits H-45.981
Our American Medical Association urges federal action to require all US air carriers to report data on in-flight medical emergencies, specific uses of in-flight medical kits and emergency lifesaving devices, and unscheduled diversions due to in-flight medical emergencies; this action should further require the Federal Aviation Administration to work with the airline industry and appropriate medical specialty societies to periodically review data on the incidence and outcomes of in-flight medical emergencies and issue recommendations regarding the contents of in-flight medical kits and the use of emergency lifesaving devices aboard commercial aircraft.
Our AMA will:

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

Resolution 39-2025: Overdose Prevention Education

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

1. The Ohio State Medical Association (OSMA) advocates for the use of medication-assisted treatment, including but not limited to methadone or buprenorphine, and harm reduction methods without penalty when clinically appropriate.
2. The OSMA supports public awareness campaigns to increase education of evidence-based services for opioid addiction, including but not limited to medication-assisted treatment, harm reduction, and recovery services.
3. The OSMA supports existing and pilot programs for the distribution of fentanyl test strips in at risk communities in Ohio.
4. The OSMA supports legislation prohibiting prior authorization requirements and other restrictions on use of evidence-based medications for opioid use disorder.
5. The OSMA supports research, policy, and education concerning the impacts of racism and classism on patient awareness of and access to substance use disorder treatment.
6. The OSMA supports legislation directing residential treatment providers to offer opioid agonist or partial agonist therapies, with associated trained medical personnel, on-site, or to facilitate access off-site.

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

1. OSMA Policy 13-2022 - curbing opioid-related deaths in Ohio through medication-assisted treatment and harm reduction services be amended to read as follows:
    1. The Ohio State Medical Association (OSMA) advocates for the use of medication-assisted treatment, including but not limited to methadone or buprenorphine, and harm reduction methods without penalty when clinically appropriate.
    2. The OSMA supports public awareness campaigns to increase education of evidence-based services for opioid addiction, including but not limited to medication-assisted treatment, harm reduction, and recovery services.

3. The OSMA supports existing and pilot programs for the distribution of fentanyl test strips in at-risk communities in Ohio.
4. THE OSMA SUPPORTS LEGISLATION PROHIBITING PRIOR AUTHORIZATION REQUIREMENTS AND OTHER RESTRICTIONS ON USE OF EVIDENCE-BASED MEDICATIONS FOR OPIOID USE DISORDER.
5. THE OSMA SUPPORTS RESEARCH, POLICY, AND EDUCATION CONCERNING THE IMPACTS OF RACISM AND CLASSISM ON PATIENT AWARENESS OF AND ACCESS TO SUBSTANCE USE DISORDER TREATMENT.

AMA Policy
N/A

Resolution 40-2025: Action to Address the Increase in Xylazine-Related Overdoses

OSMA Policy
Insurance Coverage for Substance Use Disorder Treatment. OSMA Policy Compendium. Updated April 2024: Policy 79-1977. Accessed December 6, 2024.

Policy 1-2024 - Insurance Coverage for Substance Use Disorder
1. OSMA Policy 79–1977 – Insurance Coverage for Alcoholism Treatment is amended as follows:
   Policy 79–1977 – Insurance Coverage for ~~Alcoholism~~ SUBSTANCE USE DISORDER Treatment
   1. The OSMA continues to recognize ~~alcoholism~~ SUBSTANCE USE DISORDER as an illness or disease.
   2. The OSMA continues to support treatment of ~~alcoholism~~ SUBSTANCE USE DISORDER.
   3. The OSMA supports health insurance coverage for treatment ~~alcoholism~~ OF SUBSTANCE USE DISORDER in whatever setting is most appropriate and cost effective.

Recognition of Substance Use Disorder (SUD) as a Disease, Advocate for Expansion of Safe Treatment. OSMA Policy Compendium. Updated April 2024: Policy 27-2021. Accessed December 6, 2024.

Policy 27-2021 - Recognition of Substance Use Disorder (SUD) as a Disease, Advocate for Expansion of Safe Treatment
1. The OSMA recognizes Substance Use Disorder as a medical condition, and recognizes that those suffering from this disease should be treated like any other patient with a serious illness and should thus have appropriate access to treatment.
2. The OSMA supports affordable and accessible evidence-based prevention and treatment of Substance Use Disorder.

Curbing Opioid-Related Deaths in Ohio Through Medication-Assisted Treatment and Harm Reduction Services. OSMA Policy Compendium. Updated April 2024: Policy 13 - 2022. Accessed December 6, 2024.

Policy 13-2022 - Curbing Opioid-Related Deaths in Ohio Through Medication-Assisted Treatment and Harm Reduction Services
1. The Ohio State Medical Association (OSMA) advocates for the use of medication-assisted treatment, including but not limited to methadone or buprenorphine, and harm reduction methods without penalty when clinically appropriate.
2. The OSMA supports public awareness campaigns to increase education of evidence-based services for opioid addiction, including but not limited to medication-assisted treatment, harm reduction, and recovery services.
3. The OSMA supports existing and pilot programs for the distribution of fentanyl test strips in at-risk communities in Ohio.
4. The OSMA supports legislation prohibiting prior authorization requirements and other restrictions on use of evidence-based medications for opioid use disorder.
5. The OSMA supports research, policy, and education concerning the impacts of racism and classism on patient awareness of and access to substance use disorder treatment.

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

AMA Policy
N/A

Resolution 41-2025: Improving Patient Access to Pharmacies and Medications in Pharmacy Deserts

OSMA Policy
N/A

AMA Policy
N/A

Resolution 42-2025: Automatic Pharmacy Refill Requests

OSMA Policy
N/A

AMA Policy
N/A

Resolution 43-2025: Support for Medical Professionals and Trainees Who Breastfeed

OSMA Policy
N/A

AMA Policy
AMA Support for Breastfeeding H-245.982

1. Our AMA: (a) recognizes that breastfeeding is the optimal form of nutrition for most infants; (b) endorses the 2012 policy statement of American Academy of Pediatrics on Breastfeeding and the use of Human Milk, which delineates various ways in which physicians and hospitals can promote, protect, and support breastfeeding practices; (c) supports working with other interested organizations in actively seeking to promote increased breastfeeding by Supplemental Nutrition Program for Women, Infants, and Children (WIC Program) recipients, without reduction in other benefits; (d) supports the availability and appropriate use of breast pumps as a cost-effective tool to promote breast feeding; and (e) encourages public facilities to provide designated areas for breastfeeding and breast pumping; mothers nursing babies should not be singled out and discouraged from nursing their infants in public places.
2. Our AMA: (a) promotes education on breastfeeding in undergraduate, graduate, and continuing medical education curricula; (b) encourages all medical schools and graduate medical education programs to support all residents, medical students and faculty who provide breast milk for their infants, including appropriate time and facilities to express and store breast milk during the working day; (c) encourages the education of patients during prenatal care on the benefits of breastfeeding; (d) supports breastfeeding in the health care system by encouraging hospitals to provide written breastfeeding policy that is communicated to health care staff; (e) encourages hospitals to train staff in the skills needed to implement written breastfeeding policy, to educate pregnant women about the benefits and management of breastfeeding, to attempt early initiation of breastfeeding, to practice "rooming-in," to educate mothers on how to breastfeed and maintain lactation, and to foster breastfeeding support groups and services; (f) supports curtailing formula promotional practices by encouraging perinatal care providers and hospitals to ensure that physicians or other appropriately trained medical personnel authorize distribution of infant formula as a medical sample only after appropriate infant feeding education, to specifically include education of parents about the medical benefits of breastfeeding and encouragement of its practice, and education of parents

about formula and bottle-feeding options; and (g) supports the concept that the parent's decision to use infant formula, as well as the choice of which formula, should be preceded by consultation with a physician.
3. Our AMA: (a) supports the implementation of the WHO/UNICEF Ten Steps to Successful Breastfeeding at all birthing facilities; (b) endorses implementation of the Joint Commission Perinatal Care Core Measures Set for Exclusive Breast Milk Feeding for all maternity care facilities in the US as measures of breastfeeding initiation, exclusivity and continuation which should be continuously tracked by the nation, and social and demographic disparities should be addressed and eliminated; (c) recommends exclusive breastfeeding for about six months, followed by continued breastfeeding as complementary food are introduced, with continuation of breastfeeding for 1 year or longer as mutually desired by mother and infant; (d) recommends the adoption of employer programs which support breastfeeding mothers so that they may safely and privately express breast milk at work or take time to feed their infants; and (e) encourages employers in all fields of healthcare to serve as role models to improve the public health by supporting mothers providing breast milk to their infants beyond the postpartum period.
4. Our AMA supports the evaluation and grading of primary care interventions to support breastfeeding, as developed by the United States Preventive Services Task Force (USPSTF).
5. Our AMA's Opioid Task Force promotes educational resources for mothers who are breastfeeding on the benefits and risks of using opioids or medication-assisted therapy for opioid use disorder, based on the most recent guidelines.

Burdensome Paperwork for Breast Pumps H-185.928
Our AMA will vigorously oppose unnecessary and burdensome paperwork which presents barriers to lactation support, such as prescriptions to support physiologic functions; and further, to ensure that The Joint Commission and Healthy People 2020 breastfeeding goals are met.

Improving and Standardizing Pregnancy and Lactation Accommodations for Medical Board Examinations H-275.915
1. Our American Medical Association supports and will advocate for the implementation of a minimum of 60 minutes of additional, scheduled break time for all test takers who are pregnant and/or lactating during all medical licensure and certification examinations.
2. Our AMA supports the addition of pregnancy comfort aids, including but not limited to ginger teas, saltines, wastebaskets, and antiemetics, to any medical licensure or certification examination’s pre-approved list of Personal Item Exemptions (PIEs) permitted in the secure testing area for all test takers who are pregnant and/or lactating.

Protecting Trainees' Breastfeeding Rights D-310.950
1. Our American Medical Association will work with appropriate bodies, such as the Accreditation Council for Graduate Medical Education (ACGME) and the Liaison Committee on Medical Education (LCME), to include language in housestaff manuals or similar policy references of all training programs regarding protected times and locations for milk expression and secure storage of breast milk.
2. Our AMA will work with appropriate bodies, such as the LCME, ACGME, and Association of American Medical Colleges (AAMC), to include language related to the learning and work environments for breastfeeding people in regular program reviews.

Resolution 44-2025: Support for Increased Training for Physicians on Screening for Elder Abuse and Injustice

OSMA Policy
N/A

AMA Policy
Elder Mistreatment H-515.949
Our American Medical Association encourages all physicians caring for the elderly to become more proactive in recognizing and treating vulnerable elders who may be victims of mistreatment through prevention and early

identification of risk factors in all care settings. Encourage physicians to participate in medical case management and APS teams and assume greater roles as medical advisors to APS services.

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

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

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

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

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

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

Health Care for Older Patients H-25.999
Our American Medical Association endorses and encourages further experimentation and application of home-centered programs of care for older patients and recommends further application of other new experiments in providing better health care, such as rehabilitation education services in nursing homes, chronic illness referral centers, and progressive patient care in hospitals.

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

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

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

Elder Mistreatment H-515.961
Our American Medical Association recognizes elder mistreatment as a serious and pervasive public health problem that requires an organized effort from physicians and all medical professionals to improve the timely recognition and provision of clinical care in vulnerable elders who experience mistreatment.

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

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

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

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

Resolution 45-2025: Opposing the Targeting of Healthcare Workers and Facilities in Conflict Zones

OSMA Policy
N/A

AMA Policy
H-520.985 - Protection of Healthcare and Humanitarian Aid Workers in all Areas of Armed Conflict
1. Our American Medical Association supports peace in Israel and Palestine in order to protect civilian lives and healthcare personnel.
2. Our AMA supports the safety of healthcare and humanitarian aid workers along with safe access to healthcare, healthcare facilities, and humanitarian aid for all civilians in areas of armed conflict.

Resolution 46-2025: Equitable Access to Healthcare Through Paid Time Off

OSMA Policy
Policy 12-2024 Support for Paid Parental Leave
1. OSMA supports paid parental leave following the birth, adoption, or foster placement of a new child and following loss of pregnancy.

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

Resolution 47-2025: Reducing the Burden of Medical Debt on Patients

OSMA Policy
Policy 19-2020 - Out-of-Network Billing
1. The OSMA rescinds Policy 19 - 2010 (Lifting the Restrictions on Balance Billing).
2. The OSMA supports repeal of regulations currently in place that prohibit balance billing for physicians.
3. The OSMA adopts its own policy similar to AMA policy H-285.904, to read as follows:
1. The OSMA adopts the following principles related to unanticipated out-of-network care:

A. Patients must not be financially penalized for receiving unanticipated care from an out-of-network provider.
B. Insurers must meet appropriate network adequacy standards that include adequate patient access to care, including access to hospital-based physician specialties. Ohio regulators should enforce such standards through active regulation of health insurance company plans.
C. Insurers must be transparent and proactive in informing enrollees about all deductibles, copayments and other out-of-pocket costs that enrollees may incur.
D. Prior to scheduled procedures, insurers must provide enrollees with reasonable and timely access to in-network physicians.
E. Patients who are seeking emergency care should be protected under the "prudent layperson" legal standard as established in state and federal law, without regard to prior authorization or retrospective denial for services after emergency care is rendered.
F. Out-of-network payments must not be based on a contrived percentage of the Medicare rate or rates determined by the insurance company.
G. Minimum coverage standards for unanticipated out-of-network services should be identified. Minimum coverage standards should pay out-of-network providers at the usual and customary out-of-network charges for services, with the definition of usual and customary based upon a percentile of all out-of-network charges for the particular health care service performed by a provider in the same or similar specialty and provided in the same geographical area as reported by a benchmarking database. Such a benchmarking database must be independently recognized and verifiable, completely transparent, independent of the control of either payers or providers and maintained by a non-profit organization. The non-profit organization shall not be affiliated with an insurer, a municipal cooperative health benefit plan or health management organization.
H. Mediation and/or Independent Dispute Resolution (IDR) should be permitted in all circumstances as an option or alternative to come to payment resolution between insurers and providers.

2. The OSMA will advocate for the principles delineated in this policy for all health plans, including ERISA plans.
3. The OSMA will advocate that any legislation addressing surprise out of network medical bills use an independent, non-conflicted database of commercial charges.
4. The OSMA's delegation to the AMA submit a resolution at A-20 asking for this amendment to Item H in their policy.

Policy 12-2017 - Medical Price Transparency

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

AMA Policy

Exclusion of Medical Debt That Has Been Fully Paid or Settled H-373.996

Our AMA supports the principles contained in The Medical Debt Relief Act as drafted and passed by the US House of Representatives to provide relief to the American consumer from a complicated collections process and supports medical debt resolution being portrayed in a positive and productive manner.

Health Plan Payment of Patient Cost-Sharing D-180.979

Our AMA will: (1) support the development of sophisticated information technology systems to help enable physicians and patients to better understand financial obligations; (2) encourage states and other stakeholders to monitor the growth of high deductible health plans and other forms of cost-sharing in health plans to assess the impact of such plans on access to care, health outcomes, medical debt, and provider practice sustainability; (3) advocate for the inclusion of health insurance contract provisions that permit network physicians to collect patient cost-sharing financial obligations (eg, deductibles, co-payments, and co-insurance) at the time of service; and (4) monitor programs wherein health plans and insurers bear the responsibility of collecting patient co-payments and deductibles.

Patient Medical Debt H-373.990

Our American Medical Association encourages health care organizations to manage medical debt with patients directly, considering several options including but not limited to discounts, payment plans with flexibility and

extensions as needed, or forgiveness of debt altogether, before resorting to third-party debt collectors or any punitive actions.

Our AMA supports innovative efforts to address medical debt for patients, including sliding-scale, interest-free payment plans before collection or litigation activities and public and private efforts to eliminate medical debt, such as purchasing debt with the intent of cancellation.

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

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

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

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

Resolution 48-2025: Support for Proactive and Strategic Stockpiling of Health Care Supplies in Times of Crises

OSMA Policy

Policy 09-2021 - Pandemic Preparedness

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

AMA Policy

H-440.847- Pandemic Preparedness

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

1. urges the Department of Health and Human Services Emergency Care Coordination Center, in collaboration with the leadership of the Centers for Disease Control and Prevention (CDC), state and local health departments, and the national organizations representing them, to urgently assess the shortfall in funding, staffing, supplies, vaccine, drug, and data management capacity to prepare for and respond to a pandemic or other serious public health emergency.
2. urges Congress and the Administration to work to ensure adequate funding and other resources: (a) for the CDC, the National Institutes of Health (NIH), the Strategic National Stockpile and other appropriate federal agencies, to support the maintenance of and the implementation of an expanded capacity to produce the necessary vaccines, anti- microbial drugs, medical supplies, and personal protective equipment, and to continue development of the nation's capacity to rapidly manufacture the necessary supplies needed to protect, treat, test and vaccinate the entire population and care for large numbers of seriously ill people, without overreliance on unreliable international sources of production; and (b) to bolster the infrastructure and capacity of state and local health departments to effectively prepare for and respond to a pandemic or other serious public health emergency.
3. encourages states to maintain medical and personal protective equipment stockpiles sufficient for effective preparedness and to respond to a pandemic or other major public health emergency.

4. urges the federal government to meet treaty and trust obligations by adequately sourcing medical and personal protective equipment directly to tribal communities and the Indian Health Service for effective preparedness and to respond to a pandemic or other major public emergency.
5. urges the CDC to develop and disseminate electronic instructional resources on procedures to follow in an epidemic, pandemic, or other serious public health emergency, which are tailored to the needs of health care personnel in direct patient care settings;
6. supports the position that:
    a. relevant national and state agencies (such as the CDC, NIH, and the state departments of health) continue to plan and test distribution activities in advance of a public health emergency, to assure that physicians, nurses, other health care personnel, and first responders having direct patient contact, receive any appropriate vaccination or medical countermeasure in a timely and efficient manner, in order to reassure them that they will have first priority in the event of such a pandemic.
    b. such agencies should publicize now, in advance of any such pandemic, what the plan will be to provide immunization to health care provider.
7. will monitor progress in developing a contingency plan that addresses future vaccine production or distribution problems and in developing a plan to respond to a pandemic in the United States.
8. will encourage state and federal efforts to locate the manufacturing of goods used in healthcare and healthcare facilities in the United States.
9. will support federal efforts to encourage the purchase of domestically produced personal protective equipment.

D-120.961- Personal Medication and Medical Supplies in Times of Disaster
Our AMA urges continued dialogue with appropriate federal agencies, medical societies, health care organizations, and other appropriate stakeholders to: (a) ensure timely distribution of and access to medications for acute and chronic medical conditions in a disaster; (b) issue guidance to health professionals and the public on the appropriate stockpiling of medications for acute and chronic medical conditions in a disaster or other serious emergency; and (c) deliberate the design, feasibility, and utility of a universal mechanism, that provides the essential health and medical supplies and information that can assist emergency medical responders and other health care personnel with the provision of medical care and assistance in a disaster or other serious emergency.

H-440.810- Availability of Personal Protective Equipment (PPE)
Our American Medical Association affirms that the medical staff of each health care institution should be integrally involved in disaster planning, strategy and tactical management of ongoing crises.

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

Our AMA will advocate that it is the responsibility of health care facilities to provide sufficient personal protective equipment (PPE) for all employees and staff, as well as trainees and contractors working in such facilities, in the event of a pandemic, natural disaster, or other surge in patient volume or PPE need.

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

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

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

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

Resolution 49-2025: Reaffirmation of Policy 06-2013: Graduate Medical Education, and Identification of Potential Funding Solutions Through Legislative Initiatives

OSMA Policy

Policy 06-2013 - Crafting Innovative Ways of Funding Graduate Medical Education

1. The OSMA supports legislation to convene a state based task force of key stakeholders to include representatives from private business enterprises such as health insurance companies, private practice physicians, members of the general public, and academic medical center employees to study current graduate medical education (GME) financing in Ohio and investigate creative alternatives for GME funding that rely less on federal resources.

AMA Policy

The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education D-305.967

1. Our American Medical Association will actively collaborate with appropriate stakeholder organizations, (including Association of American Medical Colleges, American Hospital Association, state medical societies, medical specialty societies/associations) to advocate for the preservation, stability and expansion of full funding for the direct and indirect costs of graduate medical education (GME) positions from all existing sources (e.g. Medicare, Medicaid, Veterans Administration, CDC and others).
2. Our AMA will actively advocate for the stable provision of matching federal funds for state Medicaid programs that fund GME positions.
3. Our AMA will actively seek congressional action to remove the caps on Medicare **funding** of GME positions for resident physicians that were imposed by the Balanced Budget Amendment of 1997 (BBA-1997).
4. Our AMA will strenuously advocate for increasing the number of GME positions to address the future physician workforce needs of the nation.
5. Our AMA will oppose efforts to move federal funding of GME positions to the annual appropriations process that is subject to instability and uncertainty.
6. Our AMA will oppose regulatory and legislative efforts that reduce funding for GME from the full scope of resident educational activities that are designated by residency programs for accreditation and the board certification of their graduates (e.g. didactic teaching, community service, off-site ambulatory rotations, etc.).
7. Our AMA will actively explore additional sources of GME funding and their potential impact on the quality of residency training and on patient care.
8. Our AMA will vigorously advocate for the continued and expanded contribution by all payers for health care (including the federal government, the states, and local and private sources) to fund both the direct and indirect costs of GME.
9. Our AMA will work, in collaboration with other stakeholders, to improve the awareness of the general public that GME is a public good that provides essential services as part of the training process and serves as a necessary component of physician preparation to provide patient care that is safe, effective and of high quality.
10. Our AMA staff and governance will continuously monitor federal, state and private proposals for health care reform for their potential impact on the preservation, stability and expansion of full funding for the direct and indirect costs of GME.
11. Our AMA:
    a. recognizes that funding for and distribution of positions for GME are in crisis in the United States and that meaningful and comprehensive reform is urgently needed.
    b. will immediately work with Congress to expand medical residencies in a balanced fashion based on expected specialty needs throughout our nation to produce a geographically distributed and appropriately sized physician workforce; and to make increasing support and funding for GME programs and residencies a top priority of the AMA in its national political agenda.
    c. will continue to work closely with the Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, American Osteopathic Association, and other key

stakeholders to raise awareness among policymakers and the public about the importance of expanded GME funding to meet the nation's current and anticipated medical workforce needs.

12. Our AMA will collaborate with other organizations to explore evidence-based approaches to quality and accountability in residency education to support enhanced funding of GME.
13. Our AMA will continue to strongly advocate that Congress fund additional graduate medical education (GME) positions for the most critical workforce needs, especially considering the current and worsening maldistribution of physicians.
14. Our AMA will advocate that the Centers for Medicare and Medicaid Services allow for rural and other underserved rotations in Accreditation Council for Graduate Medical Education (ACGME)-accredited residency programs, in disciplines of particular local/regional need, to occur in the offices of physicians who meet the qualifications for adjunct faculty of the residency program's sponsoring institution.
15. Our AMA encourages the ACGME to reduce barriers to rural and other underserved community experiences for graduate medical education programs that choose to provide such training, by adjusting as needed its program requirements, such as continuity requirements or limitations on time spent away from the primary residency site.
16. Our AMA encourages the ACGME and the American Osteopathic Association (AOA) to continue to develop and disseminate innovative methods of training physicians efficiently that foster the skills and inclinations to practice in a health care system that rewards team-based care and social accountability.
17. Our AMA will work with interested state and national medical specialty societies and other appropriate stakeholders to share and support legislation to increase GME funding, enabling a state to accomplish one or more of the following: (a) train more physicians to meet state and regional workforce needs; (b) train physicians who will practice in physician shortage/underserved areas; or (c) train physicians in undersupplied specialties and subspecialties in the state/region.
18. Our AMA supports the ongoing efforts by states to identify and address changing physician workforce needs within the GME landscape and continue to broadly advocate for innovative pilot programs that will increase the number of positions and create enhanced accountability of GME programs for quality outcomes.
19. Our AMA will continue to work with stakeholders such as Association of American Medical Colleges (AAMC), ACGME, AOA, American Academy of Family Physicians, American College of Physicians, and other specialty organizations to analyze the changing landscape of future physician workforce needs as well as the number and variety of GME positions necessary to provide that workforce.
20. Our AMA will explore innovative funding models for incremental increases in funded residency positions related to quality of resident education and provision of patient care as evaluated by appropriate medical education organizations such as the Accreditation Council for Graduate Medical Education.
21. Our AMA will utilize its resources to share its content expertise with policymakers and the public to ensure greater awareness of the significant societal value of graduate medical education (GME) in terms of patient care, particularly for underserved and at-risk populations, as well as global health, research and education.
22. Our AMA will advocate for the appropriation of Congressional funding in support of the National Healthcare Workforce Commission, established under section 5101 of the Affordable Care Act, to provide data and healthcare workforce policy and advice to the nation and provide data that support the value of GME to the nation.
23. Our AMA supports recommendations to increase the accountability for and transparency of GME funding and continue to monitor data and peer-reviewed studies that contribute to further assess the value of GME.
24. Our AMA will explore various models of all-payer funding for GME, especially as the Institute of Medicine (now a program unit of the National Academy of Medicine) did not examine those options in its 2014 report on GME governance and financing.
25. Our AMA encourages organizations with successful existing models to publicize and share strategies, outcomes and costs.

26. Our AMA encourages insurance payers and foundations to enter into partnerships with state and local agencies as well as academic medical centers and community hospitals seeking to expand GME.
27. Our AMA will develop, along with other interested stakeholders, a national campaign to educate the public on the definition and importance of graduate medical education, student debt and the state of the medical profession today and in the future.
28. Our AMA will collaborate with other stakeholder organizations to evaluate and work to establish consensus regarding the appropriate economic value of resident and fellow services.
29. Our AMA will monitor ongoing pilots and demonstration projects, and explore the feasibility of broader implementation of proposals that show promise as alternative means for funding physician education and training while providing appropriate compensation for residents and fellows.
30. Our AMA will monitor the status of the House Energy and Commerce Committee's response to public comments solicited regarding the 2014 IOM report, Graduate Medical Education That Meets the Nation's Health Needs, as well as results of ongoing studies, including that requested of the GAO, in order to formulate new advocacy strategy for GME funding, and will report back to the House of Delegates regularly on important changes in the landscape of GME funding.
31. Our AMA will advocate to the Centers for Medicare & Medicaid Services to adopt the concept of "Cap-Flexibility" and allow new and current Graduate Medical Education teaching institutions to extend their cap-building window for up to an additional five years beyond the current window (for a total of up to ten years), giving priority to new residency programs in underserved areas and/or economically depressed areas.
32. Our AMA will:
    a. encourage all existing and planned allopathic and osteopathic medical schools to thoroughly research match statistics and other career placement metrics when developing career guidance plans.
    b. strongly advocate for and work with legislators, private sector partnerships, and existing and planned osteopathic and allopathic medical schools to create and fund graduate medical education (GME) programs that can accommodate the equivalent number of additional medical school graduates consistent with the workforce needs of our nation.
    c. encourage the Liaison Committee on Medical Education (LCME), the Commission on Osteopathic College Accreditation (COCA), and other accrediting bodies, as part of accreditation of allopathic and osteopathic medical schools, to prospectively and retrospectively monitor medical school graduates' rates of placement into GME as well as GME completion.
33. Our AMA encourages the Secretary of the U.S. Department of Health and Human Services to coordinate with federal agencies that fund GME training to identify and collect information needed to effectively evaluate how hospitals, health systems, and health centers with residency programs are utilizing these financial resources to meet the nation's health care workforce needs. This includes information on payment amounts by the type of training programs supported, resident training costs and revenue generation, output or outcomes related to health workforce planning (i.e., percentage of primary care residents that went on to practice in rural or medically underserved areas), and measures related to resident competency and educational quality offered by GME training programs.f
34. Our AMA will publicize best practice examples of state-funded Graduate Medical Education positions and develop model state legislation where appropriate.
35. Our American Medical Association will ask federal agencies that fund graduate medical education (including but not limited to the Centers for Medicare and Medicaid Services, the Department of Veterans Affairs, the Department of Defense, the Health Resources and Services Administration, and others) to issue an annual report detailing the quantity of total GME funding for each year including how Direct GME funds are allocated on a per resident or fellow basis, for the previous year.

Resolution 50-2025: Increase State Funding for Graduate Medical Education (GME)

OSMA Policy

Policy 06-13 - Crafting Innovative Ways of Funding Graduate Medical Education

1. The OSMA supports legislation to convene a state based task force of key stakeholders to include representatives from private business enterprises such as health insurance companies, private practice physicians, members of the general public, and academic medical center employees to study current graduate medical education (GME) financing in Ohio and investigate creative alternatives for GME funding that rely less on federal resources.

AMA Policy

Refer to The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education D-305.967 above in Resolution 49-2025.

Resolution 51-2025: Support of Comprehensive Healthcare Reform Through Exploration of Other Models

OSMA Policy

Policy 05-2011 - Universal Health Insurance Coverage

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

AMA Policy

Educating the American People About Health System Reform H-165.844

Our American Medical Association reaffirms support of pluralism, freedom of enterprise and strong opposition to a single payer system.

Evaluating Health System Reform Proposals H-165.888

1. Our AMA will continue its efforts to ensure that health system reform proposals adhere to the following principles:
   A. Physicians maintain primary ethical responsibility to advocate for their patients' interests and needs.
   B. Unfair concentration of market power of payers is detrimental to patients and physicians, if patient freedom of choice or physician ability to select mode of practice is limited or denied. Single-payer systems clearly fall within such a definition and, consequently, should continue to be opposed by the AMA. Reform proposals should balance fairly the market power between payers and physicians or be opposed.
   C. All health system reform proposals should include a valid estimate of implementation cost, based on all health care expenditures to be included in the reform; and supports the concept that all health system reform proposals should identify specifically what means of funding (including employer-mandated funding, general taxation, payroll or value-added taxation) will be used to pay for the reform proposal and what the impact will be.
   D. All physicians participating in managed care plans and medical delivery systems must be able without threat of punitive action to comment on and present their positions on the plan's policies and procedures for medical review, quality assurance, grievance procedures, credentialing criteria, and other financial and administrative matters, including physician representation on the governing board and key committees of the plan.
   E. Any national legislation for health system reform should include sufficient and continuing financial support for inner-city and rural hospitals, community health centers, clinics, special programs for special populations and other essential public health facilities that serve underserved populations that otherwise lack the financial means to pay for their health care.
   F. Health system reform proposals and ultimate legislation should result in adequate resources to enable medical schools and residency programs to produce an adequate supply and appropriate generalist/specialist mix of physicians to deliver patient care in a reformed health care system.

G. All civilian federal government employees, including Congress and the Administration, should be covered by any health care delivery system passed by Congress and signed by the President.
H. True health reform is impossible without true tort reform.

2. Our AMA supports health care reform that meets the needs of all Americans including people with injuries, congenital or acquired disabilities, and chronic conditions, and as such values function and its improvement as key outcomes to be specifically included in national health care reform legislation.
3. Our AMA supports health care reform that meets the needs of all Americans including people with mental illness and substance use / addiction disorders and will advocate for the inclusion of full parity for the treatment of mental illness and substance use / addiction disorders in all national health care reform legislation.
4. Our AMA supports health system reform alternatives that are consistent with AMA principles of pluralism, freedom of choice, freedom of practice, and universal access for patients.

Resolution 52-2025: Supporting the Integration of Blood Pressure Variability Data in Electronic Medical Records

OSMA Policy
N/A

AMA Policy
N/A

Resolution 53-2025: Protecting Access to IVF Treatment

OSMA Policy
N/A

AMA Policy
D-5.999 "Preserving Access to Reproductive Health Services"
Our AMA: (1) recognizes that healthcare, including reproductive health services like contraception and abortion, is a human right; (2) opposes limitations on access to evidence-based reproductive health services, including fertility treatments, contraception, and abortion; (3) will work with interested state medical societies and medical specialty societies to vigorously advocate for broad, equitable access to reproductive health services, including fertility treatments, fertility preservation, contraception, and abortion; (4) supports shared decision-making between patients and their physicians regarding reproductive healthcare; (5) opposes any effort to undermine the basic medical principle that clinical assessments, such as viability of the pregnancy and safety of the pregnant person, are determinations to be made only by healthcare professionals with their patients; (6) opposes the imposition of criminal and civil penalties or other retaliatory efforts, including adverse medical licensing actions and the termination of medical liability coverage or clinical privileges against patients, patient advocates, physicians, other healthcare workers, and health systems for receiving, assisting in, referring patients to, or providing reproductive health services; (7) will advocate for legal protections for patients who cross state lines to receive reproductive health services, including contraception and abortion, or who receive medications for contraception and abortion from across state lines, and legal protections for those that provide, support, or refer patients to these services; and (8) will advocate for legal protections for medical students and physicians who cross state lines to receive education in or deliver reproductive health services, including contraception and abortion.
(Res 028, A-22; Reaffirmed: Res 224, I-22; Modified: BOT Rep. 4, I-22; Appended: Res 317, I-22; Reaffirmation: A-23, Appended: Res 711, A-23)

G-605.009 "Establishing a Task Force to Preserve the Patient-Physician Relationship when Evidence-Based Appropriate Care is Banned or Restricted"
1. Our AMA will convene a task force of appropriate AMA councils and interested state and medical specialty societies, in conjunction with the AMA Center for Health Equity, and in consultation with relevant organizations, practices, government bodies, and impacted communities for the purpose of preserving the patient-physician relationship.

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

H-160.954 Criminalization of Medical Judgment
(1) Our AMA continues to take all reasonable and necessary steps to insure that medical decision-making exercised in good faith, does not become a violation of criminal law. (2) Henceforth our AMA opposes any future legislation which gives the federal government the responsibility to define appropriate medical practice and regulate such practice through the use of criminal penalties.
(Sub. Res. 223, I-93; Reaffirmed: Res. 227, I-98; Reaffirmed: Res. 237, A-99; Reaffirmed and Appended: Sub. Res. 215, I-99; Reaffirmation A-09; Reaffirmed: CEJA Rep. 8, A-09)

H-160.946 The Criminalization of Health Care Decision-making
The AMA opposes the attempted criminalization of health care decision-making especially as represented by the current trend toward criminalization of malpractice; it interferes with appropriate decision making and is a disservice to the American public; and will develop model state legislation properly defining criminal conduct and prohibiting the criminalization of health care decision-making, including cases involving allegations of medical malpractice, and implement an appropriate action plan for all components of the Federation to educate opinion leaders, elected officials and the media regarding the detrimental effects on health care resulting from the criminalization of health care decision-making.
(Sub. Res. 202, A-95; Reaffirmed: Res. 227, I-98; Reaffirmed: BOT Rep. 2, A-07; Reaffirmation A-09)

D-160.999 Opposition to Criminalizing Health Care Decisions
Our AMA will educate physicians regarding the continuing threat posed by the criminalization of healthcare decision-making and the existence of our model legislation "An Act to Prohibit the Criminalization of Healthcare Decision-Making."
(Res. 228, I-98; Reaffirmed: BOT Rep. 5, A-08)

H-140.835 Political Interference in the Patient-Physician Relationship
Our AMA opposes any policies that interfere with the patient-physician relationship by giving probate, inheritance, a social security number, or other legal rights to an undelivered pregnancy, or imposing legislative barriers to medical decision-making by changes in tax codes or in definitions of beneficiaries.
(Alt Res 007, I-17)

Resolution 54-2025: Third Party Payer Denials without Review of the Medical Record

OSMA Policy
Policy 19-1992 - Third Party Payor Denials
1. The OSMA supports that a hospital stay denial by an insurance carrier include the specific date of denial and the medical reasons as to why the stay was denied on that date by the carrier.

AMA Policy
Automatic Downcoding of Claims D-320.972
1. Our American Medical Association vigorously opposes health plans using software, algorithms, or methodologies, other than manual review of the patient's medical record, to deny or downcode evaluation and management services, except correct coding protocol denials, based solely on the Current Procedural Terminology/Healthcare Common Procedure Coding System codes, International Classification of Diseases, 10th revision, codes, and/or modifiers submitted on the claim.
2. Our AMA supports that, after review of the patient's medical record and determination that a lower level of evaluation and management code is warranted, the explanation of benefits, remittance advice documents, or other claim adjudication notices provide notice that clearly indicates a service was downcoded using the proper claim adjustment reason codes and/or remittance advice remark codes.
3. Our AMA will advocate for legislation to provide transparency and prohibit automated denials, other than National Correct Coding Initiative denials, or downcoding of evaluation and management services based solely on the Current Procedural Terminology/Healthcare Common Procedure Coding System codes, International Classification of Diseases, 10th Revision, codes, or modifiers submitted on the claim.
4. Our AMA will further evaluate what legislative and/or legal action is needed to bar insurers from automatic downcoding and to provide transparency on all methodology of processing claims.

Resolution 55-2025: Interstate Compact to Facilitate Out-of-State Medicaid Provider Enrollment for Emergency Care

OSMA Policy
Policy 23-2024 - Advocating for 12-Month Continuous Medicaid Enrollment Periods to Improve Adult Health Outcomes in Ohio
1. OSMA supports the adoption of 12-month continuous eligibility across Ohio Medicaid programs.

Policy 42-2008 - Reform of Medicaid Managed Care
1. The OSMA continues to work with the State of Ohio to reform the current Medicaid managed care system to make it easier for Ohio physicians to care for this group of patients.

Policy 7-2009 - Medicaid Reform
1. The OSMA shall work to get one set of rules for the Medicaid system.
2. The OSMA shall work to be sure that patients who are on an approved drug in one program and are switched to another program may continue the drug without another prior authorization from the physician's office (thus requiring communication between managed care programs when a patient moves from one to another).
3. The OSMA shall work to eliminate current barriers to traditional referral patterns for complicated patients who need a tertiary center regardless of which provider group they are in.
4. The OSMA shall work to eliminate needless hassles for physicians in their offices in obtaining prior authorization for medications and testing.
5. The OSMA shall encourage a statewide source of up-to-date verification of a patient's coverage.

Policy 17-2010 - Universal Real-Time Insurance Coverage Verification for Ohio

1. The OSMA shall work with the Ohio Department of Insurance and the Ohio Department of Job and Family Services to require all Ohio Medicaid and private insurers to utilize one of the universal on-line real-time coverage eligibility clearinghouses.

AMA Policy

N/A

Resolution 56-2025: Advocating for Street Medicine and Mobile Medical Units through Established Healthcare Systems for Underserved Populations

OSMA Policy

Policy 29-2022 - Supporting Housing Initiatives to Improve Health of Homeless Individuals

The OSMA supports the development of state and local policies that protect the health of low income and homeless individuals by promoting and funding housing initiatives.

AMA Policy

H-160.886 - 2023 "Payment for Physicians who Practice Street Medicine"

a. 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.

b. 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."

Resolution 57-2025: Copayments for Primary Care and Preventative Services Should be Eliminated

OSMA Policy

N/A

AMA Policy

N/A