Revised for Supplement
Items in Supplement are in italics
Late Business

AGENDA
REFERENCE COMMITTEE ON FINANCIAL AND ORGANIZATIONAL AFFAIRS
Friday, May 17, 2019
Tower Lobby, Topaz - Hilton Anatole

1. TMA President Report 1 – Nominations for Board of Governors, Texas Medical Liability Trust
2. Board of Councilors Report 4 – Emeritus Nomination
3. *Board of Councilors Report 5 – Honorary Nominations*
4. Board of Councilors Report 6 – Sunset Policy Review
5. Board of Trustees Report 14 – Inactive County Medical Societies
6. Board of Trustees Report 15 – Sunset Policy Review
7. Council on Constitution and Bylaws Report 1 – Inactive Specialty Societies
8. Committee on Membership Report 2 – Women in Medicine Section
9. Committee on Physician Health and Wellness Report 1 – Policy Review and Amendment to Committee Charge
10. Committee on Physician Health and Wellness Report 2 – Sunset Policy Review
11. Patient-Physician Advocacy Committee Report 2 – Sunset Policy Review
12. Council on Practice Management Service Report 1 – Patient-Centered Medical Responsibilities, Resolution 101-A-18
13. Council on Practice Management Service Report 3 – Establish a Standing Committee on Health Information Technology
14. Council on Socioeconomics Report 3 – Gender Disparities in Physician Compensation
15. Council on Socioeconomics Report 4 – Establishing a Standing Committee on Medicaid, CHIP, and the Uninsured
16. Council on Science and Public Health Report 6 – Task Force on Behavioral Health
17. Texas Delegation to the AMA Report 3 – Texas Delegation Operating Procedures Changes
18. Resolution 101 - Saturday-Sunday Meeting Schedule for the Texas Medical Association
19. Resolution 102 - Written Testimony at TMA Reference Committees
20. Resolution 103 – Gratitude for Continuing Medical Education Courses

21. Resolution 104 – Alternate Delegates May Address the House of Delegates

22. Resolution 105 – Pharmacies Practicing Medicine

23. Resolution 106 – Establish a Coalition of Medical Societies to Protect Competition and Sustainability in the Health Insurance Marketplace

24. Resolution 107 – Physician Dispensing of Prescriptions

25. Resolution 108 – Initial Assessment and Treatment Recommendation by Specialists

26. *Resolution 109 – Licensure Status on TMA Membership Applications*

27. *Resolution 110 – Blue Cross and Blue Shield of Texas Charitable Requirements as a Not-for-Profit Corporation*

28. *Resolution 111 – Opposing Legislation That Mandates Physician Discrimination*

29. *Resolution 112 – Equal Pay for Equal Work*

Late Business

REPORT OF TMA PRESIDENT

PRES Report 1-A-19

Subject: Nominations for Board of Governors, Texas Medical Liability Trust

Presented by: Douglas W. Curran, MD, President

Referred to: Reference Committee on Financial and Organizational Affairs

---

The trust instrument that controls the operations of the Texas Medical Liability Trust (TMLT) requires that nominations for the Board of Governors be made by the TMLT board and submitted to the Texas Medical Association House of Delegates by the TMA president. When the house approves the nominations, they will be placed before TMLT policyholders for election.

Positions on the TMLT board are slotted.

John Holcomb, MD, will fulfill his term and board tenure at the end of 2019. The TMLT Board of Governors recommends the following nomination for one three-year term beginning in 2020:

Luis M. Benavides, MD, Laredo, family medicine, for election to Place 6.

Recommendation: Approval of Dr. Luis M. Benavides, nominee of the TMLT Board of Governors, to be placed before TMLT policyholders for election.

REPORT OF BOARD OF COUNCILORS

BOC Report 4-A-19

Subject: Emeritus Nomination

Presented by: Steven M. Petak, MD, Chair

Referred to: Reference Committee on Financial and Organizational Affairs

---

The House of Delegates, upon nomination by the county medical society in which the member belongs and approval by the Board of Councilors, may elect a member of the association who has rendered exceptional and distinguished service to scientific or organized medicine, or both, to the status of member emeritus.

The Board of Councilors has approved the nomination of Mary C. Spalding, MD, and Josie R. Williams, MD, for emeritus membership and recommends their election to such by the House of Delegates. A brief sketch follows for Drs. Spalding and Williams.

Mary C. Spalding, MD (El Paso County Medical Society)
Dr. Spalding has been a professor at Texas Tech University Health Sciences Center-El Paso from 1996 to present in the Department of Family Medicine. During her career, she has mentored many residents and medical students to become outstanding physicians in the El Paso community, as well as throughout the United States.

During her career, she received many prestigious awards such as Faculty of the Year Best Doctors in America 2005-17, Who's Who Among American Higher Education, and Cambridge Who's Who Executive and Professional Women.

Dr. Spalding is active within the professional organizations she belongs to, as has done a lot of work throughout her community. She has always led the charge to improve Texas health care throughout her career.

Josie R. Williams, MD (Lamar-Delta County Medical Society)
Dr. Williams developed a reputation as an excellent physician and served as a physician leader in the field of gastroenterology in Paris, Texas for many years. After much success, she decided to pursue opportunities to make an impact at the state and national levels.

Dr. Williams began her career after becoming the first female graduate of Texas A&M to attend medical school. Following her practice in Paris, she facilitated and created multiple research programs and services at Texas A&M Health Science Center. Dr. Williams also contributed substantial work to the founding of the Knowledge, Skills, Training, Assessment and Research (KSTAR) program in her area to assist physicians with health and wellness issues. She has spent a great deal of time making the voice of medicine heard before committees and panels at the state and federal levels, including as a past president of the Texas Medical Association.

Recommendation: Elect Mary C. Spalding, MD, and Josie Williams, MD, to emeritus membership in TMA.

Revised

REPORT OF BOARD OF COUNCILORS

BOC Report 5-A-19

Subject: Honorary Nominations

Presented by: Steven M. Petak, MD, Chair

Referred to: Reference Committee on Financial and Organizational Affairs

---

The Texas Medical Association Board of Councilors has approved the nominations of Richard M. Holt, MD; Wesley Stafford, MD; Jane Stafford,MD; Harris M. Hauser, MD; Milton Altschuler, MD; and John D. Milam, MD for honorary membership and recommends their election by the House of Delegates. A brief sketch follows for each member.

Richard M. Holt, MD (Travis County Medical Society)
Dr. Holt received his undergraduate education at Yale University before receiving his medical degree at The University of Texas Medical Branch at Galveston. Upon completion of his postgraduate training, Dr. Holt and his family moved to Austin, where he entered private practice in 1973. Dr. Holt has served in various leadership positions, including the Central Texas Medical Foundation Board, the Travis County Medical Society Community and Public Health Committee, the Disaster Preparedness Committee, and the Wrong Site Wrong Procedure Committee. Dr. Holt's 44-year career has been characterized by his devotion to his profession and his patients.

Wesley Stafford, MD (Nueces County Medical Society)
Dr. Stafford received his medical degree from The University of Texas Medical Branch at Galveston. He has served as Nueces County Medical Society president, a TMA delegate, a member of the TMA Council Scientific Program, and as chair of the TMA Continuing Education committee. Dr. Stafford has written several scientific papers and publications.

Jane Stafford, MD (Nueces County Medical Society)
Dr. Stafford received her medical degree from The University of Texas Medical Branch at Galveston and her Bachelor of Arts in Biology and English from Southwestern University. She has been a member of TMA, the American Medical Association, and the Nueces County Medical Society for 30 years. Dr. Stafford served as the Nueces County Medical Society president and within the TMA House of Delegates. She is an associate medical director with a demonstrated history of working in the hospital and health care industry.

Harris M. Hauser, MD (Harris County Medical Society)
Dr. Hauser received medical degree with honors at Baylor College of Medicine. Upon completion of his postgraduate training, Dr. Hauser entered private practice in 1962 as co-founder of the Hauser Clinic in Houston. Dr. Hauser has served in numerous leadership positions, including president of the Houston Academy of Medicine, Vice President of the Harris County Medical Society, and HCMS Delegate to the TMA. He has had numerous administrative and civic appointments and many professional memberships including president of the Houston Psychiatric Society. He has been a member of the Texas Medical Association, American Medical Association and Harris County Medical Society for 63 years. Dr. Hauser has had a career of distinguished service and outstanding achievements in medicine.

Milton Altschuler, MD (Harris County Medical Society)
Dr. Altschuler received his medical degree from the University of Texas Branch at Galveston. He has served on the TMA Physicians Benevolent Fund Committee, Houston Psychiatric Society, and the Steering

Committee of the HCMS Retired Physicians Organization. He has been a member of the Texas Medical Association and Harris County Medical Society for 59 years. Dr. Altschuler has written several scientific papers and publications.

John D. Milam, MD (Harris County Medical Society)
Dr. Milam received his medical degree from the Louisiana State University School of Medicine and had a teaching appointment at the University of Texas Health Science Center at Houston. Dr. Milam has been a member of the Texas Medical Association and Harris County Medical Society for 53 years. Dr. Milam served as an HCMS alternate delegate to the TMA, HCMS Membership Committee and president of the Texas Society of Pathologists. Dr. Milam has also received several medical awards, including the George T. Caldwell Distinguished Service Award. He has written numerous scientific papers and publications.

Recommendation: Elect Richard M. Holt, MD; Wesley Stafford, MD; Jane Stafford, MD; Harris M. Hauser, MD; Milton Altschuler, MD; and John D. Milam, MD to honorary membership in TMA.

REPORT OF BOARD OF COUNCILORS

BOC Report 6-A-19

Subject: Sunset Policy Review

Presented by: Steven M. Petak, MD, Chair

Referred to: Reference Committee on Financial and Organizational Affairs

---

The Texas Medical Association periodically reviews House of Delegates policies in the association's Policy Compendium for relevance and appropriateness. Following are policies reviewed by the Board of Councilors with recommendations for retention, amendment, and deletion.

The Board of Councilors recommends retention of the following policies:

245.010 **Physician Discrimination**. Discrimination Against International Medical Graduates: The Texas Medical Association supports and promotes the right of every licensed physician to be treated meritoriously without discrimination based on national origin or geographic location of medical school (Amended Res. 301-I-99; amended BOC Rep. 6-A-09).

160.019 **Temporary Texas License for Medical Opinion or Testimony**: The Texas Medical Association will seek legislation and/or rule making to establish a temporary license for any non-Texas-licensed physician seeking to provide medical opinion or testimony associated with any action, court proceeding, arbitration hearing, mediation proceeding, or other action or negotiation taking place within Texas (Amended Res. 104-A-09).

160.012 **Antitrust Laws**: The Texas Medical Association, along with other state medical associations, the American Medical Association and national medical specialty societies, supports national efforts to address appropriate federal antitrust reforms and to provide the foundation for fair contract negotiations designed to preserve clinical autonomy and patient interest and to redirect medical decision making to patients and physicians (Res. 410-A-99; reaffirmed BOC Rep. 6-A-09).

The Board of Councilors recommends retaining the policies because the basis for each of the policies remains valid.

Recommendation 1: Retain.

The Board of Councilors recommends deletion of the following policies:

195.029 **Registry for Advance Directives**: The Texas Medical Association supports a Centers for Medicare & Medicaid Services requirement for all Medicare patients to register the advance directive of their choice to facilitate their end-of-life preferences being respected (Res. 307-A-09).

TMA Policy 195.029 (Registry for Advance Directives) expresses support for a requirement by the Centers for Medicare & Medicaid Services for Medicare patients to register advance directives. Upon review, the Board of Councilors found this policy to be unclear and also developed concerns about the relevance of this policy. For instance, the Centers of Medicare & Medicaid Services does not currently have a requirement for advance directive registries, but also a central registry for these directives could be operationally difficult to implement and could be

burdensome. The Board of Councilors found that underlying this policy is the importance of education about advance directives – a topic already addressed and expressed in TMA Policy 85.003. Accordingly, the Board of Councilors recommends deletion of this policy.

105.017 **Privacy of Medical Records**: The Texas Medical Association opposes any weakening of state laws protecting medical privacy, any establishment of a new corporate right to own, collect, or use medical databases, and any funding or implementation of a national patient identifier pursuant to the Health Insurance Portability and Accountability Act (Res. 105-A-99; amended BOC Rep. 6-A-09).

TMA Policy 105.017 (Privacy of Medical Records) expresses opposition to issues being addressed in federal legislation that was being considered in the late 1990s. Because the fate of that federal legislation is now well-settled, the Board of Councilors recommends deletion of this policy. Further, the Board also notes that several other TMA polices address the principles behind this policy relating to the privacy of medical records. TMA Policies 105.006, 105.019, 118.004, and 235.019 all address aspects of privacy of medical records that were addressed to a limited extent in Policy 105.017. Because Policy 105.017 is redundant and does not as clearly state TMA's positions on privacy issues as other polices do, the Board recommends deletion.

Recommendation 2: Delete.

The Board of Councilors recommends amending the following:

165.004 **Government Competency Checks**: The Texas Medical Association vigorously opposes any attempt by the federal government to establish boards which would oversee state licensure bodies and impose federal competency checks ~~through onsite inspection, chart reviews, or periodic written examination~~ (Res. 106-A-99; reaffirmed BOC Rep. 6-A-09).

The Board of Councilors finds that the basis for this policy remains valid, but that federal competency checks through *any means* – not just chart reviews, written examinations, or onsite inspection – should be opposed.

Recommendation 3: Retain as amended.

REPORT OF BOARD OF TRUSTEES

BOT Report 14-A-19

Subject: Inactive County Medical Societies

Presented by: Diana L. Fite, MD, Chair

Referred to: Reference Committee on Financial and Organizational Affairs

---

The Board of Trustees has continued to study the issue of inactive county medical societies. In 2019, the board reviewed reports on the organizational challenges of inactive small to medium-sized county medical societies. It was determined that if these challenges remained unchecked, the inactive societies could lose viability and membership. To address the challenges and increase engagement of these societies, TMA Board of Trustees Chair Diana Fite, MD, appointed an ad hoc Committee on Inactive County Medical Societies.

The ad hoc committee consisted of five members from the TMA Board of Trustees (Ray Callas, MD; David Fleeger, MD; Susan Strate, MD; Joseph Valenti, MD; and Arlo Weltge, MD). TMA President-Elect Dr. Fleeger chaired the committee. The committee met at TMA's 2018 Advocacy Retreat on Nov. 30 and by conference call on Jan. 8.

The ad hoc committee discussed minimum requirements to be an active county medical society; the number of leaders required for small county societies; at-large counties; ways TMA can support at-large members and small county societies; and other matters.

Minimum Requirements to Be an Active County Medical Society

One of the issues discussed was using TMA's collection of dues on behalf of a county medical society as an incentive for the society to maintain a basic level of activity. Currently TMA collects dues for all but two county medical societies. The ad hoc committee discussed the possibility of continuing to do so only for a county society that meets a basic threshold of activity.

The committee recommended that to be considered active, a county medical society would have to provide the following information annually to TMA:

1. A list of currently elected officers and delegates with their terms of office. Elections must be held by each society annually.
2. A list of the reporting year's meetings with attendance noted.
3. Confirmation of the society's annual membership dues rate.
4. Evidence of filing the society's annual nonprofit tax returns, such as Form 990.

An inactive county medical society would be one that fails to satisfy this reporting requirement. The TMA Board of Councilors would be the TMA component to designate a county medical society as inactive. The ad hoc committee recommended discontinuing the collection of dues from a county society determined to be inactive and to collect dues only on behalf of an active society. Members of an inactive county medical society would still be treated as members of the society for purposes of eligibility for TMA membership.

Reducing the Number of Leaders Required for Small County Medical Societies
Fifty-seven county medical societies have 50 or fewer members. Of those, 28 have five to 20 members. Expecting a large percentage of members of these societies to serve as leaders is unrealistic.

Currently, the minimum requirement of officers for a county medical society is a president, secretary/treasurer, and board of censors made up of three physicians for a total of five leaders. The ad hoc committee recommends changing the TMA Bylaws to allow a county society with fewer than 50 members to have the option to reduce the number officers to three: president, president-elect, and secretary/treasurer.

For those societies with fewer than 50 members that choose not to have a board of censors, the officers could assume the functions of the county's board of censors, including membership application processing and disciplinary investigations. In this circumstance, any action performed by a board of censors that is otherwise reviewed by or appealed to a county medical society's executive board could be reviewed or appealed to the district councilor.

Enhanced County Medical Society Leadership Development
County medical society leaders often are elected to serve in the same position more than once. Often, when an engaged leader moves, retires, or no longer wants to be involved, a small society becomes inactive. TMA needs to support smaller county medical societies in developing new leaders. A healthy county society increases member engagement and membership numbers. In 2019, the board approved enhancing TMA-sponsored leadership development for county medical societies.

In addition, TMA Practice Management Education is scheduling a free webinar with CME for the first half of 2019 on leadership training. It will teach best practices for chairing a council or committee, becoming more involved at the local and state levels, and the expectations of leadership.

TMA also hosts a leadership forum targeting newly elected county medical society officers and newly hired county society staff to provide best practices and education on TMA resources, support for county medical societies, and strategies for membership recruitment and retention. In the past, this forum has been held in person, but for 2019 it will be offered as a virtual meeting.

Virtual CMS Meetings and Support of the Lone Star Caucus' Virtual Meeting Efforts
Members who live in rural counties may not have opportunities for engagement with their county medical society or TMA. To provide greater services to these members, TMA will offer virtual meetings highlighting the latest legislative, legal, or other business-of-medicine topics. Tentative plans for 2019 are:

- April – Legislative update
- June – Recap of the 2017 legislative session and actions from the TMA 2019 Annual Meeting
- September – Leadership and organized medicine
- November – Legal issues

At-Large Member Representation
In 2012, the TMA House of Delegates amended TMA Bylaws by adding a section on "at-large members." TMA Bylaws allows at-large members to elect delegates to the TMA House of Delegates. TMA currently has 91 at-large members.

Acting upon the ad hoc committee's recommendation, the board instructed TMA to schedule a 2019 meeting for at-large members to elect a delegate to represent this membership category in the house. If

there is interest and participation by the at-large members, the Board of Councilors will help them adopt bylaws so they may elect officers and function as a virtual county medical society.
The ad hoc committee reported its study and findings to the Board of Trustees at its September 2018 meeting, and the committee was discharged. As a result of the committee's work, the board makes the following recommendations to the House of Delegates.

Recommendation 1: Define an active county medical society as one that provides the following annually: (a) a list of the reporting year's elected officers and delegates with their terms of office; (b) a list of the reporting year's meetings with attendance noted; (c) confirmation of the county medical society annual membership dues rate; and (d) evidence of filing county medical society annual federal nonprofit tax returns, such as IRS Form 990.

Recommendation 2: Allow county medical societies with 50 or fewer members to reduce the number of required officers to three: president, president-elect, and secretary/treasurer.

Recommendation 3: Referral of Board of Trustees Report 14-A-19 to the Council on Constitution and Bylaws for recommended bylaws amendments to implement recommendations 1 and 2.

REPORT OF BOARD OF TRUSTEES

BOT Report 15-A-19

Subject: Sunset Policy Review

Presented by: Diana L. Fite, MD, Chair

Referred to: Reference Committee on Financial and Organizational Affairs

---

House of Delegates policies in the association's Policy Compendium are reviewed periodically for relevance and appropriateness. The board reviewed the following two policies and recommends retention.

105.018 Fraud and Abuse Initiative: The Texas Medical Association approves continued fraud and abuse advocacy for members through implementation of educational services and practice support programs (BOT 22-A-99; reaffirmed BOT 14-A-09).

160.018 Statute of Limitations for Administrative Violations: The Texas Medical Association supports legislation and/or rulemaking to enact a reasonable statute of limitations for administrative violations (Amended Res. 103-A-09).

Recommendation: Retain.

REPORT OF COUNCIL ON CONSTITUTION AND BYLAWS

CCB Report 1-A-19

Subject: Inactive Specialty Societies

Presented by: Lenore C. DePagter, DO, Chair

Referred to: Reference Committee on Financial and Organizational Affairs

---

Background

The House of Delegates recognizes Texas specialty societies as voting members of the house based on several criteria outlined in the Texas Medical Association's Bylaws, as well as delegate representation on the Interspecialty Society Committee (ISC), which is a standing committee of the TMA Board of Trustees. Specialty society representation in the house requires board certification and formal approval by the house to qualify for delegate representation.

Criteria in TMA Bylaws, Chapter 3, House of Delegates, Section 3.20, Composition, Subsection 3.221, Selection of specialty societies for representation, outlines requirements for certification of a Texas specialty society by the board as follows:

(1) Represent only a medical society of subspecialty for which there is a national examining board listed in *Directory of Graduate Medical Education Programs Accredited by the Accreditation Council for Medical Education.*
(2) Be a Texas specialty society of at least 100 physician members, with at least 60 percent of its physician membership TMA members. A society that meets all other criteria but has less than 100 members may be considered for delegate representation if it can be demonstrated that it is not otherwise represented and is recommended by the Board of Trustees.
(3) Be an active organization as manifested by an established constitution and bylaws, a slate of periodically elected officers, and yearly meetings.

TMA Bylaws Subsection 3.222, Board of Trustees certification, provides that the board may certify specialty societies who meet all but the first (1) criteria listed in Subsection 3.221 with the advice and consent of the Council on Medical Education. Currently, 27 specialty societies are approved for representation in the House of Delegates and are listed in Subsection 3.227. Approved specialty societies are eligible to participate on the ISC and designate a delegate and alternate delegate.

The board continually monitors inactive specialty societies, and part of these efforts included appointing a Task Force on Specialty Societies Represented in the TMA House of Delegates in May 2015. The task force determined there were a number of societies that did not participate in house or ISC meetings. It was noted that some of the societies and/or state chapters may no longer be in existence. ISC and House of Delegates staff were directed by the board to reach out to inactive societies to determine continued interest in delegate representation in the house and, if not, communicate the names of those societies to the Council on Constitution and Bylaws for proposed amendments removing them from the TMA Bylaws.

Inactive Specialty Societies

The following specialty societies have been identified as being inactive with the House of Delegates and ISC:

1. Texas Association of Physicians in Nuclear Medicine: The last recorded delegate was Donald A. Podoloff, MD, who served from 1992-2013. The last recorded alternate delegate was Ramesh D. Dhekne, MD, who served from 1992-2004. There is no longer a Texas Chapter of the national society. TMA currently has 33 physician members in the Nuclear Medicine specialty.

2. Texas Thoracic Society: Texas no longer has an active chapter within the American Thoracic Society (ATS), but the ATS is in the process of forming a Texas chapter. There is no set date for completion. The last recorded delegate for this society was Raymond C. Perkins II, MD, who last attended a TMA House of Delegates meeting in 2001.

Discussion

During a recent review of inactive specialty societies in September 2018, the board recommended the Council on Constitution and Bylaws be asked to propose amendments to the TMA Bylaws removing the following specialty societies from Chapter 3, House of Delegates, Section 3.20, Composition, Subsection 3.227, Specialty societies qualifying for delegate representation: Texas Thoracic Society and Texas Association of Physicians in Nuclear Medicine. The option to reapply for representation in the house is clearly outlined in the TMA Bylaws by seeking certification by the board (Bylaws subsection 3.222).

Recommendation: Amend Chapter 3, House of Delegates, Section 3.20, Composition, Subsection 3.227, Specialty societies qualifying for delegate representation and renumber the listing accordingly:

CHAPTER 3. HOUSE OF DELEGATES

3.20 Composition

3.227 Specialty societies qualifying for delegate representation. The following Texas specialty societies are approved for delegate representation:

(1) American College of Surgeons, North and South Texas Chapters (American Board of Surgery);
(2) Texas Academy of Family Physicians (American Board of Family Medicine);
(3) Texas Allergy, Asthma and Immunology Society (American Board of Allergy and Immunology);
(4) Texas Association of Neurological Surgeons (American Board of Neurological Surgery);
(5) Texas Association of Obstetricians and Gynecologists (American Board of Obstetrics and Gynecology);
(6) Texas Association of Otolaryngology-Head and Neck Surgery (American Board of Otolaryngology);
~~(7) Texas Association of Physicians in Nuclear Medicine (American Board of Nuclear Medicine);~~
~~(8)~~(7) Texas Chapter of the American College of Cardiology (American Board of Internal Medicine);
~~(9)~~(8) Texas Chapter of the American College of Physicians-American Society of Internal Medicine (American Board of Internal Medicine);
~~(10)~~(9) Texas College of Emergency Physicians (American Board of Emergency Medicine);
~~(11)~~(10)Texas Dermatological Society (American Board of Dermatology);
~~(12)~~(11)Texas Geriatrics Society (American Board of Family Medicine and American Board of Internal Medicine);
~~(13)~~(12)Texas Neurological Society (American Board of Psychiatry and Neurology);
~~(14)~~(13)Texas Ophthalmological Association (American Board of Ophthalmology);
~~(15)~~(14)Texas Orthopaedic Association (American Board of Orthopaedic Surgery);
~~(16)~~(15)Texas Pain Society (American Board of Anesthesiology);
~~(17)~~(16)Texas Pediatric Society (American Board of Pediatrics);
~~(18)~~(17)Texas Physical Medicine and Rehabilitation Society (American Board of Physical Medicine and Rehabilitation);

~~(19)~~(18)Texas Radiological Society (American Board of Radiology);
~~(20)~~(19)Texas Society for Gastroenterology and Endoscopy (American Board of Internal Medicine);
~~(21)~~(20)Texas Society of Anesthesiologists (American Board of Anesthesiology);
~~(22)~~(21)Texas Society of Medical Oncology (American Board of Internal Medicine);
~~(23)~~(22)Texas Society of Pathologists (American Board of Pathology);
~~(24)~~(23)Texas Society of Plastic Surgeons (American Board of Plastic Surgery);
~~(25)~~(24)Texas Society of Psychiatric Physicians (American Board of Psychiatry and Neurology); and
~~(26) Texas Thoracic Society (American Board of Thoracic Surgery);~~
~~(27)~~(25)Texas Urological Society (American Board of Urology).

REPORT OF COMMITTEE ON MEMBERSHIP

CM-M Report 2-A-19

Subject: Women in Medicine Section

Presented by: Tina J. Philip, DO, Chair

Referred to: Reference Committee on Financial and Organizational Affairs

---

Background

Among the reasons that the Texas Medical Association established sections for specific segments of the membership was to provide opportunities for participation, influence association policy, foster dialogue, and provide relevant services to meet the unique needs of section members. Each section contributes to the success and effectiveness of TMA and provides a representative forum for its members.

TMA Female Physician Membership Data

The percent of active female physician members has seen a steady increase, from 29 percent in 2013 to 31 percent in 2018. Male physician membership has decreased from 71 percent in 2013 to 68 percent in 2018. The number of female physicians in the United States has greatly increased in recent years. In 1981, females comprised only 12 percent of all physicians. Today, approximately 50 percent of medical students are female. Additionally, 40 percent of nonmembers are female physicians. Thus, the opportunity to increase membership and engagement for this key membership segment remains strong.

TMA Membership	Male	Female	Total	% Male	% Female
Physician Member	27,311	11,364	38,675	71%	29%
Resident Member	3,983	3,022	7,005	57%	43%
Total	31,294	14,386	45,680	69%	31%
TMA Membership	Male	Female	Total	% Male	% Female
Physician Nonmember	16,019	10,846	26,865	60%	40%

Discussion

No such section currently exists for women in medicine. However, in November 2016 TMA conducted a survey to better understand member and nonmember needs, and perception of and overall satisfaction with TMA and its county medical societies. TMA also retained Robin Rather, CEO, Collective Strength, to validate the results and delve into the quantitative findings by conducting in-depth physician interviews.

TMA sought to know how changes in the marketplace are affecting the attitudes of members of varied demographics and how these might affect TMA membership. The research findings pointed to six areas of focus that require TMA attention, including the need to better serve female physicians. Additionally, the research noted that female physicians have lower membership and less engagement with TMA. As a result, TMA revisited the idea of establishing Women in Medicine events and programming and made better serving women in medicine a top priority. TMA hosted special programming, events, and tables at the TMA Foundation gala, and supported the efforts of county medical societies, many of which

have strong Women in Medicine committees. TMA hopes to continue supporting these local outreach efforts.

In 2018-19, a series of three Women in Medicine events held in conjunction with TMA conferences were at capacity and had a waitlist of those who wanted to attend. During 2018 TMA Fall Conference, the focus of the Women in Medicine program was on how TMA might enhance its activities to better serve and represent female physicians. Linda Villarreal, MD, vice chair of the TMA Board of Trustees, and Robin Rather guided the conversation.

Participants reviewed current TMA and other medical society policies on nondiscrimination and made four recommendations for TMA to consider, including the creation of a women's section within TMA. Additionally, participants discussed needed programming, advocacy, and services, such as professional and leadership development; improving female representation within TMA; more point-of-entry and leadership opportunities for women; creation of implicit bias training; a campaign to address gender pay inequity; and creation of a watch dog function at TMA to identify discrimination and propose direct action.

Conclusion

The Committee on Membership believes that due to the overwhelming popularity of these "sold out" events and the recommendation from program attendees to create a Women in Medicine section, there is sufficient evidence to support the creation of such a section. The TMA Board of Trustees supports the recommendations in this report.

Recommendation 1: Establish a TMA Women in Medicine Section.

Recommendation 2: Approve the following charge to the section:

> The purpose of the Women in Medicine Section is to strengthen engagement and representation of female physicians in organized medicine through the development of relevant policy, programming, and services.

Recommendation 3: Amend Chapter 3, House of Delegates, Section 3.25, Sections, as follows:

> **3.25 Sections**
>
> **3.255 Women in Medicine Section:** The House of Delegates shall have a section named the Women in Medicine Section. Any TMA physician member may become a member of the section, and female physicians who are TMA members are members of the section automatically. The section shall have the authority to elect one voting delegate to serve in the House of Delegates. The section shall elect an alternate delegate who may serve as provided in 3.32. The section will be directed by an elected governing council and governed by operating procedures approved by the House of Delegates. The operating procedures shall provide the purposes, organization, and procedures of the Women in Medicine Section.

REPORT OF COMMITTEE ON PHYSICIAN HEALTH AND WELLNESS

CM-PHW Report 1-A-19

Subject: Policy Review and Amendment to Committee Charge

Presented by: Cheryl L. Hurd, MD, Chair

Referred to: Reference Committee on Financial and Organizational Affairs

---

The Committee on Physician Health and Wellness recently evaluated its function and programs, including the drug screen program, established in 1996.

Upon the conclusion of the evaluation, the committee moved to refine its purposes and administered programs. The recommended changes will ensure that the TMA Bylaws and TMA policy accurately reflect these purposes and programs, and will enhance the Committee on Physician Health and Wellness programs' compliance positioning. Additionally, the recommended changes will strengthen the committee's commitment to providing and advocating for prevention and educational resources to improve the wellness of medical students, resident physicians, and physicians in Texas.

The committee voted to discontinue the drug screen program, which has only 11 current participants. This change will make it necessary to repeal House of Delegates policy relating to the existence of the drug screen program.

The committee recommends deletion of the following policy:

95.014 **Drug Screening of Physicians:** The Texas Medical Association will continue to maintain a service at the state level for drug screening of physicians under contract with county medical society physician health and wellness committees, district coordinators, and hospital-based peer assistance committees.

Recommendation 1: Delete.

The committee recommends amending its charge in the TMA Bylaws as follows:

> **10.621 Committee on Physician Health and Wellness.** It shall be the duty of this committee to promote healthy lifestyles in Texas to medical students, residents, and physicians~~,~~; to provide advocacy and support for and education on physician wellness; and to promote prevention of potentially impairing conditions. ~~and to identify, strongly urge evaluation and treatment of, and review rehabilitation provided to physicians with potentially impairing conditions and impairments.~~ The committee shall be required to report its activities to the Board of Councilors. The committee shall maintain liaison with the Texas Medical Board and the Texas Physician Health Program. The committee shall be responsible also for making recommendations to the Council on Legislation in instances where there are needed changes in the laws relative to physician wellness and potentially impairing conditions. ~~The committee shall provide responsible advocacy and support, provide education on physician health and wellness topics, and promote prevention of potentially impairing conditions.~~

Recommendation 2: Amend TMA Bylaws Section 10.621.

REPORT OF THE COMMITTEE ON PHYSICIAN HEALTH AND WELLNESS

CM-PHW Report 2-A-19

Subject: Sunset Policy Review

Presented by: Cheryl L. Hurd, MD, Chair

Referred to: Reference Committee on Financial and Organizational Affairs

---

The Texas Medical Association periodically reviews House of Delegates policies in the association's Policy Compendium for relevance and appropriateness.

The Committee on Physician Health and Wellness recommends retention of the following policy:

265.019 **Physician Behavior Standards.** The Texas Medical Association encourages bylaws and policies that promote a safety culture and asserts that standards for physician behavior should not use ambiguous terms that can be used against physicians for retaliation or for economic gain. (Amended CM-PHR Rep. 5-A-09; amended CM-PPA Rep. 2-A-18).

Recommendation: Retain.

REPORT OF PATIENT-PHYSICIAN ADVOCACY COMMITTEE

CM-PPA Report 2-A-19

Subject: Sunset Policy Review

Presented by: R. Larry Marshall, MD, Chair

Referred to: Reference Committee on Financial and Organizational Affairs

---

The Texas Medical Association periodically reviews House of Delegates policies in the association's Policy Compendium for relevance and appropriateness.

The Patient-Physician Advocacy Committee recommends retention of the following policy:

245.009 **Disciplinary Investigation Reporting**. The Texas Medical Association supports the reporting of final disciplinary actions only and prohibiting health care entities from requiring physicians to report pending investigations by the Texas Medical Board, and supports legislation to prohibit such reporting (Res. 102-A-99; amended BOC Rep. 6-A-09).

Recommendation: Retain.

REPORT OF COUNCIL ON PRACTICE MANAGEMENT SERVICES

CPMS Report 1-A-19

Subject: Patient-Centered Medical Responsibilities, Resolution 101-A-18

Presented by: D. Allen Schultz, MD, Chair

Referred to: Reference Committee on Financial and Organizational Affairs

---

Resolution 101-A-18, introduced by the Webb-Zapata-Jim Hogg County Medical Society, was referred to the Council on Practice Management Services, Ad Hoc Committee on Health Information Technology, and Division of Public Affairs. It addresses the promotion of patients accessing their own health records as part of a medical record checkup day, especially as related to disaster preparedness.

The resolution recommended that the Texas Medical Association (1) encourage appropriate organizations, e.g., disaster preparedness agencies, utility companies, and county health departments, to educate Texans on the importance of having access to or possession of an accurate summary of their medical record whenever and wherever it is needed; and (2) support a legislative proclamation that designates a Texans Medical Record Checkup Day at the beginning of hurricane and tornado season to encourage Texans to have access to or possession of an accurate summary of their medical record should it be needed.

Status

Testimony at the reference committee indicated concerns regarding the implementation and need to tighten up the language of the resolution. The intent of the resolution was not to overburden practices with a rush of patients seeking a copy of their medical record, but rather to educate patients on the importance of having a care summary that includes up-to-date:

- Demographics,
- Allergies and medications,
- Immunizations,
- Medical problems,
- Recent hospitalizations and relevant lab results,
- Primary care/specialty physicians, and
- Other key information needed for care such as special medical equipment or supplies.

If a patient is displaced and needs care or medications replaced, having a medical record summary is immensely helpful to physicians and other care providers. Legislative action could focus on hurricane preparedness and an annual proclamation day including activities that patients should take in preparing for a natural disaster including making sure that individuals have a summary of their medical record.

Implementation

A partial medical record summary, in most cases, can be accessed through the patient's online portal, which is typically available with physicians using an electronic health record (EHR). A medical record checkup campaign, similar to TMA's Be Wise – Immunize and Walk With a Doc outreach initiatives, could be developed that educates patients on how to access and download their medical record summary. The Ad Hoc Committee on HIT compiled ideas for implementation that are listed in the attachment. Patients having a copy or a summary of their medical record is helpful in any situation, but especially during times of disaster.

Recommendation: That the house adopt the following revised Resolution 101-A-18:

RESOLVED, That the Texas Medical Association support a medical record checkup campaign encouraging individuals to ensure they have an up-to-date medical record summary in the month of May that is accessible in a disaster; and be it further

RESOLVED, That the Texas Medical Association support a legislative proclamation each May encouraging individuals to have access to or possess an accurate summary of their medical record in the event of a disaster.

Attachment

PATIENT-CENTERED MEDICAL RESPONSIBILITIES

A Medical Record Checkup campaign could be modeled after existing TMA public health campaigns such as Be Wise – Immunize and Walk With a Doc.

Audience: Individuals of all ages.

Support: Support could be sought from numerous entities such as:

- Disaster preparedness agencies,
- State and local health departments,
- Local health coalitions,
- Educational institutions at all levels,
- Health systems and medical schools, and
- Other nonprofits expressing interest in wellness education.

Events: Designed to educate patients on how to download information from their patient portal. These can be hosted by local nonprofits expressing an interest in disaster preparedness activities.

Creatives:

- Flyers that can be repurposed with practice-specific instructions for accessing the patient portal,
- Patient-facing webpage urging patients to access their portal and download their medical information, and
- T-shirts for events – can be worn by organizers and given to attendees.

Slogan ideas:

- I have my medical information.
- I downloaded my medical information.
- I got my medical information. Do you have yours?
- Sharing is caring. I have my medical information.
- Power of sharing my medical information to improve my health care.
- Disaster doesn't have a schedule, so make sure your medical record is up-to-date, accessible, and available.

REPORT OF COUNCIL ON PRACTICE MANAGEMENT SERVICES

CPMS Report 3-A-19

Subject: Establish a Standing Committee on Health Information Technology

Presented by: Dean A. Schultz, MD, Chair

Referred to: Reference Committee on Financial and Organizational Affairs

---

In recognition of the rapid move towards electronic systems, at its May 2005 meeting, the TMA Board of Trustees approved establishing a health information technology task force. It has since become known as the Ad Hoc Committee on Health Information Technology (HIT). The ad hoc committee reports to the Council on Practice Management Services. The charge for the new task force was to:

- Guide the research project to determine member needs in the area of HIT,
- Determine and initiate TMA's strategies for in-office support for HIT,
- Oversee TMA's role in the development of regional health information organizations in Texas, and
- Host TMA's HIT Summit.

At the time, approximately 22 percent of Texas physicians used an electronic health record (EHR). TMA's 2018 survey of Texas physicians indicates that number has grown to 85 percent. Through the committee, TMA continues to meet the charge to provide robust resources that support and guide TMA members.

The need remains to support members in fulfilling one of the TMA's strategic goals and strategy:

TMA 2020 Goal: Practice Strength: Protect, improve, and strengthen the viability of medical practices in Texas.

Strategy C: Promote effective use of technology that supports practice efficiency, quality improvement activities, and management of population health.

Because of this need, it is recommended that the ad hoc committee be established as a standing Committee on Health Information Technology.

Now that the majority of physicians use an EHR, their needs have changed since the original charges were developed for the task force. The following revised charges are recommended for the new standing committee:

1. Promote the safe and effective use of technology that supports practice efficiency, quality care, and management of population health;
2. Monitor and influence state and federal laws, regulations, and programs impacting physician and patient use of technology;
3. Develop association policy related to health technology;
4. Collaborate with other professional organizations and governmental agencies working on health technology issues and serve as the association's voice and advocate; and
5. Oversee development of health information technology education and resources for physicians.

The Council on Practice Management Services will remain as the parent council. The committee shall be composed of nine physicians who have expertise or experience with health information technology and relevant issues. Consultants would be appointed as needed to augment the committee.

The following bylaw amendments are proposed to section 10.52, Council on Practice Management Services, to include a new section, 10.521, Committee on Health Information Technology. The TMA Board of Trustees supports the recommendations in this report.

Recommendation 1: Establish a standing Committee on Health Information Technology.

Recommendation 2: That TMA Bylaws Chapter 10, Committees, Section 10.52 be amended to include a new section for the Council on Practice Management Services, with a new subsection, 10.521, Committee on Health Information Technology to read as follows, and the remainder of the chapter be renumbered accordingly:

> **10.52 ~~Committee on Science and Public Health.~~ Council on Practice Management Services**
>
> **10.521 ~~Committee on Cancer.~~ Committee on Health Information Technology**: The purpose of this committee shall be to (1) Promote the safe and effective use of technology that supports practice efficiency, quality improvement activities, and management of population health; (2) monitor and influence state and federal laws, regulations, and programs impacting physician and patient use of technology; (3) develop association policy related to health technology; (4) collaborate with other professional organizations and governmental agencies working on health technology issues and serve as the association's voice and advocate; and (5) oversee development of health information technology education and resources for physicians.

REPORT OF COUNCIL ON SOCIOECONOMICS

CSE Report 3-A-19

Subject: Gender Disparities in Physician Compensation

Presented by: John G. Flores, MD, Chair

Referred to: Reference Conference Committee on Financial and Organizational Affairs

---

Background

In September 2018, the Board of Trustees directed the Council on Socioeconomics to look into the challenges of discrimination and gender disparities in physician compensation and present policy language to the House of Delegates at TexMed 2019. This topic also was discussed at the Women in Medicine Fall Conference luncheon, and the council received recommendations from that event.

Thirty-one percent of Texas Medical Association's physician members and 44 percent of our resident members are women. These figures track national data compiled by the American College of Physicians (ACP) showing women representing 34 percent of the active physician workforce and 46 percent of all physicians in training in 2015.

Data from a recent TMA Workforce Study, focused on Texas physicians licensed in 2015 who had received their first Texas medical license in 2013, found more newly licensed female than male physicians in one-third of the 100 counties where new physicians practiced. The data also showed women were less likely to practice in nonmetro and border counties than were men.

Comparison of New Physicians, by Gender	Female	Male
MD	45%	55%
DO	48%	52%
Metro County	46%	54%
Non-Metro County	38%	62%
Border County	39%	61%
Non-Border County	46%	54%

Increasing numbers of female physicians in the workforce represent great progress for medicine and for patients receiving care. The increasing numbers also have made gender disparities in physician experiences more pronounced and visible. This is especially evident in the area of compensation.

An ACP study published in 2018 concluded that gender inequities in physician compensation persist, with reported gender-based pay gaps of 16 to 37 percent. The study identified several factors frequently cited as causes of the compensation inequity for women physicians. These include specialty choice, years of experience, number of hours worked, choice made to balance work and family, and scarcity of mentors/senior role models. Researchers concluded that even after accounting for those factors, the disparities continue to exist. The disparities were even greater for minority female physicians.

The Council on Socioeconomics considered two additional academic studies on gender disparities in physician compensation. "Sex Differences in Physician Salary in US Public Medical Schools" concluded that among physicians with faculty appointments at 24 U.S. public medical schools, significant gender differences

in salary and faculty rank exist even after accounting for age, experience, specialty, faculty rank, and measures of research productivity and clinical revenue. "Differences in Incomes of Physicians in the U.S. by Race, and Sex: Observational Study" found substantial differences in annual income between black and white male physicians in the United States and between male and female physicians overall that persist after adjustment for several characteristics of physicians and practices, including specialty and work hours.

Several national physician organizations have conducted extensive study and policy development on the disparities in compensation between female and male physicians. The Council on Socioeconomics reviewed some of the work at ACP and the American Medical Association.

ACP has adopted an official statement affirming that physician compensation (pay; benefits; clinical and administrative support; clinical schedules; institutional responsibilities; and where appropriate, lab space and support for researchers) should be equitable; based on comparable work at each stage of physicians' professional careers in accordance with their skills, knowledge, competencies, and expertise; and not based on characteristics of personal identity, including gender. ACP also has policy encouraging organizations employing physicians to conduct routine assessments of the equity of physician compensation arrangements and to provide regular and recurring implicit bias training.

The American Medical Association adopted new policy and a plan to address the gender gap in physician compensation at its June 2018 Annual Meeting as follows:

D-65.989 Advancing Gender Equity in Medicine:
1. Our AMA will draft and disseminate a report detailing its positions and recommendations for gender equity in medicine, including clarifying principles for state and specialty societies, academic medical centers and other entities that employ physicians, to be submitted to the House for consideration at the 2019 Annual Meeting.

2. Our AMA will: (a) advocate for institutional, departmental and practice policies that promote transparency in defining the criteria for initial and subsequent physician compensation; (b) advocate for pay structures based on objective, gender-neutral objective criteria; (c) encourage a specified approach, sufficient to identify gender disparity, to oversight of compensation models, metrics, and actual total compensation for all employed physicians; and (d) advocate for training to identify and mitigate implicit bias in compensation determination for those in positions to determine salary and bonuses, with a focus on how subtle differences in the further evaluation of physicians of different genders may impede compensation and career advancement.

3. Our AMA will recommend as immediate actions to reduce gender bias: (a) elimination of the question of prior salary information from job applications for physician recruitment in academic and private practice; (b) create an awareness campaign to inform physicians about their rights under the Lilly Ledbetter Fair Pay Act and Equal Pay Act; (c) establish educational programs to help empower all genders to negotiate equitable compensation; (d) work with relevant stakeholders to host a workshop on the role of medical societies in advancing women in medicine, with co-development and broad dissemination of a report based on workshop findings; and (e) create guidance for medical schools and health care facilities for institutional transparency of compensation, and regular gender-based pay audits.

4. Our AMA will collect and analyze comprehensive demographic data and produce a study on the inclusion of women members including, but not limited to, membership, representation in the House of Delegates, reference committee makeup, and leadership positions within our AMA, including the Board of Trustees, Councils and Section governance, plenary speaker invitations, recognition awards, and grant funding, and

disseminate such findings in regular reports to the House of Delegates and making recommendations to support gender equity.

5. Our AMA will commit to *pay* equity across the organization by asking our Board of Trustees to undertake routine assessments of salaries within and across the organization, while making the necessary adjustments to ensure equal *pay* for equal work.

TMA Women in Medicine Fall Conference Luncheon

A facilitated, well-attended discussion on issues affecting women in TMA occurred during the Women in Medicine Luncheon at 2018 TMA Fall Conference. Participants adopted and shared with this council four recommendations to forward to the Board of Trustees for evaluation and consideration:

- Create a watchdog function at TMA to identify discrimination and propose direct action,
- Create a women's section within TMA,
- Create implicit bias training for both male and female TMA members, and
- Create an education campaign designed to unify TMA around improving conditions for women.

Summary

Thirty-one percent of TMA physician members and 44 percent of our resident members are women. The American Medical Association reports that over the past 10 years, the total number of female physicians has grown by 43 percent.

Increasing numbers of women physicians in the workforce represent great progress in medicine and have raised awareness of gender disparities in physician experiences. Studies conducted by several physician-led organizations have identified gender disparity in physician compensation (including pay; benefits; clinical and administrative support; clinical schedules; institutional responsibilities; and where appropriate, lab space and support for researchers) to be especially evident and in need of addressing.

The council reviewed recent academic studies on gender disparities in physician compensation and policy work by national physician-led organizations. The council also considered recommendations from the Women in Medicine Luncheon held during 2018 TMA Fall Conference. Because of liability implications expressed by the TMA Office of General Council, the council voted not to forward a recommendation to create a watchdog function at the TMA.

Recommendation 1: The council recommends adopting new Texas Medical Association policy opposing discrimination in physician compensation:

> **Discrimination in Physician Compensation.** The Texas Medical Association (1) affirms that physician compensation should be based on merit; equitable; transparent; and based on comparable work at each stage of physicians' careers in accordance with their skills, knowledge, competencies, and expertise; and (2) opposes discrimination in compensation on the basis of gender, age, race, ethnicity, gender identity, sexual orientation, disability or religion; and (3) opposes discrimination in compensation based on national origin or geographic location of medical schools.

Recommendation 2: That the Texas Delegation to the AMA closely monitor and report back on the recommendations for improving gender equity in medicine (including principles for state and specialty societies, academic medical centers, and other entities that employ physicians) that will be presented at the AMA Annual Meeting in June 2019.

Recommendation 3: That the Board of Trustees appoint a special task force of representatives from the Committee on Membership, Council on Health Service Organizations, Council on Medical Education Committee on Continuing Education, and Board of Councilors, with input from the TMA Office of the General Counsel and the TMA Division of Communications, to develop and/or recommend (1) policy; (2) advocacy options; and (3) communication strategies stemming from the recommendations adopted at the Women in Medicine Luncheon to:

1. Create a Women's Section within TMA,
2. Create implicit bias training for both male and female TMA members, and
3. Create an education campaign designed to unify TMA around improving conditions for women.

Recommendation 4: That TMA policy containing references to "sex" or "gender" reflect the proper usage of the words. The *AMA Journal of Ethics* suggests "sex" be used when referencing the biological differences between males and females and "gender" be used when referencing the complex psychosocial self-perceptions, attitudes, and expectations people have about members of both sexes.

Sources:

1. Butkus R, et al. Achieving Gender Equity in Physician Compensation and Career Advancement: A Position Paper of the American College of Physicians. *Ann Intern Med*. 2018. https://annals.org/aim/fullarticle/2678630.
2. Jena, AB; Andrew, R; Olseski, BS; Bluementhal, DM. Sex Differences in Physician Salary in US Public Medical Schools. *JAMA Intern Med.* 2016,176(9):1294-1304. https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2532788.
3. Ly, DP; Seabury, SA; Jena, AB; and Newhouse, RL. Differences in incomes of physicians in the United States by race and sex: observational study. *BMJ*. 2016; 353; I2923 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4897176/.
4. Tseng, J. Sex, Gender, and Why the Differences Matter. *Virtual Mentor.* 2008;10(7):427-428. doi: 10.1001/virtualmentor.2008.10.7.fred1-0807. https://journalofethics.ama-assn.org/sites/journalofethics.ama-assn.org/files/2018-06/fred1-0807.pdf.

REPORT OF COUNCIL ON SOCIOECONOMICS

CSE Report 4-A-19

Subject: Establishing the Standing Committee on Medicaid, CHIP, and the Uninsured

Presented by: John G. Flores, MD, Chair

Referred to: Reference Committee on Financial and Organizational Affairs

---

Background

In 1999, the Council on Socioeconomics and the Council on Legislation jointly appointed an Ad Hoc Committee on Medicaid and Access to Care to develop TMA policy recommendations on Medicaid, the Children's Health Insurance Program (CHIP), and the uninsured population. This ad hoc committee was given the charge to:

- Identify and develop TMA regulatory and legislative policy relating to Medicaid, CHIP, and the uninsured, including efforts to reduce the administrative complexity or "hassle factor."
- Monitor and respond to regulatory and legislative issues pertaining to these programs as well as issues pertaining to safety net providers and systems.
- Coordinate and collaborate with appropriate state agency officials to ensure the efficient and sensible implementation of legislation relating to Medicaid, CHIP, and uninsured and to develop TMA positions and/or policy as appropriate.
- Monitor the impact of legislative and budget decisions on the Medicaid physician network, patient access to services, and quality of care.
- Collaborate, as appropriate, with provider associations, consumer groups, Medicaid/CHIP managed care plans, and external research organizations to improve Medicaid and other publicly-financed mhealth care programs.
- Assist the association in efforts to promote the economic value of Medicaid and CHIP to employers, local governmental officials, state policy makers, and the public.
- Collaborate with county medical societies to track and assess innovative health coverage options.
- In 2010, the councils affirmed that the unique policy and financing issues associated with these
- programs are ever evolving and that the ad hoc committee should continue its work. They renamed it the select committee on Medicaid, CHIP, and the Uninsured. Over the years, the select committee has successfully developed strong TMA policy, identified legislative priorities, and worked closely with state agencies and outside stakeholder groups to implement new program initiatives.

In October 2018, the Board of Trustees directed all councils with ad hoc committees under their purview to study and consider establishing them as standing committees or amending the council's charge to incorporate the duties of the ad hoc committee. In response to this directive, the Council on Socioeconomics received and discussed a draft report from the select committee on Medicaid, CHIP, and the Uninsured during the 2019Winter Conference. The report included a recommendation that its status be changed to standing committee. Ryan Van Ramshorst, MD, outgoing chair of the select committee, verbally informed the council that the committee had since voted to rescind that recommendation and preferred retaining its ad hoc status. Select committee members were concerned about bylaws language limiting service tenure and the number of members for standing committees, as well as the restriction against serving simultaneously on other boards, councils, or standing committees. TMA Bylaws provide:

TMA Bylaws 10.22 Ad Hoc Committees

Ad hoc committees for specific tasks are encouraged at all association levels. These committees shall consist of as many members as the president, appointing board, council, or standing committee deem necessary. The tenure of an ad hoc committee shall be for a limited period, normally not to exceed one year.

TMA Bylaws 10.21 Standing Committees

10.212 Membership

a. Number of members. There shall be nine members of each standing committee, with the exception that, according to Section 10.211, the House of Delegates, acting upon recommendation of the Board of Trustees, may specify a greater or lesser number of members for certain committees.
b. Term and tenure. Except as provided in this subsection, the term of service shall be for three years, and the terms shall be staggered. Tenure of service shall not exceed two terms; serving as much as two years shall be considered a full term.
c. Appointment; vacancies. At the time the president assumes office, he or she shall make committee member appointments, except for Interspecialty Society Committee members, who are selected by the specialty society they represent. Interim vacancies shall be filled by presidential appointment.
d. Attendance. If any member of a standing committee fails to attend two consecutive scheduled meetings, the position shall be declared vacant.
e. Dual service. No committee member shall serve simultaneously as a member of another association board, council, or standing committee. Committee members may serve as delegates or alternate delegates to the American Medical Association.

Summary

The select committee on Medicaid, CHIP, and the Uninsured has been in ad hoc status for twenty years. TMA Bylaws specify the tenure of ad hoc committees should be for a limited time, normally not to exceed one year. The focus of the select committee's work remains a very high priority for the association. There is an ongoing need for a policymaking body to: develop and maintain expertise in Medicaid and indigent care policy, financing, and operations; develop TMA policy and advocacy initiatives for improving care for low- income populations; track state and federal initiatives related to these issues; and collaborate closely with state agencies on regulatory efforts.

The specific purpose of the Committee on Medicaid, CHIP, and the Uninsured shall be to research and formulate TMA policy on Medicaid, CHIP, and indigent care; track regulatory initiatives related to these programs; research and develop legislative recommendations to improve patient care and service delivery for recipients of Medicaid and CHIP services and for the uninsured.

Specific programs of the Committee on Medicaid, CHIP, and the Uninsured shall include efforts to: improve patient outcomes and quality; sensibly constrain Medicaid costs; reduce the administrative complexity for physicians and patients; track the impact of legislative and budget decisions on the Medicaid physician network, patient access to services, and quality of care; develop initiatives to help physician practices successfully implement Medicaid value-based payment initiatives/alternative payment models; coordinate with TMA policy making councils and committees with policy interests that intersect with Medicaid.

Specific expected results of activities of the Committee on Medicaid, CHIP, and the Uninsured shall include: constructive and regular engagement with the Health and Human Services Commission on TMA policy objectives to strengthen and simplify Medicaid, ensure pragmatic, evidence-informed approaches towards delivery system reform; continuation of TMA efforts to ameliorate or eliminate undue Medicaid and CHIP programmatic red tape hassles; development of TMA policy regarding Medicaid, CHIP, and

the uninsured; and development of TMA resources to help Medicaid participating physicians implement value-based payment initiatives.

The Council on Socioeconomics recommends membership of the Committee on Medicaid, CHIP, and the Uninsured should include representatives from state specialty societies, county medical societies, TMA policy components with interest in Medicaid, and affiliated organizations, such as the Border Health Caucus and the Texas Medical Group Management Association. Members shall be drawn from all regions of the state, represent diverse practice backgrounds, and include physicians not participating in the Medicaid program. The number of members should be 15 members. The TMA Board of Trustees supports the recommendations in this report.

Recommendation 1: That the select committee on Medicaid, CHIP, and the Uninsured be made a standing committee called the Committee on Medicaid, CHIP, and the Uninsured, reporting to the Council on Socioeconomics.

Recommendation 2: That the number of members of the committee be set at 15 to allow broad representation to address the programs and activities of the committee.

Recommendation 3: That TMA Bylaws Chapter 10, Committees, Section 10.53 be amended to include a new subsection, 10.531, Committee on Medicaid, CHIP, and the Uninsured to read as follows, and to renumber the remainder of the chapter accordingly:

> 10.531 Committee on Medicaid, CHIP, and the Uninsured**.** The committee shall: (1) research and formulate TMA policy on Medicaid, CHIP, and indigent care; (2) track regulatory initiatives related to these programs; and (3) research and develop legislative recommendations to improve patient care and service delivery for recipients of Medicaid and CHIP services and for the uninsured.

REPORT OF COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSPH Report 6-A-19

Subject: Task Force on Behavioral Health

Presented by: Alice Gong, MD, Chair

Referred to: Reference Committee on Financial and Organizational Affairs

---

The Council on Science and Public Health conducted a sunset review of the Task Force on Behavioral Health as directed by the Board of Trustees.

The Task force on Behavioral Health was established by the council in 2014 and charged with guiding TMA's activities on behavioral health and substance use disorder legislation. The Task force was also directed to review and make recommendations on Texas Medical Association's mental/behavioral health policies. Les Secrest, MD, was appointed as chair and other appointments were made in consultation with the council. Membership on the Task force on Behavioral health is diverse and includes representation of multiple specialty areas.

The task force has met regularly at TMA conferences and has completed reviews and made recommendations on TMA policies related to behavioral health. It has prepared two House of Delegates reports on substance use and mental health: CSPH Report 1-A-15, Addressing Prescription Drug Abuse and Drug Overdoses; and CSPH report 7-A-18, Evidence-based Management of Substance Use Disorders; the recommendations in each report were adopted. The task force prepared a report on adverse childhood events, which will be considered by the House at TexMed 2019 (CSPH Report 4-A-19, Early Childhood Adversity).

Most recently, the task force has been a consultant on TMA's behavioral health care and policy development for pregnant and postpartum women and also conducted a CME program on adverse childhood experiences at TMA's 2017 Fall Conference; *Adversity and Toxic Stress, what does it mean for your patients?* The task force has also convened several meetings with statewide stakeholders in behavioral health to identify common concerns on behavioral health care.

Discussion and Recommendations

Over several sessions, the Texas state legislature has dedicated significant state resources in order to better understand and develop effective measures to address mental illness and substance use disorders. Mental illness and addiction impair individual functioning and typically at great cost to individuals, families, and the community. The task force has actively monitored legislative proposals to ensure that physician expertise on behavioral health is informing legislative decision making. The council strongly encourages that TMA continue its proactive and measured approach in studying and advocating on the physician's role in caring for persons with mental illness or addiction.

The council believes the council's charge should be amended to clearly identify behavioral health as part of its charge. The council will also recommend to each committee that reports to the council that they have access to consultation and support from physicians with expertise on behavioral health issues. The TMA Board of Trustees supports the recommendations in this report. Therefore, the council recommends that:

Recommendation 1: The Task Force on Behavioral Health be designated a subcommittee of the Council on Science and Public Health, renaming the task force as the Subcommittee on Behavioral Health.

Recommendation 2: Amend the charge of the council in the TMA Bylaws Section 9.808 as follows:

> The purposes of this council shall be to (1) advance the scientific basis of medical practice; (2) anticipate high-priority public health, behavioral health, and medical science issues and develop policy on these issues; (3) advance the association as a leader in medical science and advocacy in public and behavioral health; (4) provide physicians with evidence-based public health and scientific information; and (5) communicate association policy and expertise on public health, behavioral health, and medical science.

REPORT OF TEXAS DELEGATION TO THE AMA

TEXDEL Report 3-A-19

Subject: Texas Delegation Operating Procedures Changes

Presented by: David N. Henkes, MD, Chair

Referred to: Reference Committee on Financial and Organizational Affairs

---

Changes to the Operating Procedures of the Texas Delegation's Policy and Procedures Manual require approval from the House of Delegates.

Section 5.3 addresses the evaluation of candidacy for the reelection of each delegate based upon certain criteria. One of the criteria focuses on any physician who is past the age of 75 at the time of reelection. The delegation views this policy as age discrimination and recommends amending the policy by removing the language.

The delegation recommends the following amendment to its operating procedures:

5.0 Delegate Review Committee

5.3 The committee shall evaluate the candidacy for reelection of each delegate who has (1) served six (6) terms, or (2) ~~who will be past the age of 75 at the time of reelection, or~~ ~~(~~3~~)~~ who, in the judgment of the committee, is substantially retired from his or her activities in the profession of medicine, whether that be clinical practice, teaching, or administration.

Recommendation: Approve amendment to Section 5.3 of the Texas Delegation's Operating Procedures.

TEXAS MEDICAL ASSOCATION HOUSE OF DELEGATES

Resolution 101
A-19

Subject: Saturday-Sunday Meeting Schedule for the Texas Medical Association

Introduced by: Lone Star Caucus

Referred to: Reference Committee on Financial and Organizational Affairs

---

Whereas, the House of Delegates is the policymaking arm of the Texas Medical Association; and

Whereas, the Texas Medical Association has nearly 53,000 members; and

Whereas, the widest possible representation is desirable; and

Whereas, the participation at reference committees on Fridays is significantly less than the participation in the House of Delegates on Saturdays; and

Whereas, participation in the House of Delegates requires a significant commitment out of the office, especially for younger physicians; and

Whereas, the change to a Saturday and Sunday schedule for the House of Delegates has not been debated in several years; and

Whereas, plans are made years in advance for the TexMed meetings; therefore be it

RESOLVED, That all meetings of the Texas Medical Association be moved to a Saturday-Sunday format from the current Friday-Saturday format; and be it further

RESOLVED, That this resolution be referred to the Board of Trustees to study the feasibility and economic impact on physicians and the association and report back to the House of Delegates in 2020.

Related TMA Policy:
None.

Related AMA Policy:
None.

TEXAS MEDICAL ASSOCATION HOUSE OF DELEGATES

Resolution 102
A-19

Subject: Written Testimony at TMA Reference Committees

Introduced by: Lone Star Caucus

Referred to: Reference Committee on Financial and Organizational Affairs

---

Whereas, The House of Delegates of the Texas Medical Association at its annual meeting refers to the reference committees on Financial and Organizational Affairs, Science and Public Health, Medical Education and Health Care Quality, and Socioeconomics all resolutions submitted to the House of Delegates; and

Whereas, The House of Delegates refers to the reference committees all recommendations from the Texas Medical Association's various committees, councils, and boards; and

Whereas, Reference committees provide an opportunity for all members of the Texas Medical Association to testify on, suggest changes to, and speak in favor or not in favor of any resolutions or recommendations by appearing in person; and

Whereas, Reference committees hear all the comments on each resolution and recommendation before making recommendations on each of its assigned items to the House of Delegates; and

Whereas, The membership of the Texas Medical Association is nearly 53,000 members in 2019; and

Whereas, The number of members attending the annual meaning of the Texas Medical Association may be less than 5 percent of its total membership; and

Whereas, All four reference committees are meeting at the same time, making it difficult for a member to speak at more than one or two reference committees, even though late testimony is allowed; and

Whereas, The *Handbook for Delegates* contains all the resolutions and recommendations and is published early enough for all members of the Texas Medical Association to know what items each of the four reference committees will address; therefore be it

RESOLVED, That the reference committees may receive written testimony prior to the meeting of the House of Delegates for resolutions and recommendations assigned to the reference committees from any member of the Texas Medical Association in a format to be determined by the speaker of the House of Delegates; and be it further

RESOLVED, That written testimony received on resolutions and recommendations before the reference committee should be considered carefully by the reference committee along with in-person testimony prior to the formation of its recommendations to the House of Delegates.

Related TMA Policy:
Written comments are encouraged after members have provided verbal testimony at reference committee hearings.

Related AMA Policy:
The AMA is conducting a pilot use of online member forums whereby testimony is accepted online from AMA members in advance of the HOD meeting. Following verbal testimony at a reference committee hearing, the wording for alternative language or a proposed substitute resolution also should be submitted in writing to reference committee staff, but not in any special format. Handwritten comments are acceptable. Other written material that accompanies the testimony may also be presented to the reference committee staff for discussion at the committee's executive session.

TEXAS MEDICAL ASSOCATION HOUSE OF DELEGATES

Resolution 103
A-19

Subject: Gratitude for Continuing Medical Education Courses

Introduced by: Lone Star Caucus

Referred to: Reference Committee on Financial and Organizational Affairs

---

Whereas, The Texas Medical Association offers many benefits to its membership; and

Whereas, The Texas Medical Association has become the largest state medical society in the United States in part because of its service to its membership in the many areas of medicine; and

Whereas, The Texas Medical Association has offered excellent educational opportunities to its membership in the past; and

Whereas, Recently, the Texas Medical Association's Knowledge Center began offering an educational opportunity to its membership at no cost, compliments of the Texas Medical Association Insurance Trust; and

Whereas, This educational opportunity consists of hundreds of hours of continuing medical education courses, including 54 courses on ethics, 14 on physician health, 42 on practice operations, and 29 on risk management; therefore be it

RESOLVED, That the Texas Medical Association House of Delegates express its gratitude for the continuing medical education courses offered to TMA members courtesy of the TMA Insurance Trust.

Related TMA Policy:
None.

Related AMA Policy:
None.

TEXAS MEDICAL ASSOCATION HOUSE OF DELEGATES

Resolution 104
A-19

Subject: Alternate Delegates May Address the House of Delegates

Introduced by: Lone Star Caucus

Referred to: Reference Committee on Financial and Organizational Affairs

---

Whereas, Alternate delegates may be new members to the House of Delegates; and

Whereas, New members receive an orientation on the workings of the House of Delegates; and

Whereas, Alternate delegates can address reference committees on any pending subject before the reference committees, as can any member of the Texas Medical Association; and

Whereas, It often takes several sessions to become familiar with the workings of the House of Delegates; and

Whereas, Addressing the House of Delegates can be a daunting experience to some members of the Texas Medical Association; and

Whereas, Delegates usually address the House of Delegates to help further discussion and debate on items before the house; therefore be it

RESOLVED, That alternate delegates to the Texas Medical Association House of Delegates be allowed to address the house on matters pending before the House of Delegates without being credentialed as a delegates and that under these circumstances may suggest but cannot make any changes to the content of any resolution or recommendation being considered by the House of Delegates.

Related TMA Policy:
Nonseated alternate delegates and vice councilors do not have the privilege to speak on the floor of the House of Delegates. (Texas Medical Association House of Delegates Guide)

12.443 Credentials: Credentials certifying their right to membership in the House of Delegates shall be issued to all delegates. An alternate delegate may serve in the place of a delegate by presenting verification to the Credentials Committee as provided in 3.32 of the TMA Bylaws.

Related AMA Policy:
2.8.5 Rights and Privileges: An alternate delegate may substitute for a delegate, on the floor of the House of Delegates, at the request of the delegate by complying with the procedures established by the Committee on Rules and Credentials. While substituting for a delegate, the alternate delegate may speak and debate on the floor of the House, offer an amendment to a pending matter, make motions, and vote.

2.8.6 Status: The alternate delegate is not a “member of the House of Delegates” as that term is used in these Bylaws. Accordingly, an alternate delegate may not introduce resolutions into the House of Delegates, nor vote in any election conducted by the House of Delegates. An alternate delegate is not eligible for nomination or election as Speaker or Vice Speaker of the House of Delegates. The alternate delegate must immediately relinquish his or her position on the floor of the House of Delegates upon the request of the delegate for whom the alternate delegate is substituting.

TEXAS MEDICAL ASSOCATION HOUSE OF DELEGATES

Resolution 105
A-19

Subject: Pharmacies Practicing Medicine

Introduced by: Harris County Medical Society

Referred to: Reference Committee on Financial and Organizational Affairs

---

Whereas, Certain large pharmacy chains are developing policies that require physicians to provide diagnostic information about a patient before they will fill a prescription; and

Whereas, Certain pharmacies are unilaterally making changes to physicians' prescriptions, including dosage and amounts, without first confirming with the prescribing physician; and

Whereas, Pharmacists who have a concern about a prescription they are being asked to fill need only contact the prescribing physician's office to get their questions answered; and

Whereas, The Texas Medical Board considers setting medication dosage and amounts as the practice of medicine; and

Whereas, The practice of medicine is reserved to physicians in order to protect the health and safety of patients; therefore be it

RESOLVED, That the Texas Medical Association work with the state legislature to pass a law declaring that pharmacies in Texas may not require physicians to disclose any patient medical records information beyond basic diagnoses as a condition for filling a prescription; and be it further

RESOLVED, That TMA work with the Texas Medical Board and the Texas State Board of Pharmacy to prevent pharmacists from engaging in conduct that is defined as "the practice of medicine," including, but not limited to, alteration of dosage, duration, frequency, or quantity of a prescription while in the execution of their duties; and be it further

RESOLVED, That pharmacists may not rely on corporate policy as justification to usurp the orders of a physician lawfully acting under the Texas Medical Practice Act.

Related TMA Policy:
30.007 Prescribing by Pharmacists: The Texas Medical Association reaffirms is position in opposition to independent prescribing by pharmacists. TMA affirms its readiness to work with the Texas Pharmaceutical Association and the American Medical Association to review prescription drugs for appropriate transfers to "over the counter" status (Board of Councilors, p 44, A-93; reaffirmed BOC Rep. 5-A-10).

95.012 Drug Antisubstitution Laws and Generic Prescriptions: Compulsory generic prescribing should be opposed because generic equivalency in drugs does not necessarily mean therapeutic equivalence. The patient's right to receive the drugs and medications best suited for his or her individual needs should be protected by preserving the current system of brand name prescribing. Legislation and regulations which prohibit generic drug substitution without prior agreement between the pharmacist and the physician should be supported (Council on Socioeconomics, p 177, I-94; reaffirmed CSE Rep. 3-A-04; reaffirmed CSE Rep. 2-A-14).

95.018 Physician Pharmacy Interactions: Pharmacy employees who are in contact by phone with physician offices should be properly trained in the nomenclature of prescription medications and protocols of handling and confirming physician prescriptions in order to minimize the risk of error in making these products available to patients (Amended Res. 29W, p 161A, A-98; reaffirmed CSA Rep. 4-A-08; reaffirmed CSPH Rep 5-A-18).

TEXAS MEDICAL ASSOCATION HOUSE OF DELEGATES

Resolution 106
A-19

Subject: Establish a Coalition of Medical Societies to Protect Competition and Sustainability in the Health Insurance Marketplace

Introduced by: Harris County Medical Society

Referred to: Reference Committee on Financial and Organizational Affairs

---

Whereas, Evidence suggests growing support among national politicians and the general public for expansive health care reform. It is feasible that national legislation creating a universal Medicare or single-payer system will be proposed in the near future; and

Whereas, Such legislation would further damage a private health insurance marketplace rendered significantly less stable and competitive since the passing of the Affordable Care Act and the implementation of onerous federal regulations that have not been proven to improve patient outcomes; and

Whereas, In the absence of a competitive health insurance marketplace, the integrity of the patient-physician relationship is undermined and the patient-centered practice of medicine becomes secondary to the whims of government; and

Whereas, The creation of a national single-payer system, or one that further undermines a competitive health insurance marketplace, would directly conflict with the principles of responsible and incremental health care reform as described in Texas Medical Association Policy 120.010; and

Whereas, The need for more robust political advocacy and public education is evidenced by the growing popularity of policies that are in direct conflict with those supported by past TMA and American Medical Association resolutions; and

Whereas, The political advocacy efforts of separate medical societies are inherently fractured and less effective than joint ones, and a clear and consolidated message from the medical community can better advocate for favorable health care policies, the medical community, and the well-being of our patients; therefore be it

RESOLVED, That the Texas Medical Association, in collaboration with other state and specialty medical societies, create and provide support for a permanent coalition that, through political advocacy and public outreach, advocates for incremental health care reform that preserves patient choice, physician autonomy, competition in the health insurance marketplace, and sustainability within the health care system; and be it further

RESOLVED, That TMA, in collaboration with other medical societies, search out and provide support for a distinct entity whose purpose is to study the current health care system and compare it to other systems as a means to develop and support model state and national legislation that is responsible, incremental, and sustainable; and be it further

RESOLVED, That TMA, in collaboration with other medical societies, search out and provide support for a distinct entity whose function is to educate the public on issues pertinent to potential health care

legislation. This entity will promote greater public awareness of the benefits of competition in health care and the health insurance marketplace; and be it further

RESOLVED, That the Texas Delegation to the American Medical Association carry this resolution to the AMA House of Delegates.

Related TMA Policy:
60.004 Freedom of Choice: Free and open competition of physicians and free choice of physicians for the primary benefit of patients is a goal which public and private policy should support. Hospital governing bodies should (1) seek the advice and expert opinion of their hospital medical staffs in making policy decisions regarding medical coverage and privileges; and (2) honor the commitments expressed in adopted and approved medical staff bylaws when considering action to limit or restrict the patient's free choice of physicians and the right of qualified physicians to diagnose and treat patients who seek their services utilizing all hospital facilities and equipment for which they are qualified.

A variety of health care delivery plans offers to patients the greatest freedom of choice and the best opportunity for further improvements in health care.

A patient should be free to select the physician, insurance company, or type of policies which he or she prefers. The physician, in turn, except in an emergency, is free to select the patients whom he or she will serve, to accept or not accept reimbursement from a third party, and to participate or not participate in any type of legal insurance contract.

Multiple systems of medical care delivery, such as fee-for-service and prepaid, and multiple kinds of insurance contracts (i.e., indemnity, service, or participating physician) are acceptable arrangements between physicians and third parties for delivery of and payment for medical services (Council on Socioeconomics, p 178, I-94; reaffirmed CSE Rep. 3-A-04; reaffirmed CSE Rep. 2-A-14).

110.003 Private Individualized Medical Care: The Texas Medical Association reaffirms its position that private, individualized medical care and free enterprise insurance mechanisms which involve a specific degree of direct patient responsibility within and allow pluralistic, free choice options offer the highest quality of medical care at the lowest possible cost (CSE, p 144, A-93; reaffirmed CSE Rep. 6-A-03; reaffirmed CSE Rep. 1-A-13).

110.009 Health Care Coverage: The Texas Medical Association supports tax law reforms which (1) increase the tax-preferenced insurance and spending choices available to patients; (2) encourage individuals to buy insurance and set aside funds for medical needs; (3) provide subsidies to those who are most in need; and (4) encourage personal responsibility and participation of patients in the financing and benefit design decisions that ultimately determine their health benefit coverage. TMA supports efforts to develop viable policies that can improve the provision of care for the uninsured population. If federal standards are relaxed or revised to allow risk rating and coverage exclusions for preexisting conditions, the State of Texas should act immediately to create a new high-risk health insurance pool to provide insurance coverage for individuals who cannot otherwise secure it (CSE Rep. 6-I-01; amended CSE Rep. 8-A-11; amended CSE Rep. 5-A-17).

120.001 Health Care Reform: The Texas Medical Association weighs heavily in its evaluation of health care reform proposals the following concepts:

Make health insurance benefits part of the gross wage of employees and allow tax credits for premiums on individual tax returns so that employees, rather than employers, bear the cost of waste and reap the benefits of prudence;

Allow individuals who are otherwise uninsured the same tax credit incentive as the above to purchase health insurance;

Make tax credits refundable for low income families;

Allow insurers to sell no-frills, catastrophic group insurance not subject to state-mandated benefits, premium taxes, risk pool assessments, and other costly regulations;

Allow each employee or individual to choose a health insurance policy tailored to individual and family needs;
Limit favorable tax treatment for health insurance to catastrophic policies;

Allow each employee to choose between wages and health insurance coverage so that employees who choose less expensive coverage will have more take home pay;

Establish tax credits for deposits to individual Health Savings Accounts from which individuals would use their own money to pay small medical expenses without penalty;

Allow private insurers to repackage Medicare benefits and establish diverse policies tailored to the different needs of Medicare beneficiaries;

Give the elderly and future elderly and their employers tax incentives to self insure through Health Savings Accounts;

Allow Medicare patients to negotiate outside Medicare for more fair prices to both patient and physician;

Allow Medicaid patients to draw on an account, negotiate prices, and add their own money, if necessary, in order to purchase certain types of medical services--particularly prenatal care;

Encourage hospitals to negotiate a preadmission package price with patients, particularly on elective cases, and to make their bills understandable;

Allow patients to avoid the costly effects of the tort system through voluntary contract;

Establish and support not-for-profit endowed family health clinics in local communities to care for the office visits of the poor, with all physicians volunteering a portion of their time to support these clinics.

Health System Reform Quality Improvement Organization: Under health system reform, the quality improvement organization should be retained as an essential, local base for patient-focused quality assurance activities, and the scope of QIO review should be expanded beyond Medicare to include patients treated under private sector health plans.

Health System Reform Establishment of National Health Board: The Texas Medical Association opposes establishment of a national health board under health system reform and supports continued oversight of health services through state and local agencies.

Health System Reform and Fee for Service Options: Under any health system reform plan, managed care organizations should be required to offer an out-of-network benefit. The Texas Medical Association opposes cuts in the Medicare and Medicaid programs to finance any health system reform plans. In addition, TMA voted to take appropriate actions to assure that rural physicians are not excluded from physician networks.

Health System Reform Public Health Funding: The Texas Medical Association endorses inclusion of public health funding and plans to meet public health needs in any health system reform proposals.

Health System Reform: The emphasis of Health Access America should be an incremental approach based on a defined set of AMA priorities. Any proposals for health system reform must address economic, demographic, and regional differences in the health care needs of the states. TMA voted to seek an incremental approach to directed-by-patient care needs and guided by a set of priorities that includes but is not limited to insurance reform, ERISA reform, tort reform, antitrust relief, opposition to Medicare and Medicaid cuts, and support for the Patient Protection Act.

Prompt Access to Benefits: Waiting periods to receive health care coverage in any insurance program in Texas should be eliminated.

Managed Care and Fee for Service: The Texas Medical Association opposes present and proposed managed health care plans that place third party business contracts and other intermediaries between the patient and the physician. TMA believes that medical care for American citizens can best be provided by reinstituting a simple fee for service contract between the patient and the physician with due respect for the patient's ability to pay, directly or through their individual insurance. In addition, TMA believes that insurance companies should be directed to offer individuals affordable, transportable, community-rated health care plans using appropriate actuarial data to provide coverage for preexisting conditions at equitable rates which ideally should cover high end or catastrophic health care costs (Council on Socioeconomics, p 150, I-92; amended CSE Rep. 3-A-04; amended CSE Rep. 3-A-14).

120.002 Health System Reform Cost Control: The Texas Medical Association emphasizes health system reform with cost control reform measures that protect the freedom of access and the quality of medical care to patients and leaves government in the subordinate position and role of taxation and funding (Res. 28Z, p 179D, A-93; reaffirmed CSE Rep. 6-A-03; reaffirmed CSE Rep. 1-A-13).

120.003 Health System Reform Managed Care: To provide a basic framework for association policies and activities in health system reform, the Texas Medical Association: (1) supports the concept of universal access to appropriate health care; (2) supports freedom of patients to select their own physicians; (3) supports meaningful professional liability reform for physicians as a key element of health system reform; (4) supports genuine relief from red-tape hassles and excessive administrative costs of health care; (5) supports freedom from unreasonable restrictions, including antitrust prohibitions, that prevent physicians from conducting peer review of quality and fees; (6) continues to support a health care system that includes a multiplicity of funding sources and payment mechanisms; (7) supports the right of a physician organization to negotiate at the federal or state level for payment of physician services, quality and utilization review, professional liability reform, and to reduce the hassle and cost of regulation; (8) continues to support sufficient autonomy for physicians to be advocates for patients and to make decisions in the best interests of their patients; (9) supports efforts to control costs in an efficient and effective manner that considers the needs of patients and allows the exercise of good medical judgment; (10) supports the funding of research and medical education in any health system reform proposal and believes that all corporate payers of health care share in the costs of graduate medical education; (11) supports quality assurance through practice parameters and outcomes research; (12) supports patient responsibility for first dollar coverage to allow patients to make individual decisions regarding their own health care spending with consideration given to patients' ability to pay.
In addition, TMA offers the following principles for managed care for adoption as AMA policy: (1) physician participation in any managed care organization he or she chooses, (2) patient freedom to select his or her own physician, (3) physician autonomy and freedom to be patient advocates (Second Supplemental BOT, p 36P-36S, A-93; amended CSE Rep. 6-A-03; reaffirmed CSE Rep. 1-A-13).

120.010 Principles for Evaluating Health System Reform: The Texas Medical Association will use the following principles as evaluation criteria in examining all national health system reform proposals. These principles are not ranked in order of importance; all are viewed as high priorities.

Promote portable and continuous health care coverage for all Americans using an affordable mix of public and private payer systems.

Promote patient safety as a top priority for reform, recognizing an effective mix of initiatives that combine evidence-based accountability standards, committed financial resources, and rewards for performance that incent and ensure patient safety.

Adopt physician-developed, evidence-based tools for use in scientifically valid quality/patient safety initiatives that incentivize the physician-led health care delivery team, and include comparative effectiveness research used only to help patient-physician relationships choose the best care for patients.

Preserve patient and physician choice and the integrity of the patient-physician relationship.

Incorporate physician-developed, evidence-based measures and preventive health and wellness initiatives into any new or expanded health benefits package as a means to promote healthier citizens.

Recognize and support the role of safety-net and public health systems in delivering essential health care services within our communities, to include essential prevention and health promotion public health services.

Support the development of a well-funded, nationwide emergency and trauma care system that provides appropriate emergency and trauma care for all Americans.

Support public policy that fosters ethical and effective end-of-life care decisions, to include requiring all Medicare patients to have an advance directive that a Medicare enrollee can discuss as part of a covered Medicare visit with a physician.

Provide sustainable financing mechanisms that ensure the aforementioned affordable mix of services, and create personal responsibility among all stakeholders for financing and appropriate utilization of the system.

Invest needed resources to expand the physician-led workforce to meet the health care needs of a growing and increasingly diverse and aging population.

Provide financial and technological support to implement physician-led, patient-centered medical homes for all Americans, including increased funding and compensation for services provided by primary care physicians and the services provided by non-primary care, specialist physicians as part of the patient-centered medical home continuum.

Through public policy enactments, require accountability and transparency among health insurers to disclose how their premium dollars are spent, eliminate preexisting condition exclusions, simplify administrative processes, and observe fair and competitive market practices.

Reform the national tort system to prevent non-meritorious lawsuits, keeping Texas reforms in place as enacted by the Texas Legislature and constitutionally affirmed by Texas voters.

Abolish the Medicare Sustainable Growth Rate annual update system and initiate a true cost of practice methodology that provides for annual updates in the Medicare Fee Schedule as determined by a credible, practice expense-based, medical economic index.

Support the implementation of an interoperable National Electronic Medical Records System, financed and implemented through federal funding.

Require payers to have a standard, transparent contract with providers that cannot be sold or leased for any other payer purposes without the express, written consent of the contracted physician.

Support efforts to make health care financing and delivery decision making more of a professionally advised function, with appropriate standard setting, payment policy, and delivery system decisions fashioned by physician-led deliberative bodies as authorized legislatively (SC-HSR Rep. 1-A-09).

145.005 Single Payer Systems: The Texas Medical Association supports the Health Access America principle stating that single payer systems are not in the best interest of the public, physicians, or the health care of the nation (Substitute Res. 28W, p 179A, A-93; reaffirmed CSE Rep. 6-A-03; reaffirmed CSE Rep. 1-A-13).

145.007 Competitive Insurance Models: A system of health care delivery free of burdensome and unnecessary government regulations is a goal which all patients and physicians should support. No national competitive health insurance model should be implemented irrevocable prior to pilot test studies which would identify and minimize problems of any new system. The Texas Department of Insurance should control the state's insurance industry and its insurance policies and programs. Health care expenditures should remain tax deductible (Council on Socioeconomics, p 177, I-94; amended CSE Rep. 1-A-10).

145.009 Individual Responsibility for Health Care: The Texas Medical Association encourages employers, employee groups, and other public policy advocates to work together to design and introduce innovative and cost-effective mechanisms to finance health insurance coverage that could be owned and selected by individuals, flexible for each individual's and family's needs, and available as part of or as an alternative to traditional employer-sponsored health plans. TMA is committed to working with business and government to preserve the private sector and to establish an insurance market that is understandable and affordable, as well as portable for individuals (Amended Res. 29X, p 161B, A-98; reaffirmed CSE Rep. 1-A-08; reaffirmed CSE Rep. 1-A-18).

145.012 Health Insurance Individual Ownership: The Texas Medical Association supports operational strategies that provide control of health care purchasing and financing to individual patients, efforts that focus on strategies that offer equal tax deductibility to persons who purchase individual policies, the use of health savings accounts with tax-deductible contributions, and consumer choice provisions as modeled by the Federal Employees Health Benefits Program and believes that these efforts include a study of the issue of individually chosen, individually purchased basic health insurance with a system of premium support for the uninsured and lower income wage earners (Amended Res. 413-A-99; amended CSE Rep. 1-A-10).

145.013 Private Healthcare System, Impact of Uninsured: The Texas Medical Association supports continued efforts to address the issue of health care for the uninsured including input from all segments of the association with an emphasis on private sector solutions (Sub. Res. 403-A-99; reaffirmed CSE Rep. 1-A-10).

190.032 Medicaid Coverage and Reform: It is the vision of the Texas Medical Association to improve the health of all Texans. Too many Texans, too many of our patients, cannot afford the health care they need. This hurts their health, the economic growth and prosperity of our state, and taxpayers all across Texas.

We currently have a tremendously cost-effective opportunity to improve access to health care for these Texans. Unfortunately, that federal offer comes in the form of expanding before reforming our Medicaid program to cover the working poor.

Medicaid provides essential health services for millions of Texans. But many parts of the current Texas Medicaid system are broken. It offers the promise of coverage without adequate funding to ensure access to care. It is fraught with exasperating, unyielding red tape. Its overzealous "fraud inspectors" are getting in the way of taking care of patients. Physicians should not accept the option of simply expanding that broken program.

On the other hand, we cannot reject the federal government's offer to help us care for the working poor of Texas. Physicians need to take this money and use it for our people, our patients.

We must look beyond the federal government's expansion solution to design a remedy that works for Texas and for Texans. The people of this state are ingenious and innovative problem-solvers. We are confident that state leaders and lawmakers with input from employers, physicians, taxpayers, and others can design a comprehensive solution that:

Draws down all available federal dollars to expand access to health care for poor Texans;

Gives Texas the flexibility to change the plan as our needs and circumstances change;

Clears away Medicaid's financial, administrative, and regulatory hurdles that are driving up costs and driving Texas physicians away from the program;

Relieves local Texas taxpayers and Texans with insurance from the unfair and unnecessary burden of paying the entire cost of caring for their uninsured neighbors;

Provides Medicaid payments directly to physicians for patient care equal to at least those of Medicare payments; and

Continues to uphold and improve due process of law for physicians in the State of Texas as it relates to the Office of Inspector General.

The Texas Medical Association calls on the American Medical Association to advocate for Medicaid payments to all physicians for patient care to be at least equal to Medicare payments (Amended BOT/COL/CSE/SC-MCU Joint Rep. 3-A-13).

Related AMA Policy:

H-165.838 Health System Reform Legislation:

1. Our American Medical Association is committed to working with Congress, the Administration, and other stakeholders to achieve enactment of health system reforms that include the following seven critical components of AMA policy:

a. Health insurance coverage for all Americans

b. Insurance market reforms that expand choice of affordable coverage and eliminate denials for pre-existing conditions or due to arbitrary caps

c. Assurance that health care decisions will remain in the hands of patients and their physicians, not insurance companies or government officials

d. Investments and incentives for quality improvement and prevention and wellness initiatives

e. Repeal of the Medicare physician payment formula that triggers steep cuts and threaten seniors' access to care

f. Implementation of medical liability reforms to reduce the cost of defensive medicine

g. Streamline and standardize insurance claims processing requirements to eliminate unnecessary costs and administrative burdens

2. Our American Medical Association advocates that elimination of denials due to pre-existing conditions is understood to include rescission of insurance coverage for reasons not related to fraudulent representation.

3. Our American Medical Association House of Delegates supports AMA leadership in their unwavering and bold efforts to promote AMA policies for health system reform in the United States.

4. Our American Medical Association supports health system reform alternatives that are consistent with AMA policies concerning pluralism, freedom of choice, freedom of practice, and universal access for patients.

5. AMA policy is that insurance coverage options offered in a health insurance exchange be self-supporting, have uniform solvency requirements; not receive special advantages from government subsidies; include payment rates established through meaningful negotiations and contracts; not require provider participation; and not restrict enrollees' access to out-of-network physicians.

6. Our AMA will actively and publicly support the inclusion in health system reform legislation the right of patients and physicians to privately contract, without penalty to patient or physician.

7. Our AMA will actively and publicly oppose the Independent Medicare Commission (or other similar construct), which would take Medicare payment policy out of the hands of Congress and place it under the control of a group of unelected individuals.

8. Our AMA will actively and publicly oppose, in accordance with AMA policy, inclusion of the following provisions in health system reform legislation:
a. Reduced payments to physicians for failing to report quality data when there is evidence that widespread operational problems still have not been corrected by the Centers for Medicare and Medicaid Services
b. Medicare payment rate cuts mandated by a commission that would create a double-jeopardy situation for physicians who are already subject to an expenditure target and potential payment reductions under the Medicare physician payment system
c. Medicare payments cuts for higher utilization with no operational mechanism to assure that the Centers for Medicare and Medicaid Services can report accurate information that is properly attributed and risk-adjusted
d. Redistributed Medicare payments among providers based on outcomes, quality, and risk-adjustment measurements that are not scientifically valid, verifiable and accurate
e. Medicare payment cuts for all physician services to partially offset bonuses from one specialty to another
f. Arbitrary restrictions on physicians who refer Medicare patients to high quality facilities in which they have an ownership interest

9. Our AMA will continue to actively engage grassroots physicians and physicians in training in collaboration with the state medical and national specialty societies to contact their Members of Congress, and that the grassroots message communicate our AMA's position based on AMA policy.

10. Our AMA will use the most effective media event or campaign to outline what physicians and patients need from health system reform.

11. AMA policy is that national health system reform must include replacing the sustainable growth rate (SGR) with a Medicare physician payment system that automatically keeps pace with the cost of running

a practice and is backed by a fair, stable funding formula, and that the AMA initiate a "call to action" with the Federation to advance this goal.

12. AMA policy is that creation of a new single payer, government-run health care system is not in the best interest of the country and must not be part of national health system reform.

13. AMA policy is that effective medical liability reform that will significantly lower health care costs by reducing defensive medicine and eliminating unnecessary litigation from the system should be part of any national health system reform.

H-165.844 Educating the American People About Health System Reform: Our AMA reaffirms support of pluralism, freedom of enterprise and strong opposition to a single payer system.

H-165.888 Evaluating Health System Reform Proposals:
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.

TEXAS MEDICAL ASSOCATION HOUSE OF DELEGATES

Resolution 107
A-19

Subject: Physician Dispensing of Prescriptions

Introduced by: Harris County Medical Society

Referred to: Reference Committee on Financial and Organizational Affairs

---

Whereas, Texas law prohibits physicians from dispensing and selling medications to patients; and

Whereas, The Texas Medical Practice Act trusts physicians to prescribe medications to patients; and

Whereas, For patients in other states, dispensing medications by physicians has proven to improve access to affordable medications; and

Whereas, Physicians are adequately licensed and regulated by the Texas Medical Board for all patient care activities and do not need additional regulatory agencies overseeing their activities; and

Whereas, Third-party intermediaries, such as pharmacy benefit managers, Medicare Part D insurers, and pharmacies have caused dramatic increases in the cost of medications for patients; therefore be it

RESOLVED, That physicians licensed by the Texas Medical Board (TMB) be allowed to prescribe, dispense, and sell prescriptions, over-the-counter medications, and medical devices to patients in Texas with regulation only by TMB.

Related TMA Policy:
95.034 Legislation to Allow Physicians to Dispense Pharmaceuticals: The Texas Medical Association supports legislation that will allow physicians to dispense and charge for dispensing pharmaceuticals other than Schedule I through V controlled substances, as defined in the Texas Health & Safety Code, Chapter 483 (2010) (Res 302-A-11).

95.041 Ensuring Patient Access to Affordable Prescription Medications: The Texas Medical Association will: (1) support programs whose purpose is to contain the rising costs of prescription drugs provided that the following criteria are satisfied: (a) physicians must have significant input into the development and maintenance of such programs; (b) such programs must encourage optimum prescribing practices and quality of care; (c) all patients must have access to medically indicated prescription drugs necessary to treat their illnesses; (d) physicians must have the freedom to prescribe the most appropriate drug(s) and method of delivery for the individual patient; and (e) such programs should promote an environment that will give pharmaceutical manufacturers the incentive for research and development of new and innovative prescription drugs; (2) study the issue of drug pricing, including whether large price increases impact patient access to critical medications; (3) support the application of greater oversight to the establishment of closed distribution systems for prescription drugs; (4) support the mandatory provision of samples of approved out-of-patent drugs upon request to generic manufacturers seeking to

perform bioequivalence assays; (5) work with interested parties to support legislation or regulatory changes that streamline and expedite the FDA approval process for generic drugs; and (6) support measures that increase price transparency for generic and brand-name prescription drugs. (Substitute Res. 405-A-16 and Res. 409-A-16).

170.008 Physician Relief from Product Class Actions: The Texas Medical Association supports federal legislation to preempt naming the treating physician as a party to product liability lawsuits when the treating physician has used an FDA approved drug or device (Res. 107-A-01; reaffirmed COL Rep. 1-A-17).

Related AMA Policy:
H-285.965 Managed Care Cost Containment Involving Prescription Drugs: (1) Physicians who participate in managed care plans should maintain awareness of plan decisions about drug selection by staying informed about pharmacy and therapeutics (P&T) committee actions and by ongoing personal review of formulary composition. P&T committee members should include independent physician representatives. Mechanisms should be established for ongoing peer review of formulary policy. Physicians who perceive inappropriate influence on formulary development from pharmaceutical industry consolidation should notify the proper regulatory authorities.

(2) Physicians should be particularly vigilant to ensure that formulary decisions adequately reflect the needs of individual patients and that individual needs are not unfairly sacrificed by decisions based on the needs of the average patient. Physicians are ethically required to advocate for additions to the formulary when they think patients would benefit materially and for exceptions to the formulary on a case-by-case basis when justified by the health care needs of particular patients. Mechanisms to appeal formulary exclusions should be established. Other cost-containment mechanisms, including prescription caps and prior authorization, should not unduly burden physicians or patients in accessing optimal drug therapy.

(3) Limits should be placed on the extent to which managed care plans use incentives or pressures to lower prescription drug costs. Financial incentives are permissible when they promote cost-effectiveness, not when they require withholding medically necessary care. Physicians must not be made to feel that they jeopardize their compensation or participation in a managed care plan if they prescribe drugs that are necessary for their patients but that may also be costly. There should be limits on the magnitude of financial incentives, incentives should be calculated according to the practices of a sizable group of physicians rather than on an individual basis, and incentives based on quality of care rather than cost of care should be used. Physician penalties for non-compliance with a managed care formulary in the form of deductions from withholds or direct charges are inappropriate and unduly coercive. Prescriptions should not be changed without physicians having a change to discuss the change with the patient.

(4) Managed care plans should develop and implement educational programs on cost-effective prescribing practices. Such initiatives are preferable to financial incentives or pressures by HMOs or hospitals, which can be ethically problematic.

(5) Patients must fully understand the methods used by their managed care plans to limit prescription drug costs. During enrollment, the plan must disclose the existence of formularies, the provisions for cases in which the physician prescribes a drug that is not included in the formulary and the incentives or other mechanisms used to encourage physicians to consider costs when prescribing drugs. In addition, plans should disclose any relationships with pharmaceutical benefit management companies or pharmaceutical companies that could influence the composition of the formulary. If physicians exhaust all avenues to secure a formulary exception for a significantly advantageous drug, they are still obligated to disclose the option of the more beneficial, more costly drug to the patient, so that the patient can decide whether to pay out-of-pocket.

(6) Research should be conducted to assess the impact of formulary constraints and other approaches to containing prescription drug costs on patient welfare.

(7) Our AMA urges pharmacists to contact the prescribing physician if a prescription written by the physician violates the managed care drug formulary under which the patient is covered, so that the physician has an opportunity to prescribe an alternative drug, which may be on the formulary.

(8) When pharmacists, insurance companies, or pharmaceutical benefit management companies communicate directly with physicians or patients regarding prescriptions, the reason for the intervention should be clearly identified as being either educational or economic in nature.

(9) Our AMA will develop model legislation which prohibits managed care entities, and other insurers, from retaliating against a physician by disciplining, or withholding otherwise allowable payment because they have prescribed drugs to patients which are not on the insurer's formulary, or have appealed a plan's denial of coverage for the prescribed drug.

(10) Our AMA urges health plans including managed care organizations to provide physicians and patients with their medication formularies through multiple media, including Internet posting.

(11) In the case where Internet posting of the formulary is not available and the formulary is changed, coverage should be maintained until a new formulary is distributed.

(12) For physicians who do not have electronic access, hard copies must be available.

H-120.991 Sample Medications: Our AMA (1) continues to support the voluntary time-honored practice of physicians providing drug samples to selected patients at no charge;
(2) reiterates that samples of prescription drug products represent valuable benefits to the patients;
(3) continues to support the availability of drug samples directly to physicians through manufacturers' representatives and other means, with appropriate safeguards to prevent diversion; and
(4) endorses sample practices that: (a) preclude the sale, trade or offer to sell or trade prescription drug samples; (b) require samples of prescription drug products to be distributed only to licensed practitioners upon written request; and (c) require manufacturers and commercial distributors of samples of prescription drug products and their representatives providing such samples to licensed practitioners to: (i) handle and store samples of prescription drug products in a manner to maintain potency and assure security; (ii) account for the distribution of prescription drug samples by maintaining records of all drug samples distributed, destroyed or returned to the manufacturer or distributor; and (iii) report significant thefts or losses of prescription drug samples.

D-120.958 Federal Roadblocks to E-Prescribing: 1. Our AMA will: work with the Centers for Medicare and Medicaid Services and states to remove or reduce barriers to electronic prescribing of both controlled substances and non-scheduled prescription drugs, including removal of the Medicaid requirement in all states that continue to mandate that physicians write, in their own hand, “brand medically necessary” or the equivalent on a paper prescription form.

2. It is AMA policy that physician Medicare or Medicaid payments not be reduced for non-adoption of e-prescribing.

3. Our AMA will work with the largest and nearly exclusive national electronic pharmacy network, all related state pharmacy regulators, and with federal and private entities to ensure universal acceptance by pharmacies of electronically transmitted prescriptions.

4. Our AMA will advocate for appropriate financial and other incentives to physicians to facilitate electronic prescribing adoption.

5. Our AMA will work to substantially reduce regulatory burdens so that physicians may successfully submit electronic prescriptions for controlled substances.

6. Our AMA will work with representatives of pharmacies, pharmacy benefits managers, and software vendors to expand the ability to electronically prescribe all medications.

7. Our AMA will work with the Centers for Medicare & Medicaid Services and the federal government to have all pharmacies, including government pharmacies, accept e-prescriptions for prescription drugs.

TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 108
A-19

Subject: Initial Assessment and Treatment Recommendation by Specialists

Presented by: Young Physician Section

Referred to: Reference Committee on Financial and Organizational Affairs

---

Whereas, Primary care physicians care for a broad spectrum of patients; and

Whereas, Primary care physicians sometimes refer patients to specialists seeking their expertise in the evaluation, diagnosis, and treatment of their patients; and

Whereas, A patient's initial assessment and thorough evaluation by a board-certified specialist is what primary care physicians need and patients need and deserve when referred to a specialist; and

Whereas, Nurse practitioners and physician assistants do not have the same level of training as a physician; and

Whereas, Nurse practitioners and physician assistants can switch "specialties" without any clinical training whatsoever in their chosen "specialty;" and

Whereas, A nurse practitioner or physician assistant assessment and treatment plan for an initial evaluation does not provide the level of expertise that primary care physicians seek and patients deserve when patients are referred to a physician specialist; and

Whereas, Optimal patient care can be compromised through delays in diagnosis and treatment resulting from initial evaluations by nurse practitioners or physician assistants rather than specialist physicians; therefore be it

RESOLVED, That Texas Medical Association recognize that the best practice of patient care dictates that it is the responsibility of the physician to develop the diagnosis and treatment in the evaluation of a patient, while it is recognized under limited circumstances that an initial evaluation may be conducted by a nurse practitioner or physician assistant.

Related TMA Policy:
255.001 Primary Care Physician Definition: The Texas Medical Association defines physician primary care as first contact care, longitudinal and continuous care, comprehensive health services, preventive health care, and coordinated services (Committee on Manpower, p 98, A-94; reaffirmed CME Rep. 1-A-05; reaffirmed CM-PDHCA Rep. 1-A-15)

105.002 Patient and Physician Relationship: If a physician does not have the training or expertise to treat the patient's health concerns, the physician should refer the patient to a physician or other health care professional with the appropriate training and experience (Council on Communication, p 73, I-92; reaffirmed CSE Rep. 3-A-04; reaffirmed CSE Rep. 2-A-14)

30.012 Nursing and Nurses with Advanced Training: While recognizing the value of nurses who have obtained advanced training, the concept of independent delivery of health care by nurses is opposed.

Nurses should, however, be encouraged to obtain advanced education and training. The nurse with such training engages in decision making about the nursing care of patients under the supervision of a physician. The nurse collaborates with social workers, nutritionists, and others in making decisions about nursing needs. The nurse plans and institutes nursing programs as a member of the health care team. The nurse is directly accountable and responsible to the patient for the quality of nursing care rendered under the Nurse Practice Act of Texas (Council on Medical Education, p 92, A-94; amended CME Rep. 4-A-04; reaffirmed CM-PDHCA Rep. 2-A-14).

30.016 Physician Assistants and Allied Health Personnel: A physician assistant is a skilled person, qualified by academic training in an accredited program and by practical training to provide patient services under the supervision and direction of a licensed physician who is ultimately responsible for the performance of that assistant. Reimbursement for services performed by a physician assistant should be made directly to the responsible physician. While greater use of non-physician personnel can improve the system, responsibility for care must be clearly defined if various personnel are to work together effectively to provide high quality services for the patient (Council on Medical Education, p 97, and Council on Socioeconomics, p 181, I-94; reaffirmed CME Rep. 4-A-04; reaffirmed CM-PDHCA Rep. 2-A-14).

Related AMA Policy:

H-360.987 Principles Guiding AMA Policy Regarding Supervision of Medical Care Delivered by Advanced Practice Nurses in Integrated Practice: Our AMA endorses the following principles: (1) Physicians must retain authority for patient care in any team care arrangement, e.g., integrated practice, to assure patient safety and quality of care. (2) Medical societies should work with legislatures and licensing boards to prevent dilution of the authority of physicians to lead the health care team. (3) Exercising independent medical judgment to select the drug of choice must continue to be the responsibility only of physicians. (4) Physicians should recognize physician assistants and advanced practice nurses under physician leadership, as effective physician extenders and valued members of the health care team. (5) Physicians should encourage state medical and nursing boards to explore the feasibility of working together to coordinate their regulatory initiatives and activities. (6) Physicians must be responsible and have authority for initiating and implementing quality control programs for nonphysicians delivering medical care in integrated practices.

H-160.936 Comprehensive Physical Examinations by Appropriate Practitioners: AMA policy supports the position that performance of comprehensive physical examinations to diagnose medical conditions be limited to licensed MDs/DOs or those practitioners who are directly supervised by licensed MDs/DOs; and the AMA will actively work with state medical societies and medical specialty associations, both in the courts and in the legislative and regulatory spheres, to oppose any proposed or adopted law or policy that would inappropriately expand the scope of practice of practitioners other than MDs/DOs.

TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 109
A-19

Subject: Licensure Status on TMA Membership Applications

Presented by: Tarrant County Medical Society

Referred to: Reference Committee on Financial and Organizational Affairs

---

Whereas, The Texas Medical Association (TMA) and County Medical Society Membership Application is a unified application for membership in both TMA and county medical societies; and

Whereas, TMA generally requires for physician membership a license to practice medicine in the state of Texas that is not permanently revoked, canceled, or permanently suspended; and

Whereas, An otherwise qualified physician may be denied membership or continued membership in a county medical society only for a violation of the TMA or county medical society constitution and bylaws; a violation of the AMA Principles of Medical Ethics; criminal conduct; or unprofessional conduct likely to deceive, defraud, or injure the public; and

Whereas, The membership application includes a section entitled, "Membership Qualification and Authorization," which is an aid in screening applicants by including questions about the applicant's disciplinary and criminal history; and

Whereas, The Texas Medical Board (TMB) considers similar criteria upon application for medical licensure in the state of Texas, and, therefore, applicants who have a medical license to practice in the state of Texas can be considered eligible for membership in TMA and county medical societies; and

Whereas, Local county medical society boards of censors have little or no resources to investigate and research applicants other than verifying current medical licensure by the TMB; therefore be it

RESOLVED, That a county medical society board of censors' examination of an applicant be limited only to the applicant's licensure status with the TMB; that the membership application be updated to reflect the examination of only the applicant's licensure status (when applicable); and that TMA bylaws be amended accordingly.

Related TMA Policy:
1.12 Application. Application for membership in a component county society shall contain the following information: Full name and address, place and date of birth, medical education and degree received, locations and dates of residencies, and such other information as the association or the component county society may require. The county society shall retain any original applications it receives and forward copies to the executive vice president of the association. Copies of any original applications the association receives shall be forwarded to the county society.

1.14 Board of Censors examination and report. The boards of censors of component county societies shall examine and report on the qualifications of applicants for membership in their respective organizations.

Within 60 days of the date an application is completed, the Board of Censors shall complete its examination of the applicant's qualifications; approve or disapprove the application; and provide to the executive board (or to the other officers if there is no executive board) its report on the applicant's qualifications and on the Board of Censors' decision to approve or disapprove membership.

Related AMA Policy: None.

TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 110
A-19

Subject: Blue Cross and Blue Shield of Texas Charitable Requirements as a Not-for-Profit Corporation

Introduced by: Texas Academy of Family Physicians

Referred to: Reference Committee on Financial and Organizational Affairs

---

Whereas, Texans founded Blue Cross and Blue Shield of Texas in 1929 as a nonprofit, charitable organization with the intention of providing affordable health care coverage with a community focus, acting in the public benefit; and

Whereas, in the early 1980s, many of the commercial insurers began to challenge the fully tax-exempt status of the BCBS plans, which BCBS rebuffed by arguing that the plans provide "a unique community service"; and

Whereas, in June 1994, the national BCBS association changed its policies so that its licensees could convert to for-profit status and distribute earnings to those who exercise control over the company; and

Whereas, in 1996, BCBS Texas submitted a proposal to merge with Illinois BCBS, operated by Health Care Service Corporation (HCSC), a mutual insurance company, owned by its policyholders; and

Whereas, following a lawsuit by the Texas Attorney General to block the merger on grounds the merged entity would no longer be "nonprofit," in 1998, the trial court issued a letter opinion against the Attorney General and in favor of the merger; and

Whereas, after the merger was approved, HCSC remained unwilling to admit that BCBS Texas had a charitable asset obligation to the people of Texas; and

Whereas, HCSC acquired Blue Cross Blue Shield of New Mexico in May 2001 and Blue Cross Blue Shield of Oklahoma in 2005. HCHS now has more than 15 million members in Oklahoma, Illinois, Texas, and New Mexico; and

Whereas, in 2015 HCSC had reserves in excess of $9.9 billion in surplus funds; and

Whereas, in 2017 HCSC made $1.3 billion in net profit on $32.6 billion of revenue; and

Whereas, BCBS Texas recently announced plans to open 10 primary care medical centers in Dallas and Houston to provide a range of services beyond primary care, including urgent care, lab and diagnostic imaging, care coordination, and wellness and disease management programs; and

Whereas, BCBS Texas will open these clinics in partnership with Sanitas, a foreign-based multinational health care firm with no experience in Texas; and

Whereas, BCBS Texas has decided to compete against Texas primary care physicians rather than partner with them, despite more than a decade of claiming to support physician-led, community-based primary care initiatives and patient-centered medical homes; and

Whereas, the economic viability of independent physician owned primary care practices is increasingly at risk due to the rapid consolidation and vertical integration of health plans, health systems, and corporate health organizations into direct patient care delivery; and

Whereas, these consolidations and vertical integrations threaten to limit, if not eliminate, clinical choice, practice setting choice, and patient choice; and

Whereas, these consolidations and vertical integrations may evolve into anticompetitive oligopolies that compete over price and market share rather than value of clinical services; and

Whereas, current state law will likely prove inadequate to protect patients from and provide antitrust barriers against these new corporate-backed delivery models; therefore be it

RESOLVED, That the Texas Medical Association express its disappointment to Blue Cross Blue Shield of Texas on its decision to contract with a foreign-based, multinational health care firm to open 10 primary care medical centers in Dallas and Houston to compete against local primary care practices owned and operated by TMA members; and

RESOLVED, That the Texas Medical Association collaborate with primary care specialty organizations and other specialty societies to conduct a comprehensive study of these market developments to assess their current and prospective positive and negative influences on the delivery of health care in Texas; and be it further

RESOLVED, That the study include, but not be limited to, an analysis of geographic market concentration of health insurers doing business in Texas; how vertical integration of Texas' health care markets are impacting clinical practice choices, patient choice, and the viability of physician owned, community-based practices; and how predatory and anticompetitive managed care business practices are hurting the stability and viability of physician-owned practices; and be it further

RESOLVED, That, as part of the aforementioned study, the Texas Medical Association develop a multi-year strategy to include any public policy options that assure fair business practices and enforceable protections from predatory behavior and adverse patient consequences, and that empowers physicians to compete and thrive in Texas' health care markets; and be it further

RESOLVED, that such study be prepared and submitted to the House of Delegates no later than May 2020.

Related TMA Policy: None.

Related AMA Policy: None.

TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 111
A-19

Subject: Opposing Legislation That Mandates Physician Discrimination

Introduced by: Travis County Medical Society, Texas Pediatric Society, and Texas Chapter of the American Academy of Pediatrics

Referred to: Reference Committee on Financial and Organizational Affairs

---

Whereas, The Texas Medical Association does not discriminate, opposes discrimination, and encourages nondiscrimination policies within health care settings; and

Whereas, TMA upholds the right and best medical practice of adolescents accessing sexual and reproductive health care either confidentially or with family involvement as determined by the adolescent; and

Whereas, TMA supports a health care environment that encourages adolescent and family access to care without involvement by law enforcement officials, except in cases of suspected child abuse or neglect as identified by health care professionals using their best judgment; and

Whereas, Texas Family Code § 261.101 (b) requires professionals to report child abuse or neglect; Texas Family Code § 261.001(1)(E) defines abuse to include conduct constituting an offense under Texas Penal Code § 21.11; Texas Penal Code § 21.11 makes it a crime to engage in sexual contact with or in view of a child younger than 17; Texas Penal Code § 21.11(b) establishes an affirmative defense to prosecution with several factors including only if the actor is of the "opposite sex"; physicians and other health professionals are accordingly positioned to discriminate against LGBTQ+ adolescents between the ages of 14 and 17, with possible prosecution and imprisonment of the health care professional under Texas Family Code § 261.109(c) for failure to report; and

Whereas, Pursuant to Texas Department of State Health Services (DSHS) Rider 24 and Texas Health and Human Services Commission (HHSC) Rider 215, 2018-2019 General Appropriations Act, 85th Legislature, recipients of public health funds are required to show good faith efforts to comply with all child abuse reporting guidelines and requirements, and therefore, clinics and health care facilities under audit receiving public health funding for lower-income communities are disproportionately at risk of enforcement of these laws; and

Whereas, Mandated reporting exposes LGBTQ+ adolescents to prosecution under Texas Penal Code § 21.11, while their peers in "opposite sex" relationships may qualify for the affirmative defense; and

Whereas, This reporting requirement creates an undue and unnecessary burden on physicians and their staff, and the child protection system; and

Whereas, This reporting requirement creates barriers for adolescents and families seeking health care and is an example of health-harming legislation that negatively affects patient and community health and reduces access to health care; therefore be it

RESOLVED, That the Texas Medical Association support removal of "opposite sex" as a requirement for affirmative defense to prosecution within the Texas Penal Code; and be it further

RESOLVED, That TMA oppose legislation or regulation that mandates physicians and other health professionals discriminate against or limit access to health care for a specific patient population.

Related TMA Policy:
60.008 The Texas Medical Association does not discriminate, and opposes discrimination, based on race, religion, disability, ethnic origin, national origin, age, sexual orientation, sex, or gender identity: TMA supports physician efforts to encourage that the nondiscrimination policies in their practices, medical schools, hospitals, and clinics be broadened to include "race, religion, disability, ethnic origin, national origin, age, sexual orientation, sex, or gender identity" in relation to patients, health care workers, and employees (CSPH Rep. 1-A-18).

55.035 Right to Confidential Care: The Texas Medical Association upholds the right of adolescents to receive confidential care to protect their health. Evidence indicates that requiring parental involvement in sexual and contraceptive health care reduces access to care without reducing sexual activity or increasing communication between parents and teens. In addition, TMA supports a health care environment that encourages adolescent access to care without involvement by law enforcement officials, except in cases of suspected child physical or sexual abuse as identified by the health care provider using his or her professional judgment (CM-MPH Rep. 2-A-03; reaffirmed CM-CAH Rep. 4-A-10).

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

2. Our AMA will collaborate with our partner organizations to educate physicians regarding: (i) the need for women who have sex with women to undergo regular cancer and sexually transmitted infection screenings due to their comparable or elevated risk for these conditions; and (ii) the need for comprehensive screening for sexually transmitted diseases in men who have sex with men; and (iii) appropriate safe sex techniques to avoid the risk for sexually transmitted diseases. 3. Our AMA will continue to work alongside our partner organizations, including GLMA, to increase physician competency on LGBT health issues. 4. Our AMA will continue to explore opportunities to collaborate with other organizations, focusing on issues of mutual concern in order to provide the most comprehensive and up-to-date education and information to enable the provision of high quality and culturally competent care to LGBT people
Sources:

Texas Family Code § 261.101 Persons Required to Report, Time to Report:
(a) A person having cause to believe that a child's physical or mental health or welfare has been adversely affected by abuse or neglect by any person shall immediately make a report as provided by this subchapter.

(b) If a professional has cause to believe that a child has been abused or neglected or may be abused or neglected, or that a child is a victim of an offense under Section 21.11, Penal Code, and the professional has cause to believe that the child has been abused as defined by Section 261.001, the professional shall make a report not later than the 48th hour after the hour the professional first suspects that the child has been or may be abused or neglected or is a victim of an offense under Section 21.11, Penal Code. A professional may not delegate to or rely on another person to make the report. In this subsection, "professional" means an individual who is licensed or certified by the state or who is an employee of a facility licensed, certified, or operated by the state and who, in the normal course of official duties or duties for which a license or certification is required, has direct contact with children. The term includes teachers, nurses, doctors, day-care employees, employees of a clinic or health care facility that provides reproductive services, juvenile probation officers, and juvenile detention or correctional officers.

(b-1) In addition to the duty to make a report under Subsection (a) or (b), a person or professional shall make a report in the manner required by Subsection (a) or (b), as applicable, if the person or professional has cause to believe that an adult was a victim of abuse or neglect as a child and the person or professional determines in good faith that disclosure of the information is necessary to protect the health and safety of:

(1) another child; or
(2) an elderly person or person with a disability as defined by Section 48.002, Human Resources Code.

(c) The requirement to report under this section applies without exception to an individual whose personal communications may otherwise be privileged, including an attorney, a member of the clergy, a medical practitioner, a social worker, a mental health professional, an employee or member of a board that licenses or certifies a professional, and an employee of a clinic or health care facility that provides reproductive services.

(d) Unless waived in writing by the person making the report, the identity of an individual making a report under this chapter is confidential and may be disclosed only:

(1) as provided by Section 261.201; or
(2) to a law enforcement officer for the purposes of conducting a criminal investigation of the report.

Texas Family Code § 261.001(1)(E) Definitions:
(1) “Abuse” includes the following acts or omissions by a person . . .

(E) sexual conduct harmful to a child's mental, emotional, or physical welfare, including conduct that constitutes the offense of continuous sexual abuse of young child or children under Section 21.02, Penal Code , indecency with a child under Section 21.11, Penal Code , sexual assault under Section 22.011, Penal Code , or aggravated sexual assault under Section 22.021, Penal Code ;

Texas Penal Code § 21.11 Indecency with a Child:
(a) A person commits an offense if, with a child younger than 17 years of age, whether the child is of the same or opposite sex and regardless of whether the person knows the age of the child at the time of the offense, the person:

(1) engages in sexual contact with the child or causes the child to engage in sexual contact; or
(2) with intent to arouse or gratify the sexual desire of any person:
(A) exposes the person's anus or any part of the person's genitals, knowing the child is present; or
(B) causes the child to expose the child's anus or any part of the child's genitals.
(b) It is an affirmative defense to prosecution under this section that the actor:
(1) was not more than three years older than the victim and of the opposite sex;

(2) did not use duress, force, or a threat against the victim at the time of the offense; and
(3) at the time of the offense:
(A) was not required under Chapter 62, Code of Criminal Procedure, to register for life as a sex offender; or
(B) was not a person who under Chapter 62 had a reportable conviction or adjudication for an offense under this section.

(b-1) It is an affirmative defense to prosecution under this section that the actor was the spouse of the child at the time of the offense.
(c) In this section, "sexual contact" means the following acts, if committed with the intent to arouse or gratify the sexual desire of any person:

(1) any touching by a person, including touching through clothing, of the anus, breast, or any part of the genitals of a child; or
(2) any touching of any part of the body of a child, including touching through clothing, with the anus, breast, or any part of the genitals of a person.
(d) An offense under Subsection (a)(1) is a felony of the second degree and an offense under Subsection (a)(2) is a felony of the third degree.

Texas Family Code § 261.109(c) Failure to Report Penalty:
(a) A person commits an offense if the person is required to make a report under Section 261.101(a) and knowingly fails to make a report as provided in this chapter.
(a-1) A person who is a professional as defined by Section 261.101(b) commits an offense if the person is required to make a report under Section 261.101(b) and knowingly fails to make a report as provided in this chapter.
(b) An offense under Subsection (a) is a Class A misdemeanor, except that the offense is a state jail felony if it is shown on the trial of the offense that the child was a person with an intellectual disability who resided in a state supported living center, the ICF-IID component of the Rio Grande State Center, or a facility licensed under Chapter 252, Health and Safety Code, and the actor knew that the child had suffered serious bodily injury as a result of the abuse or neglect.
(c) An offense under Subsection (a-1) is a Class A misdemeanor, except that the offense is a state jail felony if it is shown on the trial of the offense that the actor intended to conceal the abuse or neglect.

Department of State Health Services (DSHS) Rider 24, 2018-2019 General Appropriations Act, 85th Legislature: Reporting of Child Abuse. The Department of State Health Services may distribute or provide appropriated funds only to recipients who show good faith efforts to comply with all child abuse reporting guidelines and requirements set forth in Chapter 261 of the Texas Family Code. Located on Section II, Page 30: http://www.lbb.state.tx.us/Documents/GAA/General_Appropriations_Act_2018-2019.pdf

Health and Human Services Commission (HHSC) Rider 215, 2018-2019 General Appropriations Act, 85th Legislature: Reporting of Child Abuse. The Texas Health and Human Services Commission may distribute or provide appropriated funds only to recipients who show good-faith efforts to comply with all child abuse reporting guidelines and requirements set forth in Chapter 261 of the Texas Family Code. (Conference Committee Report Rider 150) Located on Section II, Page 111: http://www.lbb.state.tx.us/Documents/GAA/General_Appropriations_Act_2018-2019.pdf

Additional References:
1. Statewide Intake: Source of Abuse/Neglect Reports https://public.tableau.com/shared/K4SMMYF8N?:display_count=yes&:showVizHome=no
2. Confidential Health Care for Adolescents: Position Paper of the Society for Adolescent Medicine; Journal of Adolescent Health 2004;35: 160-167 https://www.jahonline.org/article/S1054-139X(04)00086-2/pdf

3. Sexual and Reproductive Health Care: A Position Paper of the Society for Adolescent Health and Medicine; Journal of Adolescent Health 54 (2014) 491e496 https://www.adolescenthealth.org/SAHM_Main/media/Advocacy/Positions/Apr-14-Sexual-Repro-Health.pdf
4. Protecting Adolescents: Ensuring Access to Care and Reporting Sexual Activity and Abuse Position Paper of the American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, and the Society for Adolescent Medicine; Journal of Adolescent Health 2004;35:420–423 https://www.adolescenthealth.org/SAHM_Main/media/Advocacy/Positions/Nov-04-Protecting_Adolescents_Ensuring_Access_to_Care_and_Reporting_Sexual_Activity_and_Abuse.pdf
5. Raz, Mical. Unintended Consequences of Expanded Mandatory Reporting Laws; Pediatrics April 2017 Volume 139 Issue 4 Pediatrics Perspective http://pediatrics.aappublications.org/content/139/4/e20163511

Revised

TEXAS MEDICAL ASSOCATION HOUSE OF DELEGATES

Resolution 112
A-19

Subject: Equal Pay for Equal Work

Presented by: Dallas County Medical Society

Referred to: Reference Committee on Financial and Organizational Affairs

---

Whereas, The principle of equanimity is a firmly held virtue in the practice of medicine; and

Whereas, Inasmuch as we are called as physicians to be equitable in our approach to provision of care to our patients, we are expected to uphold this same respect for colleagues; and

Whereas, The Texas Medical Association prides itself in being at the forefront in advancements in medicine, whether scientific, political, or social; and

Whereas, TMA has a firm and clear nondiscrimination policy that guides its practices in issues of nondiscrimination based on factors including sex, ethnicity, and religion; and

Whereas, Gender pay gaps exist in a variety of settings as borne out in the literature and, in some instances, as much as a 20 percent for the equal amount of work being performed by women vs. men; and

Whereas, As Texas physicians, we understand that the way we move forward, together, as a strong and unified house, is by being united by equanimity; therefore be it

RESOLVED, That the Texas Medical Association promote the principle of equal pay for equal work, regardless of sex, ethnicity, and religious preference; and be it further

RESOLVED, That in upholding the principle of equal pay for equal work, TMA lends its strength and affirmation to the efforts underway by the American Medical Association to address this issue of inequality.

Related TMA Policy:
60.005 Equal Rights: All individuals should have access to equal social, economic, and professional opportunities (Medical Student Section, p 123, A-95; reaffirmed BOC Rep. 3-A-05; reaffirmed BOC Rep. 4-A-15).

Related AMA Policy:
D-65.989 Advancing Gender Equity in Medicine:
1. Our AMA will draft and disseminate a report detailing its positions and recommendations for gender equity in medicine, including clarifying principles for state and specialty societies, academic medical centers and other entities that employ physicians, to be submitted to the House for consideration at the 2019 Annual Meeting.

2. Our AMA will: (a) advocate for institutional, departmental and practice policies that promote transparency in defining the criteria for initial and subsequent physician compensation; (b) advocate for pay structures based on objective, gender-neutral objective criteria; (c) encourage a specified approach, sufficient to identify gender disparity, to oversight of compensation models, metrics, and actual total compensation for all employed physicians; and (d) advocate for training to identify and mitigate implicit bias in compensation

determination for those in positions to determine salary and bonuses, with a focus on how subtle differences in the further evaluation of physicians of different genders may impede compensation and career advancement.

3. Our AMA will recommend as immediate actions to reduce gender bias: (a) elimination of the question of prior salary information from job applications for physician recruitment in academic and private practice; (b) create an awareness campaign to inform physicians about their rights under the Lilly Ledbetter Fair Pay Act and Equal Pay Act; (c) establish educational programs to help empower all genders to negotiate equitable compensation; (d) work with relevant stakeholders to host a workshop on the role of medical societies in advancing women in medicine, with co-development and broad dissemination of a report based on workshop findings; and (e) create guidance for medical schools and health care facilities for institutional transparency of compensation, and regular gender-based pay audits.

4. Our AMA will collect and analyze comprehensive demographic data and produce a study on the inclusion of women members including, but not limited to, membership, representation in the House of Delegates, reference committee makeup, and leadership positions within our AMA, including the Board of Trustees, Councils and Section governance, plenary speaker invitations, recognition awards, and grant funding, and disseminate such findings in regular reports to the House of Delegates and making recommendations to support gender equity.

5. Our AMA will commit to *pay* equity across the organization by asking our Board of Trustees to undertake routine assessments of salaries within and across the organization, while making the necessary adjustments to ensure equal *pay* for equal work.