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REPORT OF THE BOARD TRUSTEES

B of T Report 03-A-23

Subject: 2022 Grants and Donations

Presented by: Sandra Adamson Fryhofer, MD, Chair

This informational financial report details all grants or donations received by the American Medical Association during 2022.

American Medical Association
Grants & Donations Received by the AMA
For the Year Ended December 31, 2022
Amounts in thousands

Funding Institution	Project	Amount Received
Centers for Disease Control and Prevention (subcontracted to AMA through American College of Preventive Medicine)	Building Healthcare Provider Capacity to Screen, Test, and Refer Disparate Populations with Prediabetes	$ 202
Centers for Disease Control and Prevention (subcontracted to AMA through American College of Preventive Medicine)	Improving Minority Physician Capacity to Address COVID-19 Disparities	314
Centers for Disease Control and Prevention	Improving Health Outcomes through Partnerships with Physicians to Prevent and Control Emerging and Re-Emerging Infectious Disease Threats	477
Centers for Disease Control and Prevention	National Healthcare Workforce Infection Prevention and Control Training Initiative Healthcare Facilities	897
Centers for Disease Control and Prevention	Promoting HIV, Viral Hepatitis, STDs, and LTBI Screening in Hospitals, Health Systems, and Other Healthcare Settings	246
Health Resources and Services Administration (subcontracted to AMA through American Heart Association, Inc.)	National Hypertension Control Initiative: Addressing Disparities Among Racial and Ethnic Minority Populations	549
Substance Abuse and Mental Health Services Administration (subcontracted to AMA through American Academy of Addiction Psychiatry)	Providers Clinical Support System Medicated Assisted Treatment	24
Government Funding		**2,709**
American Academy of Dermatology	2022 Annual Meeting of House of Delegates - Presidential Inauguration	15
American Association for the Advancement of Science	International Congress on Peer Review and Scientific Publication	3
American College of Physicians	International Congress on Peer Review and Scientific Publication	10
American Medical Association Foundation (via contribution from Daiichi Sankyo)	Accelerating Change in Medical Education Conference co-sponsored by AMA and AMA Foundation	9
American Medical Association Foundation (via contribution from Genentech)	Accelerating Change in Medical Education Conference co-sponsored by AMA and AMA Foundation	45
American Medical Association Foundation (via contribution from Pfizer Inc.)	Accelerating Change in Medical Education Conference co-sponsored by AMA and AMA Foundation	23
Massachusetts Medical Society	International Congress on Peer Review and Scientific Publication	20
The Physicians Foundation, Inc.	Practice Transformation Initiative: Solutions to Increase Joy in Medicine	3
Nonprofit Contributors		**128**
Cabell Publishing Company	International Congress on Peer Review and Scientific Publication	10
Elsevier	International Congress on Peer Review and Scientific Publication	10
John Wiley & Sons, Inc.	International Congress on Peer Review and Scientific Publication	30
MPS Limited (formerly Highwire Press)	International Congress on Peer Review and Scientific Publication	10
Silverchair Science + Communications, Inc.	International Congress on Peer Review and Scientific Publication	10
Wolters Kluwer Health	International Congress on Peer Review and Scientific Publication	30
Other Contributors		**100**
Total Grants and Donations		**$ 2,937**

REPORT OF THE BOARD OF TRUSTEES

B of T Report 05-A-23

Subject: Update on Corporate Relationships

Presented by: Sandra Adamson Fryhofer, MD

PURPOSE

The purpose of this informational report is to update the House of Delegates (HOD) on the results of the Corporate Review process from January 1 through December 31, 2022. Corporate activities that associate the American Medical Association (AMA) name or logo with a company, non-Federation association or foundation, or include commercial support, currently undergo review and recommendations by the Corporate Review Team (CRT) (Appendix A).

BACKGROUND

At the 2002 Annual Meeting, the HOD approved revised principles to govern the American Medical Association's (AMA) corporate relationships, HOD Policy G-630.040 "Principles on Corporate Relationships." These guidelines for American Medical Association corporate relationships were incorporated into the corporate review process, are reviewed regularly, and were reaffirmed at the 2012 and 2022 Annual Meeting. AMA managers are responsible for reviewing AMA projects to ensure they fit within these guidelines.

YEAR 2022 RESULTS

In 2022, 92 activities were considered and approved through the Corporate Review process. Of the 92 projects recommended for approval, 48 were conferences or events, 11 were educational content or grants, 27 were collaborations or affiliations, five were member programs, and one was an American Medical Association Foundation (AMAF) program. See Appendix B for details.

CONCLUSION

The Board of Trustees (BOT) continues to evaluate the CRT review process to balance risk assessment with the need for external collaborations that advance the AMA's strategic focus.

Appendix A

CORPORATE REVIEW PROCESS OVERVIEW

The Corporate Review Team (CRT) includes senior managers from the following areas: Strategy, Finance, Health Solutions (HS), Advocacy, Office of the General Counsel, Medical Education, Publishing, Enterprise Communications (EC), Marketing and Member Experience (MMX), Center for Health Equity (CHE), and Health, Science and Ethics.

The CRT evaluates each project submitted to determine fit or conflict with AMA Corporate Guidelines, covering:

- Type, purpose, and duration of the activity;
- Audience;
- Company, association, foundation, or academic institution involved (due diligence reviewed);
- Source of external funding;
- Use of the AMA logo;
- Editorial control/copyright;
- Exclusive or non-exclusive nature of the arrangement;
- Status of single and multiple supporters; and
- Risk assessment for AMA.

The CRT reviews and makes recommendations regarding the following types of activities that utilize AMA name and logo:

- Industry-supported web, print, or conference projects directed to physicians or patients that do not adhere to Accreditation Council for Continuing Medical Education (ACCME) Standards and Essentials.
- AMA sponsorship of external events.
- Independent and company-sponsored foundation supported projects.
- AMA licensing and publishing programs. (These corporate arrangements involve licensing AMA products or information to corporate or non-profit entities in exchange for a royalty and involve the use of AMA's name, logo, and trademarks. This does not include database or Current Procedural Terminology (CPT ®) licensing.)
- Member programs such as new affinity or insurance programs and member benefits.
- Third-party relationships such as joint ventures, business partnerships, or co-branding programs directed to members.
- Non-profit association collaborations outside the Federation. The CRT reviews all non-profit association projects (Federation or non-Federation) that involve corporate sponsorship.
- Collaboration with academic institutions in cases where there is corporate sponsorship.

For the above specified activities, if the CRT recommends approval, the project proceeds.

In addition to CRT review, the Executive Committee of the Board must review and approve CRT recommendations for the following AMA activities:

- Any activity directed to the public with external funding.
- Single-sponsor activities that do not meet ACCME Standards and Essentials.
- Activities involving risk of substantial financial penalties for cancellation.
- Upon request of a dissenting member of the CRT.
- Any other activity upon request of the CRT.

All Corporate Review recommendations are summarized annually for information to the Board of Trustees (BOT). The BOT informs the HOD of all corporate arrangements at the Annual Meeting.

Appendix B

SUMMARY OF CORPORATE REVIEW

RECOMMENDATIONS FOR 2022

PROJECT NO.	PROJECT DESCRIPTION	CORPORATIONS	APPROVAL DATE
CONFERENCES/EVENTS			
18477	**IAIME Annual Event 2022 - Exhibit** – Sponsorship with AMA name and logo.	International Academy of Independent Medical Evaluators Veritas Association Management Axis Administration Services Independent Medical Transcription, Inc ABCDisability, Inc	01/11/2022
18380	**WBL Annual Summit 2022 and 2023 -** Repeat sponsorship with AMA name and logo.	Women Business Leaders Foundation AMGEN Anthem, Inc McKesson Tivity Health Epstein Becker Green MEDecision AMN Healthcare Aveus, LLC Johnson & Johnson West Monroe Common Spirit Newport Healthcare Progeny Health United Health Group AArete Consulting Healthcare Leadership Council Hello Heart MCG Health Mintz NTT Data Tabula Rasa Healthcare Trustmark VillageMD	01/13/2022
18538	**NHMA Virtual COVID-19 Briefing –** Sponsorship of virtual event with AMA name and logo.	National Hispanic Medical Association George Mason University	01/14/2022

		George Washington University Howard University Elizabeth Dole Foundation	
18470	**March of Dimes Gala -** Repeat sponsorship with AMA name and logo.	March of Dimes Samsung General Motors NACDS Foundation Proctor and Gamble Pampers Aflac American Beverage Association Volkswagen BNSF Railway Rocket Mortgage	01/19/2022
18460	**ViVE 2022 Conference -** Sponsorship with AMA name and logo.	ViVE College of Healthcare Information Management Executives HLTH	01/26/2022
18698	**National Press Club Event featuring Dr. Harmon** – Sponsorship with AMA name and logo.	National Press Club	02/03/2022
18691	**HIMSS Annual Conference –** Repeat sponsorship with AMA and CPT name and logo.	Health Information and Management Systems Society Premier, Inc Seal Shield Athenahealth Symplr ZS Consulting Guidehouse Vyaire Coding Services Group Masimo Red Hat	02/09/2022
18980	**Third Horizon Strategies International Women's Day Forum –** Sponsorship with AMA name and logo.	Third Horizon Strategies MATTER Chicago Alight Solutions	03/02/2022
18987	**NHIT Summit** – Sponsorship with AMA name and logo.	National Health IT Collaborative for the Underserved Sanitas Medical Center hims&hers DocuSign Health Innovation Alliance	03/04/2022

18968	**NHMA Conference** – Sponsorship with AMA name and logo.	National Hispanic Medical Association Centene Corporation Abbott Laboratories Davita Pfizer Johnson & Johnson Genentech Eli Lily and Company Vertex PhRMA Sanofi Travere NovoNordisk Orasure Technologies, Inc. Orlando Health Med Group Planned Parenthood Action Fund Sentara Healthcare Penn State Health	03/11/2022
19058	**National Rx Drug Abuse and Heroin Summit** – Repeat sponsorship with AMA name and logo.	HMP Global Psychiatry and Behavioral Health Learning Network Operation Unite University of Kentucky Northern Kentucky University Bamboo Health Deterra RTI International Advantage EMS World Georgia Department of Behavioral and Development Disabilities NASA DAD – National Association of State Alcohol and Drug Abuse Directors SAM – Smart Approaches to Marijuana PROUD – Peers in Recovery from Opioid Use and Dependence PTACC – Police, Treatment and Community Collaborative R2ISE Recovery	03/21/2022
19112	**AAPC HEALTHCON 2022 – US and International** – Repeat sponsorship with AMA name and logo.	American Academy of Professional Coders AHA Coding Clinic HC Pro Charter Oak State College Foresee Medical	03/23/2022

		GHR RevCycle Workforce MidOcean Partners MediCodio OS2 Healthcare Solutions Unify Healthcare Services	
19202	**Credentialing State Shows –** Repeat sponsorship with AMA name and logo.	Illinois Association of Medical Staff Services Texas Society for Medical Services Specialists Florida Association of Medical Staff Services California Association of Medical Services Specialists MD Staff ABMS Solutions Hardenbergh Group MD Review AMN Healthcare/Silversheet VerityStream PreCheck NAMSS PASS Edge-U-Cate SkillSurvey	04/01/2022
19263	**AMA 20th Annual Research Challenge** – AMA branded competition repeat event with Laurel Road sponsored prize.	Laurel Road Bank	04/13/2022
19267	**AMA Release the Pressure (RTP) and AKA Derby Day Scholarship Brunch** – Sponsorship of AKA -hosted event.	AKA Sorority Eta Omega Chapter Weight Watchers Ad Council Ebony iHeartRadio Hortense B. Perry Foundation Weight Watchers Fashion Fair Tgin Auda.B Henry Schein	04/14/2022
19259	**ATA Conference and Expo** – Repeat sponsorship with AMA name and logo.	American Telemedicine Association AliveCor BioIntelliSense Pexip Health Northeast Telehealth Resource Center Optum eDevice	04/15/2022

		ATA Action	
19247	**AHCJ Conference** – Sponsorship with AMA name and logo.	Association of Healthcare Journalists Nixon Peabody InterSystems HCA Healthcare Meadows Mental Health Policy Institute St. David's Foundation Arnold Ventures Robert Wood Johnson Foundation Leona and Harry Helmsley Trust Gordon and Betty Moore Foundation The Commonwealth Fund Episcopal Health Foundation The Kresge Foundation Pcori The Pew Charitable Trust John A. Hartford Foundation Mayo Clinic NYS Health Foundation Health Foundation for Western and Central New York California Health Care Foundation The Colorado Health Foundation Milbank Memorial Fund Missouri Foundation for Health Rhode Island Foundation Burroughs Wellcome Fund	04/19/2022
19428	**Rush University Medical Center – West Side Walk for Wellness** – Repeat sponsorship with AMA name and logo.	Rush Health Blue Cross and Blue Shield of Illinois	05/02/2022
19250	**Social Innovation Summit** – Presenting sponsorship with AMA and AMAF names and logos.	Landmark Ventures	05/10/2022
19647	**NLGJA Annual Convention** – Repeat sponsorship with AMA name and logo.	National Lesbian and Gay Journalists Association The Association of LGBTQ Journalists	05/23/2022
19649	**Modern Healthcare's Annual Virtual Briefing** – Repeat sponsorship with AMA name and logo.	Crain Communications Modern Healthcare Digital Magazine	06/01/2022

19699	**Black Men in White Coats Summit** – Repeat sponsorship with AMA name and logo.	Black Men in White Coats American Association of Colleges of Osteopathic Medicine Health & Medicine Policy Research Group Chicago Area Health Education Center	06/02/2022
19647	**NABJ/NAHJ Annual Convention** – Repeat sponsorship with AMA name and logo.	National Association of Black Journalists National Association of Hispanic Journalists	06/03/2022
19743	**Becker's Collaborations -** Repeat sponsorship of CEO and CFO Roundtable, Annual Meeting, and webinar collaboration with Becker's with AMA name and logo.	Becker's Hospital Review ASC Communications LLC	06/07/2022
19648	**MVJ Annual Convention** – Repeat sponsorship with AMA name and logo.	Military Veterans in Journalism CNN The Washington Post Fox News NBC U.S. Veterans Magazine DAV (Disabled American Veterans) The Lenfest Institute John S. Knight Program Facebook With Honor Action Wyncote Foundation Knight Foundation Wall Street Journal Google News Initiative	06/30/2022
19848	**NAMSS – Annual Virtual Conference** - Repeat sponsorship with AMA name and logo.	National Association of Medical Staff Services ABMS Solutions American Board of Physician Specialties CIMRO Quality Healthcare Solutions DecisionHealth MD-Staff Medallion National Commission on Certification of Physician Assistants PBI Education	06/30/2022

		PreCheck QGenda RLDatix Silversheet Symplr The Greeley Company The Hardenbergh Group UC San Diego PACE Program VerityStream	
19919	**SNOMED CT Virtual Expo 2022** – Repeat sponsorship of virtual event with AMA name and logo.	Systemized Nomenclature of Medicine (SNOMED) West Coast Informatics Meridian DLT Unai Software Consultants ERMLEX The Phoenix Partnership PHAST (France) VIDAL Group Conteir.no (Norway)	07/07/2022
19970	**Genetic Health Information Network Summit 2022** – Repeat sponsorship of virtual event with AMA name and logo.	Genetic Health Information Network Concert Genetics Illumina Genome Medical	07/12/2022
20075	**NMA Annual Convention and Scientific Assembly** – Sponsorship with AMA name and logo.	National Medical Association Council on Concerns of Women Physicians (CCWP) American College of Rheumatology The Lupus Initiative	07/19/2022
20209	**IAIABC Forum 2022** – Repeat sponsorship with AMA name and logo.	Industrial Association of Industrial Accident Boards and Commissions National Council on Compensation Insurance Optum Sedgwick The Black Car Fund Concentra Aerie EDI Group Safety National Healthesystems ODG by MCG Health Enlyte SFM Mutual Insurance Ebix Insurance Software Verisk	08/10/2022

		HealthTech, Inc Rising Medical Solutions	
20246	**SAWCA All Committee Conference** – Repeat sponsorship with AMA name and logo.	Southern Association of Workers' Compensation Administrators Verisk National Council on Compensation Insurance Safety National Optum	08/16/2022
19989	**Northwestern University Third Coast Augmented Intelligence (AI) Health Bow**l – Student competition sponsorship with AMA name and logo.	3rd Coast AI for Health Bowl Vizient Health Highmark Health Leap of Faith Technologies	08/19/2022
20375	**CFHA Annual Integrated Care Conference** – Sponsorship with AMA name and logo.	Collaborative Family Healthcare Association Cambia Health Solutions Elevance Health Merakey Mid-American Mental Health Technology Transfer Center Mayo Clinic - National Center for Integrated Behavioral Health Comagine Health Health Federation of Philadelphia National Register of Health Service Psychologists	08/30/2022
20400	**TeleHealth Academy 2022** – Repeat sponsorship with AMA name and logo.	Nashville Entrepreneur Center eVISIT NTT DATA Best Buy Health Akin Gump LLP LBMC Accounting TeleHealth Solutions Sage Growth Partners North Highland	08/31/2022
20411	**Nourishing Hope -Fighting Hunger Feeding Hope Annual Event** – Repeat sponsorship with AMA name and logo.	The Feinberg Foundation Northwestern School of Medicine Allstate Donald R. Wilson Jr (DRW) Venture Capital Kovitz Wealth Management Huntington Bank Purposeful Wealth Advisors Barack Ferrazzano LLP Saul Ewing, Arnstein and Lehr	09/01/2022

20431	**ATA Telehealth Awareness Week** – Repeat co-hosted webinar with AMA name and logo.	The American Telemedicine Association	09/02/2022
20388	**West Side United Media Event** – Event to announce sponsorship with AMA name and logo.	West Side United City Club of Chicago The Hatchery Allies for Community Business Rush Hospital Lurie Children's Hospital Northern Trust Lawndale Christian Development Corporation	09/08/2022
20465	**GCC eHealth Workforce Development Conference 2022** – Repeat sponsorship with AMA name and logo.	Gulf Cooperation Council UAE Cyber Security Council American Health Information Management Association (AHIMA) Infermedica Orion Health Philips Corporation Malaffi	09/08/2022
20507	**NMF Gratitude Gala** – Sponsorship with AMA name and logo.	National Medical Fellowships Cedars – Sinai Hospital Dana-Farber Cancer Institute Public Service Electric and Gas CO Association of American Medical Colleges (AAMC) Merck Don Levin Trust Mayo Clinic	09/12/2022
20630	**HLTH 2022 Innovation Sponsorship Program** – Sponsorship with AMA name and logo.	HLTH LLC	09/28/2022
20703	**29th Annual Princeton Conference** – Repeat sponsorship with AMA name and logo.	AARP Arnold Ventures Blue Cross Blue Shield of Massachusetts Foundation Blue Shield of California Booz Allen Hamilton California Health Benefits Review Program California Health Care Foundation Jewish Healthcare Foundation	09/30/2022

		MAXIMUS Peterson Center on Healthcare The Health Industry Forum The John A. Hartford Foundation	
20735	**Alliance for Health Policy Dinner** – Repeat sponsorship with AMA name and logo.	Blue Cross Blue Shield Association Elevance Health Kaiser Permanente Otsuka Pharmaceutical Premier Health Welsh, Carson, Anderson, and Stowe	10/03/2022
20699	**Greater Chicago - Leadership Series** – Sponsorship of leadership development series with AMA name and logo.	Leadership Greater Chicago Northern Trust Health Care Service Corporation First Midwest Bank Price Waterhouse Cooper William Blair JP Morgan Chase & Company FHLBank Chicago Slalom Blue Cross Blue Shield of Illinois ComED AON BMO Harris Bank Allstate MacArthur Foundation Nicor Gas	10/06/2022
20783	**IHI Forum 2022** – Sponsorship with AMA name and logo.	Institute for Healthcare Improvement Ethicon Digital Solutions Johnson & Johnson Exact Science Corporation GOJO Industries Gordon and Betty Moore Foundation Healthgrades Michigan Hospital Association Minitab Statistical Software Novartis Premier Healthcare Alliance Riskonnect, Inc Software John A. Hartford Foundation Vizient	10/27/2022

21140	**"The Color of Care" Screening** – Co-host screening with AMA name and logo at HLTH conference.	HLTH LLC Cityblock Health Health Tech 4 Medicaid	11/01/2022
21350	**Managing the EHR Inbox Conference** – Sponsorship with AMA name and logo.	University of California - San Francisco The Doctor's Company The Women's College Hospital at University of Toronto	11/21/2022
21400	**Primary Care Collaborative: "Better Health: Block by Block" Conference** – Sponsorship with AMA name and logo.	University of Pittsburgh Medical Center (UPMC) Blue Shield of California American Psychological Association American Academy of Physician Assistants (AAPA) Elevance Health Johnson & Johnson Blue Cross Blue Shield Michigan GTMRx (Get the Medications Right) Institute American Association of Retired Persons (AARP) CVS	11/23/2022
21693	**The ROCS Foundation's Health Summit at Sundance –** Sponsorship with AMA name and logo.	The Jewish Healthcare Foundation Pittsburgh Regional Health Initiative (PRHI) Health Careers Futures (HCF) Women's Health Activist Movement Global (WHAM Global) The John A. Hartford Foundation Center for Health Incentives and Behavioral Economics (CHIBE) - Penn Medicine	12/13/2022

EDUCATIONAL CONTENT OR GRANT

18088	**Becker's Whitepaper** – AMA co-branding and sponsorship of white paper.	Becker's Hospital Review	01/20/2022
18667	**Clinical Problem Solvers – Educational Series** – AMA EdHub hosted podcasts with AMA name and logo.	The Clinical Problem Solvers	02/07/2022
18767	**Return on Health Report** – Repeat project for co-branded white paper on findings for behavioral health integration.	Manatt Health - Manatt, Phelps & Phillips, LLP	02/10/2022
18850	**Mary Ann Liebert Journal Articles** – AMA EdHub co-branded collaboration on women's healthcare.	Mary Ann Liebert Inc	02/28/2022
17629	**Abu Dhabi Department of Health** – AMA and CPT logos featured in customer case study.	Department of Health – Abu Dhabi Malaffi Health - Information Exchange Muashir	03/11/2022
19206	**Edge-U-Cate Credentialing School Sponsorship** – Repeat sponsorship with AMA name and logo.	Edge-U-Cate ABMS Solutions Certi-Facts American Osteopathic Information Association Symplr Morisey Associates	04/06/2022
19464	**"The Value of Telehealth Amongst Specific Clinical Use Cases"** – Co-branded white paper with AMA name and logo.	Laurel Health Advisors LLC	05/05/2022
19643	**Medical News Literacy Project** – Literacy content for K-12 students with AMA name and logo.	News Literacy Project Checkology	05/25/2022

19950	**ScholarRx Proof of Concept (POC) Project** – Co-branded AMA content for ScholarRx platform.	ScholarRx	07/15/2022
20245	**Future of Health Research** – Co-branded white paper on value of virtual healthcare.	Manatt Health - Manatt, Phelps & Phillips, LLP	08/23/2022
21505	**Opioid Overdose Epidemic Project** – Research on best practice policies to help end overdose epidemic, with AMA name and logo.	Manatt Health - Manatt, Phelps & Phillips, LLP	11/15/2022

Collaborations/ Affiliations

18945	**Advancing Equity through Quality and Safety Peer Network** – Collaboration to advance equity in healthcare organizations with AMA name and logo.	The Joint Commission Brigham and Women's Hospital Atlantic Health System University of Iowa Hospitals MD Anderson Cancer Center Ochsner Health The Children's Hospital of Philadelphia Vanderbilt University Medical Center Dana-Farber Cancer Institute University of Wisconsin Hospitals and Clinics	03/01/2022
18482	**Telehealth Access for America Campaign** – AMA name and logo use for campaign on permanent approval of Medicare coverage for telehealth.	Telehealth Access for America American Hospital Association AARP American Heart Association American Telemedicine Association Adventist Health Policy Association Consumer Technology Association Athena Health, Executives for Health Innovation Teladoc Health Alliance for Connected Care Partnership to Advance Virtual Care Ascension Johns Hopkins Medicine Included Health	01/12/2022
18132	**Providers Clinical Support System Collaboration** – Co-branded materials for healthcare providers on treating Opioid Use Disorder (OUD).	Minnesota Medical Association Providers Clinical Support System	01/17/2022
18552	**DirectTrust Membership Program -** Membership with AMA name and logo.	DirectTrust Information Exchange for Human Services (IX4HS) Consensus Body	01/18/2022
19912	**MAP Dashboards for HCOs** – Repeat AMA co-branding with healthcare organizations for MAP blood pressure dashboard project.	LifeCare Value Network LifeCare Oklahoma LifeCare Ascension	07/06/2022

18857	**All In Campaign** – Repeat healthcare workforce wellbeing campaign with AMA name and logo.	Dr. Lorna Breen Heroes Foundation Thrive Global Foundation CAA Foundation American Association of Colleges of Nursing American College of Emergency Physicians American Hospital Association American Nurse Foundation Collaborative for Health and Renewal in Medicine Johnson & Johnson Center for Health Worker Innovation Medicine Forward National Black Nurses Association Philippines Nurses Association of America Schwartz Center for Compassionate Care The Physicians Foundation	02/22/2022
18934	**Collaborative for Health and Renewal in Medicine (CHARM)** - Charter committed to reducing healthcare worker burnout with AMA name and logo.	Arnold P. Gold Foundation Associate Ophthalmologists Atlantic Medical Group Cleveland Clinic Florida Edward-Elmhurst Healthcare Gillette Children's Specialty Healthcare Hartford Healthcare Huntington Hospital Lehigh Valley Health Network Mountain Area Health Education Center Moffitt Cancer Center Nemours Children's Health System NYU Langone Hospital Penn Medical Lancaster General Health Saint Francis Hospital Tulane University School of Medicine University of Florida College of Medicine University of Washington School of Medicine VITAL Worklife	03/01/2022

20181	**AMA Grand Rounds** – Webinar series on health equity supported by collaborators/sponsors with AMA name and logo.	Accreditation Council for Graduate Medical Education National Center for Interprofessional Practice Education American Society of Addiction Medicine Sinai Chicago Boston Medical Center HealthBegins Accreditation Council for Continuing Medical Education Rush University Medical Center RespectAbility American Board of Internal Medicine Foundation The Hastings Center Council of Medical Specialty Societies	08/08/2022
19225	**Rise to Health Coalition** – Co-branded coalition to embed equity in healthcare including toolkits, webinars and guides for healthcare professionals.	Institute for Healthcare Improvement (IHI) Race Forward Groundwater Institute PolicyLink HealthBegins American Health Insurance Plans (AHIP) Council of Medical Specialty Societies (CMSS) National Association of Community Health Centers (NACHC)	04/14/2022
19102	**Axuall Credentialing** – Credentialing platform partnership with AMA name and logo.	Axuall	03/28/2022
19195	**Prime Health** – Additional collaborator for "In Full Health" equitable innovation project.	Prime Health	03/30/2022
19214	**Rock Health** – Repeat annual sponsorship with AMA name and logo.	Rock Health Fenwick and West Law Firm Amazon Web Services (AWS) Morgan Stanley Goldman Sachs Myovant Russell Reynolds	04/08/2022

19698	**"The Color of Care" Documentary Medical Advisory Board** – Participation on advisory board with AMA name and logo.	Dr. Ala Stanford Center for Health Equity Black Doctors COVID-19 Consortium	06/07/2022
19964	**Joy in Medicine** – Repeat AMA recognition program for outstanding healthcare organizations.	Atlantic Health System Baylor Scott & White – The Heart Hospital Boston Children's Pediatric Physicians' Organization Centura Health Edward-Elmhurst Health Gillette Children's Specialty Healthcare Hartford HealthCare Moffitt Cancer Center MultiCare Health System Nemours Children's Health Samaritan Health Services Sea Mar Community Health Centers The Christ Hospital Health Network The Permanente Medical Group Cleveland Clinic Oak Street Health Cooper University Health Care Johns Hopkins Medicine Medical College of Wisconsin, Froedtert Children's Hospital Northwell Health Physician Partners Penn Medicine Lancaster General Health Temple University Health System Tulane University School of Medicine UMass Memorial Health UCI Health University of Mississippi Medical Center University of New Mexico School of Medicine UW Medicine | Valley Medical Center	07/07/2022
19917	**New MAP BP program channel partners** - with AMA name and logo.	Relevant Healthcare, Inc. Azara Healthcare i2i Population Health	07/11/2022

19931	**AMA/Ad Council Flu Vaccine Campaign** – Co-branded public awareness campaign.	Ad Council	07/11/2022
19695	**Frontline Physician and Nurses Documentary Series** – Documentary series with AMA name and logo.	Afropunk National Medical Association	07/13/2022
20054	**Health IT End User Alliance** – Collaboration focusing healthcare IT principles on patient and care team needs with AMA name and logo.	American Health Information Management Association American Academy of Family Physicians American College of Physicians American College of Surgeons American Medical Group Association Federation of American Hospitals Medical Group Management Association Oregon Community Health Information Network Premier, Inc. Sutter Health Wisconsin Hospital Association	07/20/2022
20506	**National Health IT Collaborative (NHIT) for the Underserved** – Sponsorship with AMA name and logo.	Gordon and Betty Moore Foundation Multicultural Media Telecom and Internet Council Wiley Law Mass General Brigham Puerto Rican Primary Care Association Network Association of Clinics for the Underserved AmeriHealth Visionary Consulting Partners Acacia Network National Association of Community Health Centers MITRE Corporation Infor Software NextGen Alliance Chicago Tyler Technologies Health Choice Network CCI Center for Civic Innovations Visualutions Keralty Tracfone Wireless	09/14/2022

		Summit Health Institute for Research and Education CIMIT Point of Care Technology in Primary Care RCHN Community Health Foundation	
20571	**Alternative Payment Models (APMs) White Paper** – Tri-branded white paper to advance the adoption of APMs with AMA name and logo.	America's Health Insurance Plans National Association of Accountable Care Organizations Manatt Health HMA-Leavitt Aurrera Health Bailit Health	09/20/2022
20652	**DTA Webinar** - AMA-hosted CPT webinar.	Digital Therapeutics Alliance	09/22/2022
20687	**National Academy of Medicine (NAM) Well-Being Collaborative** – Sponsorship with AMA name and logo.	Alliance of Independent Academic Medical Centers ChristianaCare CRICO LCMC Health National Quality Forum RENEW Patient Advocate Foundation UAB Medicine UnitedHealth Group	09/29/2022
20788	**Alternative Payment Models (APMs) Coalition** – Advocacy and Awareness program to advance the adoption of APMs with AMA name and logo.	National Association of Accountable Care Organizations Healthcare Transformation Task Force Premier, Inc.	10/11/2022
20976	**Chicago Area Public Affairs Group** – Repeat sponsorship with AMA name and logo.	Chicago Area Public Affairs Group	11/10/2022
21427	**National Academy of Medicine (NAM) Action Collaborative** – Sponsorship of stakeholder meeting series.	Joint Commission American Association of Critical-Care Nurses Johns Hopkins Medical College of Wisconsin UnitedHealth Group Cedars-Sinai American Dental Education Association	11/28/2022

21458	**SAWCA** – Repeat sponsorship with AMA name and logo.	Southern Association of Workers Compensation Administrators National Council on Compensation Insurance Optum Sedgwick	11/30/2022
21660	**The Gravity Project** – AMA co-hosted CPT webinar with name and logo.	HL7 Fast Healthcare Interoperability Resources HL7 Fast Healthcare Interoperability Resources Foundation US Core Data for Interoperability (USCDI) Logical Observation Identifiers Names and Codes (LOINC) International Classification of Diseases (ICD – 10) SNOMED CT National Library of Medicine	12/05/2022

MEMBER PROGRAMS

18311	**Laurel Road Perks Program** – Laurel Road Affinity Program with AMA name and logo.	Laurel Road Bank Brooklinen Sakara P.volve Getaway Kidpass The White Coat Investor Task Rabbit Lyft	01/27/2022
20380	**UWorld** – Medical Student Outreach Program (MSOP) test prep incentive partner with AMA name and logo.	UWorld	08/29/2022
20736	**GradFin Affinity Program** – Laurel Road Bank subsidiary added to AMA member benefit program with AMA name and logo.	Laurel Road Bank GradFin	10/17/2022
20729	**Mercedes-Benz Affinity Program** - Automobile member benefit program with AMA name and logo.	Mercedes Benz	10/14/2022
	AMA Insurance Agency Medical Malpractice Insurance Program – Co-branded medical malpractice insurance program with AMAIA name and logo.	Indigo Concert Group	12/02/2022

AMA FOUNDATION

AMA Foundation Corporate Donors – AMAF name and logo association with 2022 corporate donors.	Amgen Bristol Myers Squibb Eli Lilly Genentech GlaxoSmithKline Grail Henry Schein Merck Novartis Pfizer PhRMA Sanofi	08/29/2022

REPORT OF THE BOARD OF TRUSTEES

B of T Report 06-A-23

Subject: Redefining AMA's Position on ACA and Healthcare Reform

Presented by: Sandra Adamson Fryhofer, MD, Chair

At the 2013 Annual Meeting of the House of Delegates (HOD), the HOD adopted Policy D-165.938, "Redefining AMA's Position on ACA and Healthcare Reform," which calls on our American Medical Association (AMA) to "develop a policy statement clearly outlining this organization's policies" on several specific issues related to the Affordable Care Act (ACA) as well as repealing the SGR and the Independent Payment Advisory Board (IPAB). The adopted policy also calls for our AMA to report back at each meeting of the HOD. Board of Trustees Report 6-I-13, "Redefining AMA's Position on ACA and Healthcare Reform," accomplished the original intent of the policy. This report serves as an update on the issues and related developments occurring since the most recent meeting of the HOD.

IMPROVING THE AFFORDABLE CARE ACT

Our AMA continues to engage policymakers and advocate for meaningful, affordable health care for all Americans to improve the health of our nation. Our AMA remains committed to the goal of universal coverage, which includes protecting coverage for the 20 million Americans who acquired it through the ACA. Our AMA has been working to fix the current system by advancing solutions that make coverage more affordable and expanding the system's reach to Americans who fall within its gaps. Our AMA also remains committed to improving health care access so that patients receive timely, high-quality care, preventive services, medications, and other necessary treatments.

Our AMA continues to advocate for policies that would allow patients and physicians to be able to choose from a range of public and private coverage options with the goal of providing coverage to all Americans. Specifically, our AMA has been working with Congress, the Administration, and states to advance our plan to cover the uninsured and improve affordability as included in the "2022 and Beyond: AMA's Plan to Cover the Uninsured." The COVID-19 pandemic initially led to many people losing their employer-based health insurance. This only increased the need for significant improvements to the Affordable Care Act. Recent data indicate that the uninsured rate has decreased during the COVID-19 pandemic, due to the temporary ACA improvements included in the American Rescue Plan Act, continuous Medicaid enrollment, and state Medicaid expansions.

We also continue to examine the pros and cons of a broad array of approaches to achieve universal coverage as the policy debate evolves.

Our AMA has been advocating for the following policy provisions:

Cover Uninsured Eligible for ACA's Premium Tax Credits

- Our AMA advocates for increasing the generosity of premium tax credits to improve premium affordability and incentivize tax credit eligible individuals to get covered. Currently, eligible individuals and families with incomes between 100 and 400 percent federal poverty level

(FPL) (133 and 400 percent in Medicaid expansion states) are being provided with refundable and advanceable premium tax credits to purchase coverage on health insurance exchanges.

- Our AMA has been advocating for enhanced premium tax credits for young adults. In order to improve insurance take-up rates among young adults and help balance the individual health insurance market risk pool, young adults ages 19 to 30 who are eligible for advance premium tax credits could be provided with "enhanced" premium tax credits—such as an additional $50 per month—while maintaining the current premium tax credit structure that is inversely related to income, as well as the current 3:1 age rating ratio.
- Our AMA is also advocating for an expansion of the eligibility for and increasing the size of cost-sharing reductions. Currently, individuals and families with incomes between 100 and 250 percent FPL (between 133 and 250 percent FPL in Medicaid expansion states) also qualify for cost-sharing subsidies if they select a silver plan, which leads to lower deductibles, out-of-pocket maximums, copayments, and other cost-sharing amounts. Extending eligibility for cost-sharing reductions beyond 250 percent FPL, and increasing the size of cost-sharing reductions, would lessen the cost-sharing burdens many individuals face, which impact their ability to access and afford the care they need.

<u>Cover Uninsured Eligible for Medicaid or Children's Health Insurance Program</u>

Before the COVID-19 pandemic, in 2018, 6.7 million of the nonelderly uninsured were eligible for Medicaid or the Children's Health Insurance Program (CHIP). Reasons for this population remaining uninsured include lack of awareness of eligibility or assistance in enrollment.

- Our AMA has been advocating for increasing and improving Medicaid/CHIP outreach and enrollment, including auto enrollment.
- Our AMA has been opposing efforts to establish Medicaid work requirements. The AMA believes that Medicaid work requirements would negatively affect access to care and lead to significant negative consequences for individuals' health and well-being.

<u>Make Coverage More Affordable for People Not Eligible for ACA's Premium Tax Credits</u>

Before the COVID-19 pandemic, in 2018, 5.7 million of the nonelderly uninsured were ineligible for financial assistance under the ACA, either due to their income, or because they have an offer of "affordable" employer-sponsored health insurance coverage. Without the assistance provided by ACA's premium tax credits, this population can continue to face unaffordable premiums and remain uninsured.

- Our AMA advocates for eliminating the subsidy "cliff," thereby expanding eligibility for premium tax credits beyond 400 percent FPL.
- Our AMA has been advocating for the establishment of a permanent federal reinsurance program, and the use of Section 1332 waivers for state reinsurance programs. Reinsurance plays a role in stabilizing premiums by reducing the incentive for insurers to charge higher premiums across the board in anticipation of higher-risk people enrolling in coverage. Section 1332 waivers have also been approved to provide funding for state reinsurance programs.
- Our AMA also is advocating for lowering the threshold that determines whether an employee's premium contribution is "affordable," allowing more employees to become eligible for premium tax credits to purchase marketplace coverage.
- Our AMA strongly advocated for the Internal Revenue Service (IRS) proposed regulation on April 7, 2022 that would fix the so-called "family glitch" under the ACA, whereby families of workers remain ineligible for subsidized ACA marketplace coverage even though they face

unaffordable premiums for health insurance coverage offered through employers. The proposed regulation would fix the family glitch by extending eligibility for ACA financial assistance to only the family members of workers who are not offered affordable job-based family coverage. The Biden Administration finalized the proposed rule on October 13, 2022.

EXPAND MEDICAID TO COVER MORE PEOPLE

Before the COVID-19 pandemic, in 2018, 2.3 million of the nonelderly uninsured found themselves in the coverage gap—not eligible for Medicaid, and not eligible for tax credits because they reside in states that did not expand Medicaid. Without access to Medicaid, these individuals do not have a pathway to affordable coverage.

- Our AMA has been encouraging all states to expand Medicaid eligibility to 133 percent FPL.

New policy adopted by the AMA HOD during the November 2021 Special Meeting seeks to assist more than two million nonelderly uninsured individuals who fall into the "coverage gap" in states that have not expanded Medicaid—those with incomes above Medicaid eligibility limits but below the FPL, which is the lower limit for premium tax credit eligibility. The new AMA policy maintains that coverage should be extended to these individuals at little or no cost, and further specifies that states that have already expanded Medicaid coverage should receive additional incentives to maintain that status going forward.

AMERICAN RESCUE PLAN OF 2021

On March 11, 2021, President Biden signed into law the American Rescue Plan (ARPA) of 2021. This legislation included the following ACA-related provisions that will:

- Provide a temporary (two-year) 5 percent increase in the Federal Medical Assistance Percentage (FMAP) for Medicaid to states that enact the Affordable Care Act's Medicaid expansion and covers the new enrollment period per requirements of the ACA.
- Invest nearly $35 billion in premium subsidy increases for those who buy coverage on the ACA marketplace.
- Expand the availability of ACA advanced premium tax credits (APTCs) to individuals whose income is above 400 percent of the FPL for 2021 and 2022.
- Give an option for states to provide 12-month postpartum coverage under State Medicaid and CHIP.

ARPA represents the largest coverage expansion since the Affordable Care Act. Under the ACA, eligible individuals, and families with incomes between 100 and 400 percent of the FPL (between 133 and 400 percent FPL in Medicaid expansion states) have been provided with refundable and advanceable premium credits that are inversely related to income to purchase coverage on health insurance exchanges. However, consistent with Policy H-165.824, "Improving Affordability in the Health Insurance Exchanges," ARPA eliminated ACA's subsidy "cliff" for 2021 and 2022. As a result, individuals and families with incomes above 400 percent FPL ($51,520 for an individual and $106,000 for a family of four based on 2021 federal poverty guidelines) are eligible for premium tax credit assistance. Individuals eligible for premium tax credits include individuals who are offered an employer plan that does not have an actuarial value of at least 60 percent or if the employee share of the premium exceeds 9.83 percent of income in 2021.

Consistent with Policy H-165.824, ARPA also increased the generosity of premium tax credits for two years, lowering the cap on the percentage of income individuals are required to pay for premiums of the benchmark (second lowest-cost silver) plan. Premiums of the second lowest-cost silver plan for individuals with incomes at and above 400 percent FPL are capped at 8.5 percent of their income. Notably, resulting from the changes, eligible individuals and families with incomes between 100 and 150 percent of the FPL (133 percent and 150 percent FPL in Medicaid expansion states) now qualify for zero-premium silver plans, effective until the end of 2022.

In addition, individuals and families with incomes between 100 and 250 percent FPL (between 133 and 250 percent FPL in Medicaid expansion states) also qualify for cost-sharing subsidies if they select a silver plan, which reduces their deductibles, out-of-pocket maximums, copayments, and other cost-sharing amounts.

LEGISLATIVE EXTENSION OF ARPA PROVISIONS

On August 16, 2022, President Biden signed into law the Inflation Reduction Act of 2022 through the highly partisan budget reconciliation process, which allows both the House and Senate to pass the bill with limits on procedural delays. Most significantly, reconciliation allows the Senate to bypass the filibuster and pass legislation with a 50-vote threshold so long as it meets a series of budgetary requirements. The Inflation Reduction Act included provisions that extended for three years to 2025 the aforementioned ACA premium subsidies authorized in ARPA.

The Inflation Reduction Act did not include provisions to close the Medicaid "coverage gap" in the states that have not chosen to expand.

ACA ENROLLMENT

According to the U.S. Department of Health and Human Services (HHS), 16.3 million Americans have signed up for or were automatically re-enrolled in the 2023 individual market health insurance coverage through the marketplaces since the start of the 2022 Marketplace Open Enrollment Period (OEP) on November 1, 2022, through January 15, 2023.

TEXAS VS. AZAR SUPREME COURT CASE

The Supreme Court agreed on March 2, 2020, to address the constitutionality of the ACA for the third time, granting the petitions for certiorari from Democratic Attorneys General and the House of Representatives. Oral arguments were presented on November 10, 2020, and a decision was expected before June 2021. The AMA filed an amicus brief in support of the Act and the petitioners in this case.

On February 10, 2021, the U.S. Department of Justice under the new Biden Administration submitted a letter to the Supreme Court arguing that the ACA's individual mandate remains valid, and, even if the court determines it is not, the rest of the law can remain intact.

This action reversed the Trump Administration's brief it filed with the Court asking the justices to overturn the ACA in its entirety. The Trump Administration had clarified that the Court could choose to leave some ACA provisions in place if they do not harm the plaintiffs, but as legal experts pointed out, the entire ACA would be struck down if the Court rules that the law is inseparable from the individual mandate—meaning that there would be no provisions left to selectively enforce.

On June 17, 2021, the Supreme Court in a 7-2 decision ruled that neither the states nor the individuals challenging the law have a legal standing to sue. The Court did not touch on the larger issue in the case: whether the entirety of the ACA was rendered unconstitutional when Congress eliminated the penalty for failing to obtain health insurance.

With its legal status now affirmed by three Supreme Court decisions, and provisions such as coverage for preventive services and pre-existing conditions woven into the fabric of U.S. health care, the risk of future lawsuits succeeding in overturning the ACA is significantly diminished.

BRAIDWOOD MANAGEMENT VS. BECCERRA FEDERAL COURT CASE

A case before a federal district court judge in the Northern District of Texas, *Braidwood v. Becerra* (formerly *Kelley v. Becerra)*, would eliminate the ACA requirement that most health insurance plans cover preventive services without copayments. Those filing the case object to paying for coverage that they do not want or need, particularly for those items or services that violate their religious beliefs, such as contraception or PrEP drugs. If the case is ultimately successful, health plan enrollees will also lose access to full coverage for dozens of preventive health services, including vaccinations and screenings for breast cancer, colorectal cancer, cervical cancer, heart disease, and other diseases and medical conditions.

The AMA and 61 national physician specialty organizations issued a joint statement on July 25, 2022, sounding the alarm about the millions of privately insured patients who would be affected by an adverse ruling.

On September 7, 2022, Texas federal court judge Reed O'Connor ruled that part of the ACA's requirement that health plans cover preventive services without copayments was unconstitutional. He further held that that one of the plaintiffs, Braidwood Management, a for-profit company, could not be required to cover PrEP through its employer health plan because of Braidwood's religious objections. Judge O'Conner did not immediately issue an order blocking enforcement of the coverage requirements. He also did not specify whether such an order would be nationwide, for his district only, for all the named plaintiffs, or only for Braidwood. These issues were held for further argument before Judge O'Connor.

On November 30, 2022, the Litigation Center of the American Medical Association and State Medical Societies, along with the American College of Obstetricians and Gynecologists, American Academy of Pediatrics, American Academy of Family Physicians, and four other national associations filed an amicus brief warning against the court ordering broad, nationwide relief, arguing that such a decision would imperil access to vital preventive care that keeps patients healthier and lowers overall costs for the health care system.

On March 30, 2023, after supplemental briefing from the parties and *amici*, the federal district court issued its opinion and order addressing the remedies and final judgment. Most notably, the court ordered that all actions taken by HHS to implement or enforce the preventive care coverage requirements in response to an "A" or "B" recommendation by the U.S. Preventive Services Task Force on or after March 23, 2010 are vacated and enjoined going forward. The court also ordered that the named plaintiffs need not comply with the PrEP mandate, based on the court's prior ruling that the PrEP mandate violates the plaintiffs' rights under the Religious Freedom Restoration Act. On March 31, the federal government filed its notice of appeal, and the litigation will continue.

In a statement following the ruling, AMA President Jack Resneck, Jr., M.D., expressed alarm at the ruling and urged employers and insurers to maintain this first dollar coverage while legislative and judicial next steps are considered.

SGR REPEAL

The Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 repealing and replacing the SGR was signed into law by President Obama on April 16, 2015.

The AMA is now working on unrelated new Medicare payment reduction threats and is currently advocating for a sustainable, inflation-based, automatic positive update system for physicians.

INDEPENDENT PAYMENT ADVISORY BOARD REPEAL

The Bipartisan Budget Act of 2018 signed into law by President Trump on February 9, 2018, included provisions repealing IPAB. Currently, there are not any legislative efforts in Congress to replace the IPAB.

CONCLUSION

Our American Medical Association will remain engaged in efforts to improve the health care system through policies outlined in Policy D-165. 938 and other directives of the House of Delegates. Given that most of the ACA fixes that led to calls in 2013 for this report at every HOD meeting have been accomplished, our primary goal now related to health care reform is stabilization of the broken Medicare physician payment system, including the need for inflation-based positive annual updates and reform of budget neutrality rules.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 07-A-23

Subject: AMA Performance, Activities, and Status in 2022

Presented by: Sandra Adamson Fryhofer, MD, Chair

Policy G-605.050, "Annual Reporting Responsibilities of the AMA Board of Trustees," calls for the Board of Trustees to submit a report at the American Medical Association (AMA) Annual Meeting each year summarizing AMA performance, activities, and status for the prior year.

INTRODUCTION

The AMA's mission is to promote the art and science of medicine and the betterment of public health. As the physician organization whose reach and depth extend across all physicians, as well as policymakers, medical schools, and health care leaders, the AMA uniquely can deliver results and initiatives that enable physicians to improve the health of the nation.

Representing physicians with a unified voice

In a year that marked the organization's 175th anniversary, the AMA launched the Recovery Plan for America's Physicians, a five-point strategy to support and strengthen our nation's physician workforce. The plan was introduced at the Annual Meeting of the AMA House of Delegates in June 2022. The five objectives of the plan focus on prior authorization, Medicare payment reform, scope of practice creep, physician burnout and telehealth.

The AMA has been leading a multiyear effort to bring about Medicare payment models that give physicians greater flexibility in care delivery, minimize administrative burdens that detract from patient care, and improve the financial viability of physician practices. In 2022, we led a robust advocacy campaign that was joined by more than 150 organizations representing more than 1 million physicians that minimized the 8.5% Medicare physician payment cuts slated for 2023. In addition, AMA advocacy efforts helped secure a two-year postponement of the 4% cuts from the pay-as-you-go sequester tied to the American Rescue Plan Act

The AMA scored more than 40 state-level victories by working in partnership with state medical associations and national medical specialty societies. Pressing the fight for patient safety, we stopped bills that would have expanded the scope of practice for nurse practitioners and other APRNs, helped defeat legislation nationwide that would have allowed physician assistants to practice independently without physician oversight, and turned away measures allowing pharmacists to prescribe medications and optometrists to perform surgery.

The AMA continues to aggressively urge the Department of Veterans Affairs to reject the inappropriate scope of practice expansions outlined in the Federal Supremacy Project while advocating as strongly as ever in favor of physician-led teams and against improper scope expansions in all 50 states and the District of Columbia.

In cases ranging from COVID-19 standards of care and firearm regulations to climate change and transgender rights, the AMA continued to fight for physicians and patients in state and federal

courts in 2022. The AMA was a plaintiff in *African American Tobacco Control Leadership Council v. HHS*, which forced the federal government to take the first steps toward banning menthol cigarettes. And in the wake of the U.S. Supreme Court's *Dobbs v. Jackson Women's Health Organization* decision, the AMA joined numerous briefs outlining the need for access to reproductive care and opposing third-party interference in the patient-physician relationship.

The AMA elevated the voice of physician leadership on critical issues of public health, securing more than 175 billion media impressions representing nearly $1.6 billion in estimated ad value and achieving a commanding 43 percent share of voice among healthcare entities in the media.

Removing obstacles that interfere with patient care

The Improving Seniors' Timely Access to Care Act, the bipartisan effort to ease prior authorization burdens under the Medicare Advantage program, garnered 326 co-sponsors before it was passed by the U.S. House of Representatives in September. Its provisions were developed from the consensus statement on prior authorization reform that the AMA helped draft.

The AMA represented the interests of physicians in a federal regulatory task force exploring methods to streamline the prior authorization process. The AMA also played a key role in the successful adoption of prior authorization reform laws in Georgia, Iowa and Michigan, and paved the way for reform efforts in 2023 in nearly a dozen more states.

The AMA authored or co-authored a record 27 peer-reviewed journal articles and research reports in 2022 relating to physician burnout and improving professional satisfaction and practice sustainability. The AMA helped secure the enactment of the Dr. Lorna Breen Health Care Provider Protection Act, which enables a broad range of essential physician wellness resources, including evidence-based programs dedicated to improving mental health and resiliency.

The AMA STEPS Forward® Program exceeded 1.6 million lifetime users with new training programs that included two more playbooks, two new and 17 updated toolkits, 26 podcasts and four videos.

The AMA expanded its work in promoting physician wellness through its Joy in Medicine™ Health System Recognition Program, honoring nearly 30 health care organizations that represented more than 80,000 physicians.

The AMA expanded its national Behavioral Health Collaborative with the launch of the Behavioral Health Integration Immersion Program, a 12-month curriculum that provides enhanced technical assistance to physician practices seeking to deliver integrated care to patients. This effort builds on the success of the Overcoming Obstacles series with several new webinars on topics such as assembling a behavioral health integration care team and addressing physician and patient mental health.

Driving the future of medicine

The AMA played a key role in securing passage of legislation to extend Medicare telehealth flexibilities through the end of 2024. We launched model legislation that states can use to advance telehealth coverage and policies. The AMA further supported telehealth expansion by expanding our already-impressive library of print and online resources promoting evidence-based telehealth services to now include strategies to advance health equity in virtual care. The launch of the AMA's Telehealth Immersion Program supports practices in the implementation and optimization

of telehealth. The program expanded in 2022 with seven webinars, five clinical case studies, two virtual panel discussions and one mini bootcamp.

The industry-leading AMA Ed Hub™ online education portal received 6 million views and continued to expand its programs, affiliations and reach to support live broadcasts and enhance multimedia capabilities. The number of external education providers grew by 10 to encompass 35 organizations with the addition of the American Board of Pediatrics and the American Academy of Allergy, Asthma and Immunology, among others.

The AMA, led by its Center for Health Equity, strengthened its physician engagement with the launch of seven new social justice education modules published on the AMA Ed Hub™ learning platform. These modules focus on strategies to advance equity through quality and safety improvements to the historical foundations of racism in medicine. In addition, the AMA's popular "Prioritizing Equity" webinar series grew to 28 episodes, with new features on voting, health equity and reproductive care as a human right.

The AMA helped launch the "In Full Health Learning and Action Community to Advance Equitable Health in Innovation" initiative, building upon the expertise of 17 external collaborations to create three AMA Ed Hub™ learning modules and the "Equitable Health Innovation Solutions" toolkit.

Building on the AMA's commitment to diversity, equity and inclusion, the AMA Graduate Medical Education Competency Education Program and the AMA Undergraduate Medical Education Curricular Enrichment Program launched a series of health equity educational courses: "Social Determinants of Health," "Basics of Health Equity," and three courses in the "Racism in Medicine" series.

First published in March 2022 as part of the AMA's MedEd Innovation Series, "Coaching in Medical Education" quickly sold out. Now in its second printing, this instructor-focused guide outlines a scientific foundation for coaching competency and has ranked in the top 100 of medical education and training books since its release. The AMA also published "Protecting the Education Mission During Sustained Disruption" in 2022, a report that explores organizational strategies to support educators amid extreme stress and which formed the basis of the Educator Well-Being in Academic Medicine book published in December.

The AMA released a special 175th anniversary edition of its Code of Medical Ethics, and the Journal of the American Medical Association, under the direction of new Editor-in-Chief Kirsten Bibbins-Domingo, MD, PhD, MAS, maintained its place among the world's preeminent medical journals. All 12 specialty publications from the JAMA Network™ ranked among the top 10 in journal Impact Factor, with eight ranking in the top three for their respective specialties.

The launch of the AMA's new Current Procedural Terminology (CPT®) Developer Program helped creators of health technology and services utilize the code set for their transformative innovations. The new self-service portal gives physicians the ability to license CPT code sets through a simple pay model, including new codes introduced in 2022 relating to the mpox outbreak and ongoing releases for specific COVID-19 vaccines.

The AMA relaunched its popular Physician Innovation Network digital platform, which now has more than 18,000 collaborators and 30 industry partners, to improve user experience and more effectively connect physicians with technology innovators.

Leading the charge to confront public health crises

The AMA expanded its health equity investments with the launch of the Rise to Health: A National Coalition for Equity in Health Care, an effort that unites individuals and organizations in shared solutions for high-impact structural change, and with a $3 million multi-year investment in Chicago's West Side United, a community-based collaborative that is addressing determinants of health and helping restore economic vitality on the city's West Side.

The AMA developed a mpox resource page to provide physicians with updated information on testing access, vaccines and therapeutics, and worked with the FDA and CDC on a webinar detailing the tecovirimat (TPOXX) antiviral. And the AMA collaborated on the annual "Get My Flu Shot" campaign, with a specific focus on reaching Black and Latinx populations and kept physicians and the public up to date on the latest pandemic developments, including therapeutics and the importance of staying up to date with COVID-19 vaccines.

To close the gap in blood pressure management training within medical schools, the AMA launched a three-part eLearning series, supported by a one-year grant program to monitor the impact of this new training. AMA policy guidance led to four states increasing access to Medicaid programs for self-measured blood pressure by covering home-use devices and clinical support services. Additionally, the AMA also helped train more than 100 community health workers to help Chicago's West Side residents more accurately measure their blood pressure at home.

The AMA's Substance Use and Pain Care Task Force continues to advance evidence-based recommendations for policymakers and physicians to help end the nation's drug-related overdose and death epidemic. The AMA and Manatt Health 2022 State Toolkit identifies more than 400 state laws, regulations, and policy guidance to help end the nation's drug overdose epidemic.

The AMA's Enterprise Social Responsibility (ESR) program continues to deliver an organized and thoughtful structure to engage AMA employees in public service work aligned with the organization's values and goals. The program has strategically integrated with the Center for Health Equity's strategic plan to support healthy, thriving, equitable communities. Thirty percent of AMA employees, representing every business unit and office location, supported nearly 80 organizations and donated $160,000 to community partners.

Membership

Following 11 consecutive years of membership growth, in 2022 the AMA experienced a small decrease in overall membership (due to a drop in student numbers), but physician membership remained steady. Overall, the organization's advocacy efforts and mission activities were supported by another strong year of financial performance.

EVP Compensation

During 2022, pursuant to his employment agreement, total cash compensation paid to James L. Madara, MD, as AMA Executive Vice President was $1,281,270 in salary and $1,220,904 in incentive compensation, reduced by $2,632 in pre-tax deductions. Other taxable amounts per the contract are as follows: $151,198 distribution from a deferred compensation plan; $23,484 imputed costs for life insurance, $24,720 imputed costs for executive life insurance, and $3,650 paid for an executive physical, and $3,519 paid for parking and other. An $81,000 contribution to a deferred compensation account was also made by the AMA. This will not be taxable until vested and paid pursuant to provisions in the deferred compensation agreement. For additional information about AMA activities and accomplishments, please see the "AMA 2022 Annual Report."

REPORT OF THE BOARD OF TRUSTEES

B of T Report 08-A-23

Subject: Annual Update on Activities and Progress in Tobacco Control: March 2022 through February 2023

Presented by: Sandra Adamson Fryhofer, MD, Chair

This report summarizes trends and news on tobacco usage, policies, and tobacco control advocacy activities from March 2022 through February 2023. The report is written pursuant to AMA Policy D-490.983, "Annual Tobacco Report."

TOBACCO USE AT A GLANCE

Tobacco control efforts are often heralded as a roadmap for advocates addressing other health behaviors associated with negative health outcomes. The successes of those efforts to reduce the tobacco-related harms cannot be diminished; however, tobacco remains the leading cause of preventable disease, disability, and death in the United States.[1] According to the Centers for Disease Control and Prevention (CDC) tobacco kills more than 480,000 people annually. Based on 2020 data, an estimated 31 million U.S. adults smoke cigarettes, and each day 1600 youth under 18 years old smoke their first cigarette. More than 16 million people live with at least one disease caused by smoking.[2]

Youth Tobacco Use Associated with Social Determinants of Health Inequities

The National Youth Tobacco Survey (NYTS) is a cross-sectional, voluntary, school-based, self-administered survey of U.S. middle and high school students. In 2022, the survey was conducted using an online survey. A total of 28,291 students from 341 schools participated, yielding an overall response rate of 45.2%.[3]

An analysis of the 2022 NYTS estimates 3 million (4.5% of middle school students and 16.5% of high school students) currently use any tobacco product including electronic cigarettes (e-cigarettes). E-cigarettes are the most commonly used tobacco product by students. Three percent of middle school students and 14% of high school students reported current use of e-cigarettes. NYTS defines current tobacco use as one or more of any commercial tobacco product on ≥1 day during the past 30 days.[3]

For the first time since the initial survey in 1999, estimates for Asian, American Indian or Alaska Native (AI/AN), Native Hawaiian or Other Pacific Islander (NH/OPI), and multiracial population groups were provided. The report states, "Whereas AI/AN students reported the highest prevalence of current use of any tobacco product, current use of any combustible tobacco product, specifically cigar and hookah use, was highest among Black students. In addition, current use of any tobacco product was higher among those students identifying as LGB [lesbian, gay, bisexual] or transgender, those reporting severe psychological distress, those with low family affluence, and those with low academic achievement."[3]

The inequities suggest the impact of the continued aggressive marketing by tobacco companies and e-cigarette manufacturers to specific populations.

Because of changes in methodology, including differences in survey administration and data collection procedures, the ability to compare estimates from 2022 with those from previous NYTS waves is limited. However, the cross-sectional data provided by the 2022 survey are still valid and informative.[3]

Adult Tobacco Use

Adult tobacco use has continued to decline with an estimated 19% of U.S. adults reporting current use of any commercial tobacco product according to the 2020 National Health Interview Survey (NHIS) compared to 21% reported in 2019. NHIS is an annual, nationally representative household survey of the noninstitutionalized U.S. civilian population. Current use is defined by NHIS as having reported use of these products every day or some days at the time of survey. While e-cigarettes are the most common tobacco product of youth, an estimated 80% of adults reported using combustible products (cigarettes, cigars and pipes).[4]

The CDC report shows inequities in adults who smoke and use tobacco in the U.S. According to the report groups with high rates of smoking include people with lower income and less education, AI/AN adults, residents of the Midwest and South, residents of rural areas, LGB adults, and adults who regularly had feelings of anxiety or depression. Adults who are uninsured or enrolled in Medicaid smoke at more than double the rates of those with private health insurance or Medicare.[4]

Among all tobacco products, combustible products are the predominate cause of tobacco related morbidity and mortality indicating that policies directed at these products remain a high priority.[5] These policies should focus on providing access to evidence-based treatments for tobacco dependence and disincentives to smoking such as increases in taxes.[4]

EFFORTS TO ADDRESS TOBACCO CONTROL

ALA Releases its 2023 State of Tobacco Report

The American Lung Association (ALA) “State of Tobacco Control” report evaluates state and federal policies on actions taken to eliminate tobacco use and recommends proven-effective tobacco control laws and policies. The report provides letter grades to five interventions. At the federal level grades are given for regulation of tobacco products, coverage for smoking cessation, taxes, mass media campaigns and minimum sales age. At the state level the report evaluates smokefree workplace laws, sales of flavored tobacco products, state program funding, tobacco taxes, and access cessation services.

According to the American Lung Association’s 2023 State of Tobacco Report, the Federal government took major steps toward regulating tobacco products in 2022 but fell short in coverage of quit smoking treatments and increasing federal taxes. The states with the highest overall grades were California, District of Columbia, and Massachusetts. The report shows how widely tobacco policies vary from state to state. For example, some states still allow smoking in workplaces including restaurants and bars, and some states lack Medicaid coverage for tobacco cessation. Alabama, Mississippi, North Carolina, and Texas were states with the most need to enact evidence-based policies.

The report also highlights the need to continue funding programs like the CDC's Tips From Former Smokers® (Tips®) campaign launched in 2012. The campaign profiles real people from many different backgrounds living with serious long-term health effects from smoking and secondhand smoke exposure. State level funding for cessation efforts also should be prioritized as well as efforts to provide support for community-level engagements in addressing inequities.[6]

AMA Joins with Public Health Groups to Protect Tobacco Regulation and Funding

The CDC Office on Smoking and Health (OSH) has a proven track record in developing programs, initiatives and resources that have reduced the social, medical, and economic tolls associated with tobacco in the U.S. Dedicated and increased funding is needed by for OSH to support ongoing research that contributes to the development of innovative interventions in tobacco prevention and cessation.

In April 2022 the AMA signed on to a letter calling on the House of Representatives Appropriations Committee to increase funding for OSH by $68.5 million, for a total of $310 million.

In June 2022, when members of the House of Representative's Committee on Appropriations were reviewing the Agriculture, Rural Development, Food and Drug Administration, and Related Agencies Appropriations bill the public health community raised concerns that the bill would include language weakening FDA's authority over tobacco. The AMA was one of 70 organizations, including Federation members American Thoracic Society, American Academy of Pediatrics and American College of Cardiology, who signed a letter to the Committee calling on them to ensure that FDA has the unfettered ability to protect youth from unscrupulous marketing of any and all tobacco products.

These letters were part of a comprehensive strategy to ensure that the tobacco industry and others have limited influence in weakening the strides made in tobacco control while being prepared for new threats to public health in the future.

Supreme Court Upholds California Law Banning Flavored Tobacco Products

In 2020, California Governor Gavin Newsom signed Senate Bill 793 into law. This law prohibited the sale of menthol cigarettes and most flavored tobacco products. The law was immediately challenged and thus began a two-year legal battle by R.J. Reynolds who sued the state of California and effectively delayed implementation until the law could be considered in a ballot referendum in 2022. In November 2022, California voters overwhelmingly supported the 2020 law with more than 60% voting yes on the referendum.

R.J. Reynolds and other tobacco entities immediately appealed to the Supreme Court, requesting an emergency injunction against California's law arguing that the Federal Tobacco Control Act prohibited California from enacting its flavored tobacco law. The AMA joined with public health groups and other medical associations in an amicus brief opposing R.J. Reynolds' emergency application. On December 12, the Supreme Court denied the suit and on December 21, California became the second state to ban the sale of flavored tobacco products and menthol cigarettes. Massachusetts was the first state to ban flavors and menthol in 2019.

FDA Takes Steps to Remove Menthol

On April 28, 2022, the U.S. Food and Drug Administration (FDA) released two proposed rules on characterizing flavors in tobacco products. One of the proposed rules would ban menthol and all characterizing flavors such as strawberry flavor in cigarettes, and the other proposed rule would prohibit menthol in cigars. This news was treated with great support from public health groups, but it came after years of inaction by the FDA. The long-overdue action follows a lawsuit filed in 2020 by the African American Tobacco Control Leadership Council, Action on Smoking and Health, AMA, and National Medical Association.

According to a Substance Abuse and Mental Health Services Administration study, "85% of non-Hispanic Black and African American adults who smoke prefer menthol cigarettes, and menthol flavoring in cigarettes and e-cigarettes make it easier for youth to initiate smoking."[7] "It is estimated that nearly 1 million Americans—and about 230,000 African Americans—would quit smoking within 13 to 17 months of a ban on menthol cigarettes taking effect."[8]

FDA has announced that the final rules will be released sometime in 2023. Barring any delay from the anticipated lawsuits from the tobacco industry, products will have to be removed within one year.

Congress Closes Loophole in FDA Authority

In March, Congress took action to expand the FDA's regulatory authority over tobacco products using synthetic nicotine. FDA's authority to regulate nicotine in tobacco products was previously limited to tobacco-derived nicotine. This specificity created a loophole for manufacturers including Puff Bar to reintroduce their e-cigarette with synthetic nicotine when ordered to take their flavored tobacco-derived product off the market. Congress closed this loophole by allowing the FDA to regulate nicotine regardless of the source. Several state and local jurisdictions have already passed similar laws; however, having a federal framework in place allows for a more comprehensive approach.

Despite this promising measure, the FDA has yet to take significant enforcement actions against companies still selling unauthorized synthetic nicotine products. Tribal, state, local, and territorial governments can and should move forward to implement their own laws where necessary and ensure that synthetic nicotine is included in their tobacco control efforts.

FDA and DoJ Take Actions Against Manufacturers

Starting in September 2020, all tobacco product manufacturers are required to submit a premarket application and receive authorization from the FDA before introducing a new tobacco product into the market. In accordance with its regulatory authority, the FDA issued warning letters to two brands of e-cigarettes doing business as Puff Bar for "receiving and delivering e-cigarettes" without a marketing authorization order. The agency also issued marketing denial orders for 32 premarket tobacco applications, because they "lacked sufficient evidence demonstrating that these flavored e-cigarettes would provide a benefit to adult users that would be adequate to outweigh the risks to youth."

In October 2022 the U.S. Department of Justice (DoJ), on behalf of the FDA, filed for permanent injunctions against six e-cigarette manufacturers on behalf of the FDA. According to the FDA, this action represents the first time that the agency has begun injunction proceedings to enforce premarket review requirements under the Federal Food, Drug and Cosmetic Act.

Each of the six defendants—Lucky's Convenience & Tobacco LLC doing business as Lucky's Vape & Smoke Shop in the District of Kansas; Morin Enterprises Inc. doing business as E-Cig Crib in the District of Minnesota; Seditious Vapours LLC doing business as Butt Out in the District of Arizona; Soul Vapor LLC in the Southern District of West Virginia; Super Vape'z LLC in the Western District of Washington and Vapor Craft LLC in the Middle District of Georgia—illegally manufactured, sold and distributed their products, even after receiving warnings from the FDA.

The defendants did not submit premarket applications for their e-cigarettes and subsequently received a warning from the FDA. While most of the 300 companies that received warning labels removed their products from the marketplace, the six defendants continued manufacturing, distributing, and selling their products.

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REPORT 10 OF THE BOARD OF TRUSTEES (A-23)
American Medical Association Health Equity Annual Report
(Informational)

EXECUTIVE SUMMARY

Background: At the 2018 Annual Meeting, the House of Delegates adopted the recommendations of Policy D-180.981 directing our AMA to "develop an organizational unit, e.g., a Center or its equivalent, to facilitate, coordinate, initiate, and track AMA health equity activities" and instructing the "Board to provide an annual report to the House of Delegates regarding AMA's health equity activities and achievements." The HOD provided additional guidance via Policy H-180.944: "Health equity, defined as optimal health for all, is a goal toward which our AMA will work by advocating for health care access, research, and data collection; promoting equity in care; increasing health workforce diversity; influencing determinants of health; and voicing and modeling commitment to health equity." HOD policy was followed by creation of the AMA Center for Health Equity ("Center") in April 2019 and the AMA's Organizational Strategic Plan to Embed Racial Justice and Advance Health Equity for 2021-2023 ("Plan") in May 2021. In 2022, updated Policy H-65.946 specified that this report will also include "updates on [the AMA's] comprehensive diversity and inclusion strategy."

Discussion: The AMA has steadfastly enhanced efforts over recent years to further embed equity in our work. The Plan serves as a guide for this work. This report outlines the activities conducted by our AMA during calendar year 2022, divided into five (5) strategic approaches detailed in the Plan: (1) Embed Equity; (2) Build Alliances and Share Power; (3) Ensure Equity in Innovation; (4) Push Upstream; and (5) Foster Truth, Reconciliation, and Racial Healing. The diversity and inclusion strategy updates are included within the Embed Equity section.

Conclusion: Despite challenges, including the COVID-19 pandemic, our AMA persevered in efforts to advance equity by continuously engaging in meaningful conversations, and finding innovative ways to connect, learn, and create. The AMA increased engagement of health equity content to 1,000,000 website users, including 124,374 engagements driven by publication of 78 new activities on Ed Hub. The AMA engaged in at least two Supreme Court amicus briefs and issued more than 70 advocacy letters to policymakers related to health equity, securing wins in the Consolidated Appropriations Act. The AMA expanded its social impact investments with an additional $3 million multi-year investment. The AMA continued to promote the art and science of medicine and the betterment of public health, advancing equity and embedding racial and social justice, making significant progress towards fulfilling the commitments outlined in the Plan during its second year.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 10-A-23

Subject: American Medical Association Health Equity Annual Report

Presented by: Sandra Adamson Fryhofer, MD, Chair

BACKGROUND

At the 2018 Annual Meeting, the House of Delegates adopted Policy D-180.981, directing our AMA to "develop an organizational unit, e.g., a Center or its equivalent, to facilitate, coordinate, initiate, and track AMA health equity activities" and instructing the "Board to provide an annual report to the House of Delegates regarding AMA's health equity activities and achievements." The HOD provided additional guidance via Policy H-180.944: "Health equity, defined as optimal health for all, is a goal toward which our AMA will work by advocating for health care access, research, and data collection; promoting equity in care; increasing health workforce diversity; influencing determinants of health; and voicing and modeling commitment to health equity." HOD policy was followed by creation of the AMA Center for Health Equity ("Center") in April 2019 and the AMA's Organizational Strategic Plan to Embed Racial Justice and Advance Health Equity for 2021-2023 ("Plan") in May 2021. In 2022, updated Policy H-65.946 specified that this report will also include "updates on [the AMA's] comprehensive diversity and inclusion strategy."

DISCUSSION

Our AMA has committed itself to advancing health equity, advocating for racial and social justice, and embedding equity across the organization and beyond. In 2022, the Center continued to collect enterprise-wide equity related work and track progress toward the five strategic approaches detailed in the AMA's Plan. This report outlines the activities conducted by our AMA during calendar year 2022, divided into five strategic approaches detailed in the Plan: (1) Embed Equity; (2) Build Alliances and Share Power; (3) Ensure Equity in Innovation; (4) Push Upstream; and (5) Foster Truth, Reconciliation, and Racial Healing. The diversity and inclusion strategy updates are included within the Embed Equity section.

Embed Equity

Ensuring a lasting commitment to health equity by our AMA involves embedding equity using anti-racism, structural competency, and trauma-informed lenses as a foundation for transforming the AMA's staff and broader culture, systems, policies, and practices, including training, tools, recruitment and retention, contracts, budgeting, communications, publishing, and regular assessment of organizational change. The following are some of the relevant accomplishments during 2022:

- The AMA engaged 1,000,000 users of health equity-related content on the website, a +43% increase over the prior year, by producing 108 new health equity-related articles or other content, significantly more than any other year. The most consumed content included: (1) "GME –These courses create health equity champions in your Residency Program" (193K users), (2) "2022 a critical year to address the worsening drug overdose crisis" (13K users), (3) "The AMA's Strategic plan to embed racial justice and advance health equity" (11k users).

- The AMA incorporated health equity into the annual Medical Student Advocacy Conference (MAC) and the annual Research Challenge, which is the largest national, multi-specialty medical research conference for medical students, residents and fellows, and international medical graduates to showcase and present research. Changes included incorporating customized diversity, equity, and inclusion (DEI) statements in Research Challenge marketing, reducing bias in the Research Challenge abstract review process by removing author names, incorporating subtitles in Research Challenge and MAC training videos, and producing an education session at MAC on redefining social determinants of health in organized medicine.
- The AMA continued to reflect its commitment to health equity in its messaging, speeches, and announcements on an ongoing basis on various fronts including the All-Employee Meeting, Frontline Communicator Training, Board of Trustees message/media training, and beyond.
- The AMA produced six Prioritizing Equity episodes (including voting and health and reproductive health care as a human right) and eight podcast episodes (five Stories of Care episodes on health equity and infection control, two LGBTQ-themed episodes, and one episode on embedding racial and health equity in health systems), hosted 2 webinars on social determinants of health and racial and health equity for health systems, and published a STEPS Forward toolkit (Racial and Health Equity: Concrete STEPS for Health Systems) and five health-equity centered issues of the Journal of Ethics (Inequity Along the Medical/Dental Divide, Toward Abolition Medicine, Health Equity in US Latinx Communities, Inequity and Iatrogenic Harm, What We Owe Workers in Health Care Who Earn Low Wages) with a combined 1 million unique journal website visitors during the months of those issues.
- AMA Councils produced three reports including health equity considerations adopted by the House of Delegates on pandemic ethics, rural public health, and climate change and public health. The Board of Trustees produced two health-equity related reports adopted by the House of Delegates on a global non-discrimination policy and language related to discrimination and harassment.
- AMA staff updated over 50 years of publication illustrations of patients in procedural descriptions for the Current Procedural Terminology (CPT) Pro Book. The 2023 CPT PRO Book will have over 20 illustrations that reflect diversity in skin tones and ethnicity, with plans for more in future years.

The AMA's employee life cycle and internal diversity, equity, and inclusion (DEI) framework help to operationalize DEI initiatives across the enterprise. Within embedding equity, updates on the AMA's diversity and inclusion strategy include:

- All of the AMA's business units (BUs) created their first annual equity action plans.
- The AMA developed the second phase of its embedding equity curriculum, for launch in 2023, to help staff practically apply inclusive skills.
- The AMA developed dashboards including demographics of existing staff and new hires, with data included in the annual report to AMA senior management.
- The AMA continued to diversify its outside counsel legal spend by working with law firms owned by Black attorneys, attorneys of color and/or women, some of whom are members of the National Association of Minority & Women Owned Law Firms (NAMWOLF).
- The AMA continued efforts toward expanding its vendor base to a more diverse group.
- The AMA added to its suite of Employee Resources Groups with the launch of the Immigrant Xchange ERG. ERGs[1] are voluntary, self-coordinating employee-driven groups which are based

[1] Immigrant Xchange joins Access, BEAN (Black Employees, Advocates and Allies Network), InspirASIAN, Pride, Unidos, Veterans Community Resource Group, and Women Inspired Now (WIN).

on a constituency or shared interest, and provide community, support and networking opportunities.

- The AMA continued its partnership with Urban Alliance's Alumni Internship Program (AIP), which matches graduates of the High School Internship Program with paid 6-week summer internships at the AMA, to help them gain valuable professional experience and earn income to support their future.
- The AMA committed to improving workplace accessibility including installing auto-operators on doors in Chicago and DC, and reduced size of conference room tables to improve accommodation for mobility devices and other factors.
- The JAMA Network Equity Action Team (JNEAT) led work including an anonymous pulse survey of staff and bi-monthly newsletters and learning sessions for staff. Webinars attracting over 325 employees included a dialogue with Dilla Thomas on the history of medicine in Chicago through the lens of its marginalized groups, a learning session with Open Books Chicago on literacy levels within Chicago's marginalized communities, and an interactive practice session for staff to learn about updates and practice applying inclusive language and reporting guidance in medical publication.

Build Alliances and Share Power

Building strategic alliances and partnerships and sharing power with historically marginalized and minoritized physicians and other stakeholders is essential to advancing health equity. This work centers previously excluded voices, builds advocacy coalitions, and establishes the foundation for true accountability. The following are some of the relevant accomplishments during 2022:

- The AMA continued to sponsor events that engaged historically marginalized audiences, including National Association of Black Journalists (NABJ), National Association of Hispanic Journalists (NAHJ), the Association of LGBTQ Journalists (NLGJA).
- The AMA completed a community impact plan for improving blood pressure control in collaboration with West Side United (WSU). In October, working with the City Club of Chicago, AMA convened business and civic leaders to highlight the collaboration and the AMA's additional $3 million social impact investment, bringing the AMA's multi-year total investment to $5 million, with the intention of benefitting Chicago's 500,000 West Side residents (33% Black, 39% Hispanic or Latino, 21% white). This investment leverages AMA's new commitment as an anchor mission partner with WSU—adding to a group of collaborators committed to addressing structural inequities, eliminating health disparities and improving economic vitality and educational opportunities in Chicago's west side communities, which have been devastated by decades of neglect and disinvestment.
- The national Release the Pressure (RTP) campaign, led by the AMA in collaboration with the American Heart Association, the AMA Foundation, the Association of Black Cardiologists, the Minority Health Institute, and the National Medical Association, was designed to increase awareness of heart health, heart disease and high blood pressure among Black women. The campaign continued momentum in 2022 with over 67,000 video views and almost 31,000 pledges.
- The Medical Justice in Advocacy Fellowship, an educational initiative in collaboration with Morehouse School of Medicine's Satcher Health Leadership Institute (SHLI), showcased capstone projects of the first cohort of 12 physician fellows at the AMA HOD Interim Meeting and launched the second cohort of 11 physician fellows with intensive training at Morehouse School of Medicine.
- As part of the Physician Data Collaborative (Collaborative), the AAMC, ACGME and AMA continue to work together to establish best practices for data sharing and collection and reporting

standards for sociodemographic data, including race and ethnicity, sexual orientation, gender identity and more. These efforts enable meaningful, collaborative research to better understand the dynamics of the physician workforce continuum. During 2022, the Collaborative agreed on race and ethnicity data collection standards and the addition of a Middle Eastern and North African category (establishing a pilot on the addition of this category), and continued to refine a collaborative research agenda.

- The AMA participated in or led four meetings with Association of American Medical Colleges (AAMC) and Accreditation Council for Graduate Medical Education (ACGME) about diversifying physician workforce, three ACGME Diversity Officers Forums, two webinars (Enhancing Diversity Among Academic Physicians: Recruitment, Retention and Advancement; Removing barriers and facilitating access: Supporting trainees with disabilities across the medical education continuum), two presentations to Academic Physicians Section (equity, diversity, and belonging activities in medical education; minoritized physician burnout and wellbeing), and three presentations on the implications of the pending Supreme Court decision on *Students for Fair Admissions v. Harvard / University of North Carolina*.
- The AMA provided seven speaking engagements or workshops with organizations that serve historically marginalized communities (including one with AllianceChicago and three with Arizona Alliance, both consortia of Federally Qualified Health Centers, or FQHCs), completed burnout assessments in 32 FQHCs (representing approximately 31% of all burnout assessments during the year), updated demographic questions in burnout assessments, and built a racial bias assessment tool (to be validated in 2023). The AMA piloted the stratification of all burnout assessment data for each health system report for a 3-month period to better understand how it informs systems as well as the limitations of the data.
- The AMA engaged with Illinois March of Dimes in workgroups on dismantling racism, increasing care access, and engaging communities in private practices to support maternity care deserts.
- The health equity content on AMA's Ed Hub has established itself as an impetus for institutional memberships and partnerships, with six additional health equity-focused external partners signed and launched during the year (Clinical Problem Solvers, Boston Children's Hospital, American Academy of Allergy, Asthma & Immunology, American Academy of Dermatology, Hope for Justice, and Accreditation Council for Graduate Medical Education or ACGME). The UNC Health Systems recently selected the Ed Hub's "Basics of Health Equity" as required education for their entire medical staff. During the Mpox outbreak, the established relationships with LGBTQ health organizations allowed for swift response with accurate, effective, and destigmatizing education reaching the large Ed Hub audience.
- The AMA ChangeMedEd initiative implemented grants awarded in November to various recipients, including Kaiser Permanente (Early Assurance: Community College to Medical School) and UC Davis (Learning from Bright Spots in Equitable Grading Practices).
- The AMA continued its work with organizations representing historically minoritized and marginalized physicians, including Association of American Indian Physicians (AAIP), GLMA, National Council of Asian Pacific Islander Physicians (NCAPIP), National Hispanic Medical Association (NHMA), and National Medical Association (NMA). The AMA concluded a second year of Health Equity Strategic Development (HESD) grants, an investment in these organizations in support of the advancement of their individual organizational mission and strategic goals, and in recognition of the collective impact of their work on the field of medicine. In addition, the Center convened the organizations quarterly, building a crosswalk of shared policy priorities to identify opportunities to build on each other's advocacy in future years. The LGBTQ Advisory Committee has a permanent position for a representative from GLMA on the committee, which allowed for continued regular coordination and collaboration with GLMA. The

Minority Affairs Section has permanent positions on its Governing Council for representatives from AAIP, NHMA, and NMA.

- The Medical Student Section (MSS) Assembly includes delegates from the Association of Native American Medical Students (ANAMS), the Latino Medical Student Association (LMSA), and the Student National Medical Association (SNMA). MSS continued collaborating with the Minority Affairs Section (MAS) to enhance engagement of medical students who are underrepresented in medicine (URM), sending select members of both Governing Councils as ambassadors to the annual conferences of URM medical student societies including SNMA, LMSA and ANAMS. This year, MAS launched its Leader-To-Leader initiative to better align the section's priorities around increasing diversity, equity, inclusion, and representation in the physician workforce. MAS and MSS members worked together to host receptions at the SNMA and LMSA annual conferences where our URM AMA leaders could meet with their elected and appointed leaders to open new lines of communication, to establish informal networks, and to learn more about organizational priorities. In April, MAS supported registration and housing for approximately 10 elected leaders of MSS, SNMA, LMSA and ANAMS to attend the annual Leadership Summit on Health Disparities, to foster network expansion, informal networking, and educational opportunities among these future doctors. The MAS and MSS Governing Councils also hosted a meeting in November to specifically convene URM medical student leaders who attended our Interim Meeting in Honolulu.
- The AMA formalized its collaboration with Stanford supporting research using AMA data to explore the effects of the COVID pandemic on international medical graduate (IMG) physicians, patterns of care provided by IMGs across the U.S., and their role in providing patient care for underserved communities during COVID-19.

Push Upstream

Pushing upstream requires looking beyond cultural, behavioral, or genetic reasons to understand structural and social drivers of health and inequities, dismantle systems of oppression, and build health equity into health care and broader society. The following are some of the relevant accomplishments during 2022:

- On the international stage, the World Medical Association (WMA) General Assembly adopted a new policy to address racism in medicine, to which the AMA contributed substantial language and support, based largely on HOD policy. The AMA has also been leading the ongoing revision of a seminal WMA document, the Declaration of Helsinki Ethical Principles for Medical Research Involving Human Subjects, prioritizing diverse perspectives and issues of equity, such as ethical research in vulnerable populations. Finally, the AMA has continued centering equity in other WMA policy revisions, including addressing the disproportionate impact of forced sterilization on certain groups.
- The AMA was a powerful voice on reproductive health following the Supreme Court's *Dobbs* decision in June and continued to be visible on this topic in the media and speeches and published numerous AMA Viewpoints on topics important to health equity including LGBTQ health, pulse oximeters, and Black maternal health.
- In cases ranging from COVID-19 standards of care and firearm regulations to climate change and transgender rights, the AMA continued to fight for physicians and patients in state and federal courts. The AMA was a plaintiff in *African American Tobacco Control Leadership Council v. HHS*, which forced the federal government to take the first steps toward banning menthol cigarettes. In support of the consideration of race in higher education admissions, the AMA joined an AAMC-led U.S. Supreme Court amicus brief in the *Students for Fair Admission v. Harvard* and *Students for Fair Admission v. University of North Carolina* cases. Together with the American Academy of Pediatrics, the AMA submitted an amicus brief urging the U.S.

Supreme Court to uphold the Indian Child Welfare Act (ICWA) of 1978. And in the wake of the U.S. Supreme Court's *Dobbs v. Jackson Women's Health Organization* decision, the AMA joined numerous briefs promoting access to reproductive care and opposing government interference in the patient-physician relationship.

- The AMA now looks at every advocacy issue with an eye towards its impact on historically marginalized and minoritized communities. The AMA issued more than 175 advocacy letters to policymakers, and more than 40 percent of those were directly related to our health equity work.
- AMA advocated in many ways for policies to advance health equity including:
    - Securing legislation extending telehealth payment and regulatory flexibilities through the end of 2024, including audio-only telephone visit services. The AMA also launched model legislation that states can use to advance telehealth coverage and policies.
    - Supporting maternal and child health. The AMA developed new model state legislation to support maternal and child health in partnership with leading medical societies and national organizations. The model bill is part of a national campaign to support pregnant, postpartum and parenting individuals, newborns, children and families affected by substance use disorders. The AMA supported 27 states and DC in extending Medicaid coverage to 12 months postpartum and secured a permanent option to support states in the Consolidated Appropriations Act of 2023 (CAA).
    - Securing key provisions of the Mainstreaming Addiction Treatment (MAT) Act (such as repealing the X-waiver requirement for buprenorphine prescribing) in the CAA, revisions to CDC guidelines for prescribing opioids that emphasize the need to treat patients as individuals, Food and Drug Administration (FDA) policy allowing harm reduction organizations to more easily obtain naloxone to prevent overdose deaths, and a Drug Enforcement Administration (DEA) commitment to working for permanent availability of medication assisted treatment based on telehealth visits. The AMA also helped multiple states enact legislation to decriminalize fentanyl test strips and other drug testing supplies and equipment, acknowledging the annual more than 100,000 deaths are primarily due to illicitly manufactured fentanyl and fentanyl analogues.
    - The AMA Substance Use and Pain Care Task Force continued to advocate to reduce health care inequities, including those that disproportionately affect historically minoritized and marginalized communities. Reports from the Task Force and those conducted with Manatt Health make clear that reversing the nation's overdose and death epidemic must directly address structural barriers and social determinants of health. The Task Force continues to gather input from member organizations Association of American Indian Physicians, National Hispanic Medical Association and National Medical Association.
    - Supporting multiple state efforts to enact legislation to strengthen mental health and substance use disorder parity laws. These include requiring payers to demonstrate compliance with parity laws and for state departments of insurance and attorneys general to investigate payers' compliance.
    - The AMA and several collaborators sent a letter to Attorney General Merrick Garland urging the Department of Justice to investigate the threats of violence against physicians, hospitals and families of children for providing and seeking evidence-based gender-affirming care. The organizations also call on technology platforms to do more to stop the rhetoric that often incites threats or acts of violence and has led to harassment campaigns across the country, much of it directed at children's hospitals and the physicians and staff who provide care.
    - Highlighting inequities in Medicare Advantage including quality and administrative barriers. In a letter to the United States Department of Health and Human Services (HHS), the AMA noted that Black, Asian, and Latino enrollees sign up for Medicare Advantage (MA) at higher rates than white enrollees but tend to be in plans with lower

quality ratings. Kaiser Family Foundation data show that nearly all (99 percent) of MA enrollees are in plans that require prior authorization (PA) for some services, up from 80 percent in 2018. Institute for Patient Access data show that patients with chronic conditions who identify as Black or Latino experience insurance claim rejections at least 40% more often than white patients, going on to experience more emergency room visits and hospitalizations. The AMA helped move a bipartisan House bill to reform prior authorization for Medicare Advantage plans, H.R. 3173, the "Improving Seniors' Access to Care Act," passed via voice vote, and a companion Senate bill now with 51 co-sponsors.

- Developing principles for Medicare physician payment reform endorsed by more than 120 medical societies, which incorporate concepts to advance equity and reduce disparities.
- Cosigning a letter in conjunction with over 60 national medical specialty, hospital and patient organizations urging the House and Senate Judiciary Committees to pass the "Conrad State 30 and Physician Access Reauthorization Act," which would reauthorize the Conrad 30 waiver policy for an additional three years, to ensure international medical graduates (IMGs) can continue to play a pivotal role in greater access to health care.
- Submitting a Statement for the Record to the U.S. House of Representatives Committee on the Judiciary Subcommittee on Immigration and Citizenship as part of the hearing entitled "Is there a Doctor in the House? The Role of Immigrant Physicians in the US Healthcare System." Additionally, the AMA submitted a Statement for the Record to the U.S. Senate Subcommittee on Immigration, Citizenship, and Border Safety as part of the hearing entitled, "Flatlining Care: Why Immigrants Are Crucial to Bolstering Our Health Care Workforce."
- The AMA continues to support laws that prohibit so-called conversion therapy. We successfully supported the Oklahoma State Medical Association in opposing a bill that would have protected conversion therapy and worked with the AMA's Advisory Committee on LGBTQ+ issues to update and disseminate an issue brief summarizing the medical literature demonstrating the harm caused by conversion therapy.
- Supporting a Dear Colleague letter to the FDA Commissioner urging the end of the blanket three-month blood donation deferral period for men who have sex with men. The Dear Colleague letter was ultimately cosigned by nearly 150 members of Congress. The FDA has signaled that it will continue existing flexibilities.

- Every bi-weekly issue of the AMA's Advocacy Update includes at least one article related to our health equity work. Equity-related episodes of the AMA's Advocacy Insights webinar series, such as the limited time Public Service Loan Forgiveness Program waiver, the future of telemedicine, and the impact of the nation's drug overdose epidemic on children and adolescents, have had significant participation (hundreds of attendees) and engagement (30+ questions) each session.
- The AMA launched a bi-monthly health equity newsletter and the Federation Equity Exchange, attracting dozens of attendees each month for state and specialty societies to share promising practices.
- This is the first year covered by the AMA's annual Health Equity in Organized Medicine Survey. The survey seeks to understand the specific actions that Federation organizations are taking or contemplated taking to advance health equity, gather shareable successes stories, and confidentially identify barriers and resource needs.
  - Eighty organizations completed the survey: half (n=40) were specialty societies, about 1 in 3 (n=25) were state and District of Columbia associations, and about 1 in 5 (n=15) were local associations.
  - Most organizations (70%) indicated that health equity was a strategic priority.

    - Most organizations were aware of the AMA's Organizational Strategic Plan to Embed Racial Justice and Advance Health Equity (85%), and the AMA and AAMC's Advancing Health Equity: A Guide to Language, Narrative and Concepts (54%). Among the organizations that were aware, about half referenced or used the materials. More than half (n=44) indicated they provided equity training to staff and leadership.
    - More than 1 in 3 (n=30) organizations indicated they had identified historical harms in their organization's policies and practices, and 30% of organizations indicated that they have taken action to address past harms caused by their organization.
    - Note: All results are preliminary. The survey results are still being analyzed, with a full summary planned for later in 2023.
- The JAMA Network published over 632 articles on topics related to equity, diversity, and inclusion, viewed in full text 4 million times.
- AMA staff contributed to at least 10 publications in related to health equity.
- The AMA's Ed Hub published an unprecedented volume of heath equity content (78 activities), with usage of equity-related content exceeding the prior year (124,374 engagements; 21,625 course completions). One highlight included: undergraduate / graduate (UME/GME) and continuing medical education (CME) versions of the Historical Foundations of Racism modules were published, as well as adapted versions accessible for UME and GME curricular enhancement program (UCEP/GCEP) members and individual learners: Medical Mistrust and Medical Distrust; Pain and Racism in Medicine and Health Care. In addition, the AMA led 4 presentations at health care meetings demonstrating educational best practices for integration of equity.
- The AMA concluded its year-long Peer Network learning collaborative, led by AMA with The Joint Commission (TJC) and Brigham and Women's Hospital as key collaborators, positively influencing the development of TJC equity accreditation standards for health systems.
    - The pilot program of 49 learning sessions included more than 40 participants from eight health systems, of which 3 were AMA group members, graduating the health systems into a Quality Safety and Equity Network integrated into the Physician Innovation Network.
    - Successes of over 26 new improvement practices implemented by the health system teams included embedding a bias/discrimination question into safety reporting to track and take action on equity-related harm events, incorporating fundamental data collection tools to stratify data sets by race, ethnicity, and language (REAL), improving on disability, sexual orientation and gender identity (SOGI) data collection, developing educational content to better equip staff on how to identify inequities, bringing together multidisciplinary stakeholders across the system to identify improvements that will result in better patient and staff experience and outcomes, and incorporating health equity into the development and implementation of a racial equity plan.
    - At mid-year, survey respondents agreed or strongly agreed that the quality of the Peer Network was excellent (100%) and that it equipped them to advance health equity, strengthened their knowledge of inequities, and empowered them to dismantle structural racism (>80%).
    - Products included creating seven Ed Hub modules with CME and a Prioritizing Equity episode highlighting the work of two group member health systems, Atlantic Medical Group and Ochsner Health.
    - The Peer Network was covered in 37 articles with over 10 million views.
- The AMA laid the groundwork for Rise to Health: A National Coalition for Equity in Health Care, an effort that unites individuals and organizations in shared solutions for high-impact structural change. The Coalition, co-led by the AMA and the Institute for Healthcare Improvement (IHI), secured other collaborators including Race Forward, Groundwater Institute,

the American Hospital Association (AHA), the National Association of Community Health Centers (NACHC), Association of Health Insurance Plans (AHIP), the Council of Medical Specialty Societies (CMSS), Policy Link, and HealthBegins, with a general audience launch planned for 2023.

- The AMA expanded its social impact investments with an additional $3 million multi-year investment in West Side United (WSU), a community-based collaborative that is addressing determinants of health and helping restore economic vitality on the Chicago's west side.
    - This new investment builds on the AMA's initial $2 million investment in 2020 and will continue to support WSU's multi-pronged social impact investing approach. WSU-coordinated impact investing is done in partnership with community development financial institutions (CDFIs) to help provide much-needed capital to foster economic opportunity, revitalize neighborhoods and support community transformation. AMA's renewed commitments will lead to more investments in affordable housing, healthy food options, job creation projects and educational programs.
    - To date, WSU partners have invested a combined $177 million in Chicago's West Side neighborhoods through local procurement, small business grants, and impact investing, including the AMA's 5-year, $5 million investment. Since 2018, the collaborative's funding has contributed to approximately 475 low-interest loans, including entrepreneurs, small businesses, and community-based organizations. CDFIs leveraged these investments for an additional $28 million to support the west side community and business projects. The WSU investments also resulted in the creation and preservation of 420 housing units, as well as the construction and preservation of more than 34,000 square feet of non-profit and commercial real estate projects. Additionally, these investments have supported 432 construction jobs, preserved 64 local jobs, and created 126 community employment opportunities.
- In collaboration with West Side United and West Side Health Equity Collaborative, the AMA, trained more than 100 community health workers. In addition, the AMA MAP BP program was implemented and demonstrated success in improving blood pressure control at Cook County Health, a large health care organization serving mostly patients from historically marginalized communities.

Ensure Equity in Innovation

The AMA is committed to ensuring equitable health innovation by embedding equity in innovation, centering historically marginalized and minoritized people and communities in development and investment, and collaborating across sectors. The following are some of the relevant accomplishments during 2022:

- The AMA launched the In Full Health Learning & Action Community to Advance Equitable Health Innovation initiative which seeks to provide a framework for shared understanding and a community for stakeholders committed to learning and action to center equity within their health innovation investment, development, and purchasing efforts by committing resources to innovations created by, with, and that measurably improve health and do no harm for Black, Latino, Indigenous, communities of color, women, LGBTQ+ communities, people with disabilities, people with low income, rural communities, and other communities historically marginalized by the health industry. The initiative established an external advisory group and published Principles for Equitable Health Innovation.
- The AMA completed a health equity assessment on Verifi Health Self-Measured Blood Pressure (SMBP), an app for remote blood pressure monitoring, and continues to build features into the product that promote health equity.

- The AMA created a prototype Social Needs Administrative Coder (SNAC) and began a Voice-of-the-Customer campaign across societies, technology vendors, state level entities, health insurers, community organizations and health information exchanges to better understand the need for consistent coding of health-related social needs (HRSN) screening data into nationally accepted codesets like ICD-10-CM.

Foster Truth, Racial Healing, Reconciliation, and Transformation

The AMA recognizes the importance of acknowledging and rectifying past injustices in advancing health equity for the health and well-being of both physicians and patients. Truth, racial healing, reconciliation, and transformation is a process and an outcome, documenting past harms, amplifying and integrating narratives previously made invisible, and creating collaborative spaces, pathways, and plans. The following are some of the relevant accomplishments during 2022:

- The 175th anniversary workgroup included AMA archivists as key stakeholders, supporting truth and reconciliation, through development of historical research for programming and educational modules and networking with other medical association professionals looking to examine their histories in this way.
- The AMA began creating a charter and identifying potential participants for the Truth, Reconciliation, Healing, and Transformation Advisory Committee called for by the AMA House of Delegates, so the committee can commence work in 2023.
- AMA staff engaged in educational sessions and community events including: AMA History/Transformative Narrative, Guide to Allyship, Time for Personal Reflection, Liberation Health: Allyship, My Hood / My Block, My City Event, Color of Care Screening and Breakouts, ERG Review & Recruitment, Gardeneers Event, Women Inspired Now (WIN) Reproductive Rights Session and Discussion. One session was a deeper look at the history of work toward reproductive justice within the AMA, findings from qualitative research with patients who have received obstetric, gynecological, and related care, and policy-related implications for maternal health given recent federal level court and legislative actions, state politics, transitional care, contraceptive access for patients, providers, and public health. A Reproductive Justice panel featured obstetrics and gynecology experts as guests, and opening remarks provided by former AMA President Patrice Harris, MD, MPH.
- Dilla Thomas was invited to speak to staff on the Black History of Medicine in Chicago. He titled the event, "Everything Dope Comes from Chicago: A Look into the History of Chicago in Medicine Through the Lens of its Marginalized Groups."

Challenges and Opportunities

As cities and states across the nation updated social distancing guidance, staff returned to AMA offices and began adjusting to new hybrid schedules which required an additional layer of planning and coordination. This required strategizing innovative ways to build connections and foster engagement in a new work environment.

Commonly noted challenges to advancing health equity work included: 1) limited staff time and capacity, resource constraints, and competing priorities with tight deadlines; 2) varying levels of understanding of health equity, with persistence of some common narratives that sustain inequity; 3) still fledgling structures and processes for cross-enterprise dialogue, coordination, and reporting on initiatives and measures; and 4) the capacity, infrastructure, and time needed to develop external collaborations. While turnover was mentioned as a challenge to sustaining the health equity work, in some cases the scarcity of open positions posed challenges to increasing diversity in promotion.

Prioritizing and matching workload to capacity were mentioned as essential in avoiding contributing to burnout. Additional curriculum and sessions that foster conversations and self-reflection to further understanding and undoing harms in a psychologically safe space require substantial time, timeliness, skilled facilitators, and openness and commitment from team leaders. Additional structures and processes that support transparent sharing of goals, planning, resources, implementation, and accountability across teams and with external collaborators can help bring focus to priorities and promote sustainability.

CONCLUSION

AMA staff were asked for their most prominent equity-related accomplishments, and not everything submitted could be included in this report, so the above represents a fraction of the work completed in 2022. The AMA increased engagement of health equity content to 1,000,000 website users, including 124,374 engagements driven by publication of 78 new activities on Ed Hub. The AMA engaged in at least two Supreme Court amicus briefs and issued more than 70 advocacy letters to policymakers related to health equity, securing wins in the Consolidated Appropriations Act. The AMA expanded its social impact investments with an additional $3 million multi-year investment. Overall, the AMA has made significant progress towards fulfilling the commitments outlined in the Plan during its second year.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 16-A-23

Subject: Informal Inter-Member Mentoring

Presented by: Sandra Adamson Fryhofer, MD, Chair

At the November 2021 Special Meeting of the House of Delegates (HOD), Policy D-635.980, "Informal Inter-Member Mentoring," was adopted. As reported at the 2022 Interim Meeting (Board Report 6), last year our AMA convened on an ad hoc basis a Mentorship Steering Committee consisting of representatives from each of the AMA sections. This group was charged with identifying mentorship opportunities and best practices within individual sections and more broadly across the organization. The Committee's key conclusion was that the AMA should create informal, organic opportunities for mentors and mentees to identify one another and connect, as opposed to establishing more formal programs with assigned mentors/mentees.

The Committee's discussions prompted a variety of mentorship initiatives of this connective nature within the sections in 2022, including for example:

- The Women Physicians Section implemented a "speed mentorship" event that connected members in small group discussions with facilitators versed in career-building topics.

- The Young Physicians Section hosted a "leadership boot camp" for young physician members interested in pursuing leadership opportunities beyond the YPS and throughout the AMA.

- The Minority Affairs Section hosted a webinar and networking reception to engage and build connections among current and future MAS and AMA leaders from minoritized and marginalized backgrounds.

While many individual sections have instituted informal mentorship opportunities designed primarily to connect members, with others in the works, cross-sectional and broader organizational mentorship initiatives have remained elusive, largely due to issues of scalability. In 2023, a reconstituted Mentorship Steering Committee representative of the broad swath of AMA member backgrounds and experiences will be reconvened to continue consideration of opportunities to connect members for mentorship purposes outside the confines of any particular section. Your Board will continue to provide updates via HOD implementation status documents as this work proceeds.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 19-A-23

Subject: Medical Community Voting in Federal and State Elections (Resolution 616-A-22)

Presented by: Sandra Adamson Fryhofer, MD, Chair

Resolution 616 "Medical Student, Resident/Fellow, and Physician Voting in Federal, State and Local Elections," was adopted at the AMA House of Delegates' 2022 Annual Meeting. Per the first resolve of Resolution 616, now AMA Policy D-65.982:

> Our AMA will: (1) study the rate of voter turnout in physicians, residents, fellows and medical students in federal and state elections without regard to political party affiliation or voting record, as a step towards understanding political participation in the medical community.

This report completes the request for such a study.

EXISTING RESEARCH ON PHYSICIAN VOTING TRENDS AND BEHAVIOR

The consensus conclusion of publicly available studies and analysis addressing physician voting is that physicians consistently vote at lower rates than the general public. Three such reports that help uphold this conclusion are "Trends in Physician Voting Practices in California, New York, and Texas, 2006-2018"[1] by Hussain Lalani, MD, MPH, et al., published in *JAMA Internal Medicine* 2021; "Voting Behavior of Physicians and Healthcare Professionals"[2] by Rachel Solnick, MD, MSc, et al., published in the *Journal of General Internal Medicine* 2020; and "Do Doctors Vote?"[3] by David Grande, MD, MPA, et al., published in the *Journal of General Internal Medicine* 2007. Through modeling analysis incorporating a variety of publicly available and commercially acquired data, the authors of these studies found physicians voting anywhere from 9 to more than 12 percent less than the general public going back to 2002.

Lalani et al. looked at the states with the highest physician populations in their study. Their finding that physicians who were eligible to vote did so at rates at least 9 percent less than the general population takes into account data as recent as 2018. The authors offer their proposed reasons as to why physician turnout was lower, including fear of appearing "political" as well as other "administrative and psychological barriers." However, it should be noted that Lalani et al. acknowledge that this reasoning is speculative and that the true source(s) of limited physician engagement in voting is "unclear" as well as the possible link between physicians who register to vote and those who actually turn out to vote.

In their study, Solnick et al. looked at physicians as well as other health care professionals including dentists, nurses, physician assistants and pharmacists and found that they also consistently voted at rates lower than the general public, although except for dentists somewhat higher than physicians. The researchers based their findings on a biennial nationally representative household survey that collects self-reported or household member-reported voting rates and behavior from congressional and presidential elections. They estimated physicians voting at approximately 12 percent below that of the public. The authors further found that 70 percent of

physicians who were either not registered to vote or did not vote reported that this was due to being "Too busy, conflicting work or school." Physicians were 30 percent more likely to vote by mail and 15 percent more likely to vote prior to election day compared to the public. Solnick et al. also examined non-health care related professions as part of this study; specifically, those requiring advanced education and/or training including, postsecondary teachers, chief executives, civil engineers, social workers and lawyers. Solnick et al. found that of these, postsecondary teacher turnout was highest; 14 percent above the general population. The authors suggest that further research examine whether health care professionals voting rates can be improved by Election Day flexible scheduling, health care organization campaigns to emphasize the social value of voting, voter registration drives, and education on mail-in voting.

Finally, Grande et al. compared adjusted physician voting rates in 1996-2002 congressional and presidential elections with those of lawyers and the general population. Like the others, they found physicians voting at lower rates when compared to the public (8.7 percent lower on average) for each of these elections except in 1996. Lawyers meanwhile had voting rates that were 13.5 percent higher than the public during this same time span. Additionally, Grande et al. noted that these trends occurred even in the face of a renewed commitment at that time to prioritize civic participation and engagement within the medical profession led by multiple medical organizations including the American Medical Association that in 2001 issued its "Declaration of Professional Responsibility Medicine's Social Contract with Humanity," which included a commitment to "advocate for…political changes that ameliorate suffering and contribute to human well-being."[4]

CONCLUSION

Apart from the studies referenced in this report, there would seem to be a paucity of in-depth, credible analysis on the issue of physician voter turnout. For the studies examined as part of this report however, it is notable that in each, to the extent that the authors explored possible reasons for why physicians overall voted at lower rates than the general public, their conclusions were speculative. It seems reasonable to conclude that physicians as a group do indeed tend to vote at rates both lower than the general public and lower than that of selected professions requiring advanced education and training. With so little data available and to better inform on the issue, the AMA may consider including questions related to the subject of physician voting habits in future polling projects if appropriate.

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[1] Hussain Lalani, et al. "Trends in Physician Voting Practices in California, New York, and Texas, 2006-2018," *JAMA Internal Medicine* 181, 3 (2021): 397–399. 10.1001/jamainternmed.2020.6887

[2] Rachel Solnick, et al. "Voting Behavior of Physicians and Healthcare Professionals," *Journal of General Internal Medicine* 36, 1 (2021): 1169–1171. 10.1007/s11606-020-06461-2

[3] David Grande, et al. "Do Doctors Vote?" *Journal of General Internal Medicine* 22, 5 (2007): 585–589. 10.1007/s11606-007-0105-8

[4] American Medical Association, Declaration of Professional Responsibility: Medicine's Social Contract with Humanity (2001). Accessed February 27, 2023, at https://www.ama-assn.org/delivering-care/public-health/ama-declaration-professional-responsibility

OPINION OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Opinion 01-A-23

Subject: Amendment to Opinion 4.2.7, "Abortion"

Presented by: Peter A Schwartz, MD, Chair

At the 2022 Interim Meeting, the American Medical Association House of Delegates adopted the recommendations of Council on Ethical and Judicial Affairs Report 1-I-22, "Amendment to Opinion 4.2.7, 'Abortion.'" The Council issues this Opinion, which will appear in the next version of AMA PolicyFinder and the next print edition of the *Code of Medical Ethics*.

E-4.2.7 – Abortion

Abortion is a safe and common medical procedure, about which thoughtful individuals hold diverging, yet equally deeply held and well-considered perspectives. Like all health care decisions, a decision to terminate a pregnancy should be made privately within the relationship of trust between patient and physician in keeping with the patient's unique values and needs and the physician's best professional judgment.

The *Principles of Medical Ethics* of the AMA permit physicians to perform abortions in keeping with good medical practice. (III, IV)

* Opinions of the Council on Ethical and Judicial Affairs will be placed on the Consent Calendar for informational reports, but may be withdrawn from the Consent Calendar on motion of any member of the House of Delegates and referred to a Reference Committee. The members of the House may discuss an Opinion fully in Reference Committee and on the floor of the House. After concluding its discussion, the House shall file the Opinion. The House may adopt a resolution requesting the Council on Ethical and Judicial Affairs to reconsider or withdraw the Opinion.

OPINION OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Opinion 02-A-23

Subject: Amendment to Opinion 10.8, "Collaborative Care"

Presented by: Peter A. Schwartz, MD, Chair

At the 2022 Interim Meeting, the American Medical Association House of Delegates adopted the recommendations of Council on Ethical and Judicial Affairs Report 2-I-22, "Amendment to Opinion 10.8, 'Collaborative Care.'" The Council issues this Opinion, which will appear in the next version of AMA PolicyFinder and the next print edition of the *Code of Medical Ethics*.

E-10.8 – Collaborative Care

In health care, teams that collaborate effectively can enhance the quality of care for individual patients. By being prudent stewards and delivering care efficiently, teams also have the potential to expand access to care for populations of patients. Such teams are defined by their dedication to providing patient-centered care, protecting the integrity of the patient-physician relationship, sharing mutual respect and trust, communicating effectively, sharing accountability and responsibility, and upholding common ethical values as team members.

Health care teams often include members of multiple health professions, including physicians, nurse practitioners, physician assistants, pharmacists, physical therapists, and care managers among others. To foster the trust essential to healing relationships between patients and physicians or nonphysician practitioners, all members of the team should be candid about their professional credentials, their experience, and the role they will play in the patient's care.

An effective team requires the vision and direction of an effective leader. In medicine, this means having a clinical leader who will ensure that the team as a whole functions effectively and facilitates decision-making. Physicians are uniquely situated to serve as clinical leaders. By virtue of their thorough and diverse training, experience, and knowledge, physicians have a distinctive appreciation of the breadth of health issues and treatments that enables them to synthesize the diverse professional perspectives and recommendations of the team into an appropriate, coherent plan of care for the patient.

As clinical leaders within health care teams, physicians individually should:

(a) Model ethical leadership by:
    (i) Understanding the range of their own and other team members' skills and expertise and roles in the patient's care

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(ii) Clearly articulating individual responsibilities and accountability

(iii) Encouraging insights from other members and being open to adopting them and

(iv) Mastering broad teamwork skills

(b) Promote core team values of honesty, discipline, creativity, humility and curiosity and commitment to continuous improvement.

(c) Help clarify expectations to support systematic, transparent decision making.

(d) Encourage open discussion of ethical and clinical concerns and foster a team culture in which each member's opinion is heard and considered and team members share accountability for decisions and outcomes.

(e) Communicate appropriately with the patient and family, respecting the unique relationship of patient and family as members of the team.

(f) Assure that all team members are describing their profession and role.

As leaders within health care institutions, physicians individually and collectively should:

(g) Advocate for the resources and support health care teams need to collaborate effectively in providing high-quality care for the patients they serve, including education about the principles of effective teamwork and training to build teamwork skills.

(h) Encourage their institutions to identify and constructively address barriers to effective collaboration.

(i) Promote the development and use of institutional policies and procedures, such as an institutional ethics committee or similar resource, to address constructively conflicts within teams that adversely affect patient care.

(j) Promote a culture of respect, collegiality and transparency among all health care personnel. (II, V, VIII)

OPINION OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Opinion 03-A-23

Subject: Pandemic Ethics and the Duty of Care

Presented by: Peter A. Schwartz, MD, Chair

At the 2022 Interim Meeting, the American Medical Association House of Delegates adopted the recommendations of Council on Ethical and Judicial Affairs Report 3-I-22, "Pandemic Ethics and the Duty of Care." The Council issues this Opinion, which will appear in the next version of AMA PolicyFinder and the next print edition of the *Code of Medical Ethics*.

RECOMMENDATION

E-8.3 – Physician Responsibility in Disaster Response and Preparedness

Whether at the national, regional, or local level, responses to disasters require extensive involvement from physicians individually and collectively. Because of their commitment to care for the sick and injured, individual physicians have an obligation to provide urgent medical care during disasters. This obligation holds even in the face of greater than usual risks to physicians' own safety, health, or life.

The duty to treat is foundational to the profession of medicine but is not absolute. The health care work force is not an unlimited resource and must be preserved to ensure that care is available in the future. For their part, physicians have a responsibility to protect themselves, as well as a duty of solidarity to colleagues to share risks and burdens in a public health crisis. So too, health care institutions have responsibilities to support and protect health care professionals and to apportion the risks and benefits of providing care as equitably as possible.

Many physicians owe competing duties of care as medical professionals and as individuals outside their professional roles. In a public health crisis, institutions should provide support to enable physicians to meet compelling personal obligations without undermining the fundamental obligation to patient welfare. In exceptional circumstances, when arrangements to allow the physician to honor both obligations are not feasible, it may be ethically acceptable for a physician to limit participating in care, provided that the institution has made available another mechanism for meeting patients' needs. Institutions should strive to be flexible in supporting physicians in efforts to address such conflicts. The more immediately relevant a physician's clinical expertise is to the urgent needs of the moment and the less that alternative care mechanisms are available, the stronger the professional obligation to provide care despite competing obligations.

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With respect to disaster, whether natural or manmade, individual physicians should:

(a) Take appropriate advance measures, including acquiring and maintaining appropriate knowledge and skills to ensure they are able to provide medical services when needed.

Collectively, physicians should:

(b) Provide medical expertise and work with others to develop public health policies that:

(i) Are designed to improve the effectiveness and availability of medical services during a disaster
(ii) Are based on sound science

(iii) Are based on respect for patients

(c) Advocate for and participate in ethically sound research to inform policy decisions. (V, VI, VII, VIII)

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS

CEJA Report 06-A-23

Subject: Use of De-Identified Patient Information (D-315.969)

Presented by: Peter A. Schwartz, MD, Chair

Policy D-315.969, "Research Handling of De-Identified Patient Data," adopted in November 2021 directs the Council on Ethical and Judicial Affairs (CEJA) to "consider re-examining existing guidance relevant to the confidentiality of patient information, striving to preserve the benefits of widespread use of de-identified patient data for purposes of promoting quality improvement, research, and public health while mitigating the risks of re-identification of such data."

This informational report summarizes CEJA's research and deliberations to date and direction of further inquiry.

DO YOU KNOW WHERE YOUR PATIENTS' DATA ARE TONIGHT?

An extraordinary variety of data are now regularly collected by multiple entities and stakeholders, for multiple—and potentially discrepant—purposes:

> The last few decades have witnessed the creation of novel ways to produce, store, and analyse data, culminating in the emergence of the field of data science, which brings together computational, algorithmic, statistical and mathematical techniques towards extrapolating knowledge from big data. . . . The availability of vast amounts of data in machine-readable formats provides an incentive to create efficient procedures to collect, organise, visualise and model these data. . . . Researchers across all disciplines see the newfound ability to link and cross-reference data from diverse sources as improving the accuracy and predictive power of scientific findings and helping to identify future directions of inquiry, thus ultimately providing a novel starting point for empirical investigation [1].

As one scholar has noted, in this new data landscape "it is almost impossible to perform most daily activities without revealing personal information and providing fodder for data brokers and big data organizations, whether they are public or private" [2]. Data that in themselves are not traditionally categorized as "medical" or "health related" can still yield information about health status—for example, predictive analysis of data about customers' purchases enabled Target "to identify about 25 products that, when analyzed together, allowed the company to assign each shopper a "pregnancy prediction" score, and even to predict the shopper's due date [3].

The ease with which data from multiple sources within and outside medicine can now be linked and cross-referenced significantly exacerbates challenges of protecting patient privacy and the confidentiality of health information. The council has come to recognize that it should extend its analysis beyond research use of patient information to questions of what role physicians and health

care institutions can and should play in protecting patients' interests in how their information is shared and used more broadly.

WHY PROTECT PRIVACY/CONFIDENTIALITY?

Within the *Code,* Opinion 3.1.1, "Privacy in Health Care," distinguishes four aspects of privacy:

> personal space (physical privacy), personal data (informational privacy), personal choices including cultural and religious affiliations (decisional privacy), and personal relationships with family members and other intimates (associational privacy).

The *Code* does not explicitly examine whether personal medical or health information are ethically distinct from other kinds of personal information (e.g., financial records) or in what way. Current guidance treats the importance of protecting privacy in all its forms as self-evident, holding that respecting privacy in all its aspects is of fundamental importance, "an expression of respect for autonomy and a prerequisite for trust" (Opinion 3.1.1).

In the context of information technology, van den Hoven identifies the following concerns with respect to protecting personal data (medical or other):

- Prevention of harm
- Commodification of and asymmetry in power to control personal information
- Informational injustice and discrimination
- Encroachment on moral autonomy and human dignity [4]

Price and Cohen observe that violations of privacy can result in both harm—tangible negative consequences, such as discrimination in insurance or employment or identity theft—and in wrongs that occur from the fact of personal information being known without the subject's awareness, even if the subject suffers no tangible harm:

> One may be wronged by a privacy breach even if one has not been harmed. For example, suppose that an organization unscrupulously or inadvertently gains access to data you store on your smart phone as part of a larger data dragnet. After reviewing it, including photos you have taken of an embarrassing personal ailment, the organization realizes your data is valueless to them and destroys the record. You never find out this happened. Those reviewing your data live abroad and will never encounter you or anyone who knows you. It is hard to say you have been harmed in a consequentialist sense, but many think the loss of control over your data, the invasion, is itself ethically problematic even absent harm [5].

They further note that privacy issues can arise not only when data are known, but when data mining enables others to "generate knowledge about individuals through the process of inference rather than direct observation or access" [5]. Recall the anecdote above about Target inferring customers' current health status from data of their purchases over time.

STRATEGIES FOR PROTECTING PRIVACY/CONFIDENTIALITY

In the U.S., the Health Insurance Portability and Accountability Act (HIPAA) imposes constraints on the sharing of "protected health information" contained in the medical record—including in the context of relationships within the limited domain of "covered entities" defined in the Act, such as physicians, hospitals, pharmacies, and third-party payers. HIPAA does not cover certain other

health-relevant data, especially data generated voluntarily by patients themselves, for example, through the use of health-related apps on devices such as Fitbit or Apple Watch, let alone identifiable data individuals provide to municipal authorities, utilities, or retailers. Information that began in the medical record can take on a new, independent life when linked with personal information widely available through datasets generated outside of health care.

The current state of data science challenges the prevailing procedural model for protecting privacy: informed consent and de-identification. Yet as Barocas and Nissenbaum have observed, many continue to see these "as the best and only workable solutions for coping with privacy hazards. They do not deny the practical challenges, but their solution is to try harder—to develop more sophisticated mathematical and statistical techniques and new ways of furnishing notice . . ." [6].

That is, solutions have tended to take the form of technical solutions to enable captured data to be shared, such as the creation of synthetic datasets that replace some or all sensitive or identifying data in an original dataset with a statistically representative sample that preserves statistical properties and relationships among variables of interest [7,8]. Alternative responses have taken the form of proposals for new models of informed consent, such as "blanket consent" (permission to use without restriction), [9] "broad consent" (consent for an unspecified range of future research subject to content or process restrictions), [6,10,11] and "dynamic consent" (the use of personalized, digital interface between participants and researchers that allows participants to "tailor and manage their own consent preferences" over time) [12,13].

The Problem of Re-Identification

Whether de-identifying datasets truly prevents individual data subjects from being re-identified is increasingly called into question. Removing the 18 identifiers specified in HIPAA can no longer ensure that the data subject cannot be re-identified by triangulation with identifying information from other readily available datasets [14]. The development of ever more robust statistical strategies for de-identifying data in turn prompts the development of yet more robust strategies to enable re-identification [15,16].

The creation of "synthetic" datasets seeks to offer a technical solution that will enable research with large datasets while protecting privacy by replacing some or all sensitive or identifying data in an original dataset with a statistically representative sample that preserves statistical relationships among variables of interest [17,18]. Inspired by models in manufacturing and engineering, medical "digital twins"—AI technologies that simulate organs or tissues in real time and in relation to an identifiable patient—are proffered as tools to enable highly personalized predictive medicine for the patient whose data have been "twinned" [19,20].

AN ALTERNATIVE APPROACH: PRIVACY AS CONTEXTUAL INTEGRITY

Barocas and Nissenbaum contend that "even if [prevailing forms of consent and anonymization] were achievable, they would be ineffective against the novel threats to privacy posed by big data." [6] A more effective option, Nissenbaum has argued, would understand privacy protection as a function of "contextual integrity," i.e., that in a given social domain information flows conform to the context-specific informational norms of that domain. Whether a transmission of information is appropriate depends on "the type of information in question, about whom it is, by whom and to whom it is transmitted, and conditions or constraints under which this transmission takes place" [21].

Nissenbaum goes on to note that novel information flows, such as those enabled by contemporary data science, should be assessed in reference to how they affect the interests of key parties and whether the distribution of associated benefits, risks, and costs among parties is fair in terms of who enjoys the benefits and who endures the costs. Further, appropriate information flows serve "not merely the interests of individual information subjects, but also contextual, social ends and values—for example, whether information flows with health care achieve the ends and purposes of health care and sustain the values associated with health care.

An evaluative framework proposed by Nissenbaum and colleagues focuses on components of dataset creation and use:

- Creation of the dataset—sourcing, assembling, cleaning, assigning labels [1]
- Composition—properties of the dataset (content, mappings among data elements expressed in different modalities) and attributes of the dataset (e.g., demographic representativeness)
- Distribution—how the dataset is made available, terms of use, disclaimers
- Purpose—what the data set is for, its intended uses, the purposes for which it is optimized [22]

Nissenbaum and colleagues identify ethical values associated with these components, including privacy, autonomy, and the moral legitimacy of the purpose a dataset is created to serve, as well as issues of bias, equity, and accountability, among others.

This approach has much in common with AMA analysis of conditions for trustworthy augmented intelligence in medicine [23] and offers a starting point for thinking about how CEJA might approach recommendations for ethically responsible management of patient information for purposes of both clinical care and biomedical research.

MOVING FORWARD

Against this backdrop the council looks forward to continuing its deliberations and to presenting its analysis and recommendations at a future meeting of the House of Delegates.

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REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS

CEJA Report 07-A-23

Subject: Use of Social Media for Product Promotion and Compensation (Resolution 025-A-22)

Presented by: Peter A. Schwartz, MD, Chair

At its 2022 Annual Meeting, the House of Delegates referred Resolution 025-A-22 (Resolution 025), "Use of Social Media for Product Promotion and Compensation," which asked that the American Medical Association (AMA) "study the ethical issues of medical students, residents, fellows, and physicians endorsing non-health related products through social and mainstream media for personal or financial gain."

Over the course of its deliberations, the Council on Ethical and Judicial Affairs (CEJA) has identified several relevant issues. These include the volatile and dynamic nature of social media and the fact social media users are able to present themselves as a product, promoting themselves and/or attempting to influence others. At issue as well are the distinctive notions of professionalism attached to the profession of medicine and how they impact individuals and physician integrity; and ethical differences among different promotional activities, e.g., whether the products or services sold or promoted health- or non-health related and whether they are marketed to patients or the general public.

The AMA *Code of Ethics* has existing relevant guidance: Opinions 9.6.4, "Sale of Health-Related Products," and 9.6.5, "Sale of Non-Health-Related Goods," as well as Opinion 2.3.2, "Professionalism in the Use of Social Media." The Council will continue to review existing guidance in contemplation of the relevant issues identified above and anticipates submitting a report to the House of Delegates at a subsequent meeting.

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS

CEJA Report 08-A-23

Subject: Judicial Function of the Council on Ethical and Judicial Affairs – Annual Report

Presented by: Peter A. Schwartz, MD, Chair

At the 2003 Annual Meeting, the Council on Ethical and Judicial Affairs (CEJA) presented a detailed explanation of its judicial function. This undertaking was motivated in part by the considerable attention professionalism has received in many areas of medicine, including the concept of professional self-regulation.

CEJA has authority under the Bylaws of the American Medical Association (AMA) to disapprove a membership application or to take action against a member. The disciplinary process begins when a possible violation of the Principles of Medical Ethics or illegal or other unethical conduct by an applicant or member is reported to the AMA. This information most often comes from statements made in the membership application form, a report of disciplinary action taken by state licensing authorities or other membership organizations, or a report of action taken by a government tribunal.

The Council rarely re-examines determinations of liability or sanctions imposed by other entities. However, it also does not impose its own sanctions without first offering a hearing to the physician. CEJA can impose the following sanctions: applicants can be accepted into membership without any condition, placed under monitoring, or placed on probation. They also may be accepted, but be the object of an admonishment, a reprimand, or censure. In some cases, their application can be rejected. Existing members similarly may be placed under monitoring or on probation, and can be admonished, reprimanded or censured. Additionally, their membership may be suspended or they may be expelled. Updated rules for review of membership can be found at https://www.ama-assn.org/governing-rules.

Beginning with the 2003 report, the Council has provided an annual tabulation of its judicial activities to the House of Delegates. In the appendix to this report, a tabulation of CEJA's activities during the most recent reporting period is presented.

APPENDIX

CEJA
Judicial Function
Statistics

APRIL 1, 2022 – MARCH 31, 2023

Physicians Reviewed	SUMMARY OF CEJA ACTIVITIES
4	Determinations of no probable cause
18	Determinations following a plenary hearing
33	Determinations after a finding of probable cause, based only on the written record, after the physician waived the plenary hearing

Physicians Reviewed	FINAL DETERMINATIONS FOLLOWING INITIAL REVIEWS
9	No sanction or other type of action
2	Monitoring
14	Probation
1	Revocation
6	Suspension
2	Denied
1	Suspension lifted
4	Censure
12	Reprimand
4	Admonish

Physicians Reviewed	PROBATION/MONITORING STATUS
16	Members placed on Probation/Monitoring during reporting interval
14	Members placed on Probation without reporting to Data Bank
8	Probation/Monitoring concluded satisfactorily during reporting interval
0	Memberships suspended due to non-compliance with the terms of probation
14	Physicians on Probation/Monitoring at any time during reporting interval who paid their AMA membership dues
8	Physicians on Probation/Monitoring at any time during reporting interval who did not pay their AMA membership dues

REPORT OF THE COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT

CLRPD Report 01-A-23

Subject: Demographic Characteristics of the House of Delegates and AMA Leadership

Presented by: Edmund Cabbabe, MD, Chair

This informational report is prepared in odd numbered years by the Council on Long Range Planning and Development (CLRPD), pursuant to American Medical Association (AMA) Policy G-600.035, "The Demographics of the House of Delegates." This policy states:

> (1) A report on the demographics of our AMA House of Delegates will be issued annually and include information regarding age, gender, race/ethnicity, education, life stage, present employment, and self-designated specialty. (2) As one means of encouraging greater awareness and responsiveness to diversity, our AMA will prepare and distribute a state-by-state demographic analysis of the House of Delegates, with comparisons to the physician population and to our AMA physician membership every other year. (3) Future reports on the demographic characteristics of the House of Delegates should, whenever possible, identify and include information on successful initiatives and best practices to promote diversity within state and specialty society delegations.

This report will survey the current demographic makeup of AMA leadership in accordance with AMA Policy G-600.030, "Diversity of AMA Delegations," which states that, "Our AMA encourages…state medical associations and national medical specialty societies to review the composition of their AMA delegations with regard to enhancing diversity..." and AMA Policy G 610.010, "Nominations," which states in part:

> Guidelines for nominations for AMA elected offices include the following... (2) the Federation (in nominating or sponsoring candidates for leadership positions), the House of Delegates (in electing Council and Board members), and the Board, the Speakers, and the President (in appointing or nominating physicians for service on AMA Councils or in other leadership positions) to consider the need to enhance and promote diversity…

Like previous reports, this document compares AMA leadership with the entire AMA membership and with the overall U.S. physician population. Medical students are included in all references to the total physician population, which is consistent with past practice. For the purposes of this report, AMA leadership includes delegates; alternate delegates; the Board of Trustees (BOT); and councils and leadership of sections and special groups (hereafter referred to as CSSG; see detailed listing in Appendix A).

Additionally, this report includes information on successful initiatives and best practices to promote diversity of state and specialty society delegations, pursuant to part 3 of Policy G-600.035.

DATA SOURCES

Lists of delegates and alternate delegates are maintained by the Office of House of Delegates (HOD) Affairs and based on official rosters provided by the relevant societies. The lists used in this report reflect year-end 2022 delegation rosters. AMA council rosters as well as listings for the governing bodies of each of the sections and special groups were provided by the relevant AMA staff.

Data on demographic characteristics of individuals are taken from the AMA Physician Masterfile, which provides comprehensive demographic, medical education, and other information on all graduates of U.S. medical schools and international medical graduates (IMGs) who have undertaken residency training in the United States. Data on AMA members and the total physician population are taken from the year-end 2022 Masterfile after it is considered final.

Some key considerations must be kept in mind regarding the information in this report. Members of the BOT, the American Medical Political Action Committee (AMPAC) and the Council on Legislation who are not physicians or medical students are not included in any tables. Vacancies in delegation rosters mean the total number of delegates is fewer than the number allotted at the 2022 Interim Meeting, and the number of alternate delegates is nearly always less than the full allotment. Race and ethnicity information, which is provided directly by physicians, is missing for approximately one-fifth of AMA members (20.0%) and the total U.S. physician population (20.4%), limiting the ability to draw firm conclusions.

Readers are reminded that most AMA leadership groups considered herein designate seats for students and resident/fellow physicians. This affects some characteristics, particularly age, as well as the makeup of age-related groups, namely the student, resident, and young physician sections. To provide further clarity on this point, an additional table has been included in the appendix illustrating demographic characteristics and career stage breakdowns of AMA section governing councils.

CHARACTERISTICS OF AMA LEADERSHIP

Table 1 displays the basic characteristics of AMA leadership, AMA members, and all physicians and medical students. Raw counts for Tables 1 and 2 can be found in Appendix A. Upward- and downward-pointing arrows indicate an increase or decrease of at least two percentage points compared to CLRPD Report 1-A-21, “Demographic Characteristics of the House of Delegates and AMA Leadership”; the following observations refer to changes since CLRPD Report 1-A-21. Changes are not highlighted for the BOT due to the small number of Board members. Between year-end 2020 and year-end 2022, AMA membership increased by 3,061 members, a 1.1% increase.

- Little change was observed in the age breakdown of AMA membership and leadership. The share of delegates in the 60-69 age group decreased by 3.9 percentage points since 2020, but no age group saw a significant increase. Likewise, among councils and leadership of sections and special groups, two age groups (under age 40 and age 50-59) saw increased representation, while two others (40-49 and 60-69) saw their percentages decrease, but these changes seem more attributable to fluctuation than any specific trend.

- A continued increase in female representation among AMA delegates and alternate delegates was observed, as females in 2022 made up 34.3% of delegates (up from 30.7% in 2020) and 43.7% of alternate delegates (38.3% in 2020). Over the past decade, the number of female delegates and alternate delegates has increased steadily; in 2012, 20.2% of delegates and 21.5% of alternate delegates identified as female.

- The percentage of white delegates and alternate delegates decreased by 3.5 percentage points and 4.4 percentage points, respectively.
- The percentage of international medical graduate (IMG) alternate delegates increased by 2.7 percentage points.

Table 1. Demographic Characteristics of AMA Leadership, December 2022

	Delegates[1]	Alternate Delegates[2]	Board of Trustees[2]	Councils and Leadership of Sections and Special Groups[3]	AMA Members	All Physicians and Medical Students
Count	661	391	20	167	274,716	1,455,177
Mean age[4]	56.7	50.1	54.4	51.1	47.1	52.9
Age Distribution						
Under age 40	15.4%	30.4%	10.0%	30.5%↑	51.4%	29.4%
40-49 years	15.0%	17.7%	20.0%	13.8%↓	11.2%	17.6%
50-59 years	20.0%	19.7%	30.0%	21.6%↑	9.8%	16.4%
60-69 years	28.3%↓	22.3%	30.0%	19.2%↓	9.6%	16.2%
70 or more	21.3%	10.0%	10.0%	15.0%	18.0%	20.4%
Gender						
Male	65.7%↓	55.8%↓	60.0%	50.9%	60.0%	62.7%
Female	34.3%↑	43.7%↑	40.0%	49.1%	39.5%	36.6%
Unknown	0.0%	0.5%	0.0%	0.0%	0.6%	0.8%
Race/Ethnicity						
White non-Hispanic	65.8%↓	57.3%↓	45.0%	56.9%	48.9%	49.7%
Black non-Hispanic	5.5%	4.9%	15.0%	6.6%	4.9%	4.3%
Hispanic	3.0%	4.4%	5.0%	3.0%	4.5%	4.6%
Asian/Asian American	12.7%	15.9%	20.0%	18.6%	15.4%	15.8%
Native American	0.3%	0.3%	0.0%	0.0%	0.2%	0.2%
Other[5]	2.6%	5.9%↑	0.0%	7.2%↑	6.2%↑	5.0%↑
Unknown	10.1%	11.5%	15.0%	7.8%	20.0%	20.4%
Education						
US or Canada	92.1%	89.5%↓	100.0%	88.0%	81.9%	77.7%
IMG	7.9%	10.5%↑	0.0%	12.0%	18.1%	22.3%

[1] Numbers include medical students and residents endorsed by their states for delegate and alternate delegate positions.
[2] Numbers do not include the public member of the Board of Trustees, who is not a physician.
[3] Numbers do not include non-physicians on the Council on Legislation and the American Medical Political Action Committee. In addition, Appendix A contains a listing of the AMA Councils, Sections, and Special Groups.
[4] Age as of December 31. Mean age is the arithmetic average.
[5] Includes other self-reported racial and ethnic groups.

Table 2 displays life stage, present employment, and self-designated specialty of AMA leadership.

- No significant changes were observed to the life stage, employment, and specialty characteristics of delegates to the HOD. Among alternate delegates, decreases were observed among established physicians (from 49.7% in 2020 to 44.0% in 2022), employees of the U.S. government (4.1% in 2020, 2.1% in 2022) and internal medicine specialists (19.2% in 2020, 15.1% in 2022). The percentage of senior physician alternate delegates increased from 19.4% to 22.5% since 2020.

- Among CSSG, increases were observed among young physicians (9.6% in 2020, 13.2% in 2022), employees of non-government hospitals (4.2% in 2020, 6.6% in 2022) and internal medicine specialists (18.7% in 2020, 22.2% in 2022). Decreases were observed among senior physicians (28.9% in 2020, 24.6% in 2022), employees of state or local government hospitals (10.8% in 2020, 7.2% in 2022) and OB/GYN specialists (13.3% in 2020, 9.6% in 2022).

Table 2. Life Stage, Present Employment and Self-Designated Specialty of AMA Leadership, December 2022

	Delegates	Alternate Delegates	Board of Trustees	Councils and Leadership of Sections and Special Groups	AMA Members	All Physicians and Medical Students
Count	661	391	20	167	274,716	1,455,177
Life Stage						
Student[6]	4.8%	10.5%	5.0%	9.6%	19.5%	8.0%
Resident[6]	5.8%	8.7%	5.0%	11.4%	26.2%	10.1%
Young (Under age 40 or first eight years of practice) ^	7.4%	14.3%	0.0%	13.2%↑	9.9%	15.4%
Established (Age 40-64) ^	45.1%	44.0%↓	65.0%	41.3%	21.7%	37.9%
Senior (Age 65 or more)^	36.9%	22.5%↑	25.0%	24.6%↓	22.8%	28.6%
Present Employment						
Self-employed solo practice	12.1%	8.4%	15.0%	10.8%	6.2%	7.6%
Two physician practice	1.7%	2.1%	5.0%	1.2%	1.3%	1.8%
Group practice	39.8%	38.6%	45.0%	34.7%	24.0%	39.7%
Non-government hospital	7.7%	7.2%	10.0%	6.6%↑	3.0%	4.1%
State or local government hospital	10.3%	9.7%	5.0%	7.2%↓	3.6%	6.0%
HMO	1.1%	0.5%	0.0%	1.2%	0.2%	0.2%
Medical School	3.9%	2.8%	10.0%	3.6%	0.9%	1.4%

[6] Students and residents are so categorized without regard to age.
^ Reflects section/group definition of its membership.

U.S. Government	3.0%	2.1%↓	0.0%	3.6%	0.8%	1.6%
Locum Tenens	0.3%	0.3%	0.0%	1.2%	0.1%	0.2%
Retired/Inactive	7.7%	4.6%	0.0%	6.6%	11.4%	12.6%
Resident/Intern/ Fellow	5.8%	8.7%	5.0%	11.4%	26.2%	10.1%
Student	4.8%	10.5%	5.0%	9.6%	19.5%	8.0%
Other/Unknown	1.8%	4.6%	0.0%	2.4%	2.7%	7.0%
Self-designated specialty[7]						
Family Medicine	11.0%	11.0%	5.0%	10.8%	8.8%	11.3%
Internal Medicine	21.8%	15.1%↓	20.0%	22.2%↑	20.6%	22.8%
Surgery	22.1%	17.4%	30.0%	15.6%	13.4%	13.3%
Pediatrics	3.5%	5.4%	0.0%	7.2%	5.3%	8.7%
OB/GYN	5.9%	7.9%	15.0%	9.6%↓	4.9%	4.5%
Radiology	5.8%	5.1%	5.0%	2.4%	3.6%	4.4%
Psychiatry	3.8%	5.6%	0.0%	4.8%	4.4%	5.2%
Anesthesiology	3.8%	3.1%	5.0%	2.4%	3.9%	4.9%
Pathology	2.0%	3.8%	0.0%	0.0%	1.7%	2.2%
Other specialty	15.6%	15.1%	15.0%	15.6%	13.9%	14.7%
Student	4.8%	10.5%	5.0%	9.6%	19.5%	8.0%

For further data, including information on state medical associations and national medical specialty societies, raw counts of the above tables, and detailed state and specialty society data, please see the appendices.

PROMOTING DIVERSITY AMONG DELEGATIONS

Pursuant to Part 3 of AMA Policy G-600.035, CLRPD queried state and specialty societies on initiatives they have instituted to encourage diversity among their delegations, and the outcomes of these initiatives.

- Convening groups with a focus on diversity: several societies mentioned convening task forces, councils and/or committees with the goal of evaluating and/or increasing diversity among their organization, including their delegations and other leadership positions. Societies that have implemented these types of groups reported a number of beneficial outcomes including advising the society on internal and external action, developing educational programming and online content, writing grants, and increasing diversity at society meetings.

- Intentional recruitment: societies mentioned making a conscious effort to recruit diverse candidates from across their organizations and ready them for larger leadership opportunities. Additionally, some societies reported making conscious outreach efforts to medical students, including those from historically black colleges and universities, with the goal of increasing diversity within their respective societies, and in the case of specialties, among the specialty itself.

- Initiatives and summits: societies mentioned instituting a variety of initiatives focused on issues related to equity, diversity, and inclusion. These included convening members with interest in addressing lifestyle-related chronic disease health disparities, training and

[7] See Appendix B for a listing of specialty classifications.

certification scholarships for physicians who are representative of and delivering care to underserved communities, leadership summits to prepare young members for future leadership roles, and podcasts to discuss issues related to health and wellness through a DEI lens.

APPENDIX A

Table 3. Demographic Characteristics of AMA Leadership, December 2022

	Delegates[2]	Alternate Delegates[2]	Board of Trustees[3]	Councils and Leadership of Sections and Special Groups[4]	AMA Members	All Physicians and Medical Students
Mean age[5]	56.7	50.1	54.4	51.1	47.1	52.9
Count	661	391	20	167	274,716	1,455,177
Age distribution						
Under age 40	102	119	2	51	141,319	428,442
40-49 years	99	69	4	23	30,766	255,897
50-59 years	132	77	6	36	26,892	238,054
60-69 years	187	87	6	32	26,436	236,073
70 or more	141	39	2	25	49,303	296,711
Gender						
Male	434	218	12	85	164,789	911,708
Female	227	171	8	82	108,362	532,338
Unknown	-	2	-	-	1,565	11,131
Race/ethnicity						
White non-Hispanic	435	224	9	95	134,244	723,379
Black non-Hispanic	36	19	3	11	13,379	63,150
Hispanic	20	17	1	5	12,234	67,553
Asian/Asian American	84	62	4	31	42,310	229,363
Native American	2	1	-	-	470	2,546
Other[6]	17	23	-	12	17,096	72,773
Unknown	67	45	3	13	54,983	296,413
Education						
US or Canada	609	350	20	147	224,961	1,130,279
IMG	52	41	0	20	49,755	324,898

[2] Numbers include medical students and residents endorsed by their states for delegate and alternate delegate positions.
[3]Numbers do not include the public member of the Board of Trustees, who is not a physician.
[4]Numbers do not include non-physicians on the Council on Legislation and the American Medical Political Action Committee. In addition, Appendix A contains a listing of the AMA Councils, Sections, and Special Groups.
[5] Age as of December 31. Mean age is the arithmetic average.
[6] Includes other self-reported racial and ethnic groups.

Table 4. Life Stage, Present Employment and Self-Designated Specialty[1] of AMA Leadership, December 2022

	Delegates	Alternate Delegates	Board of Trustees	Councils and Leadership of Sections and Special Groups	AMA Members	All Physicians and Medical Students
Count	661	391	20	167	274,716	1,455,177
Life Stage						
Student[8]	32	41	1	16	53,542	116,060
Resident[1]	38	34	1	19	71,984	147,487
Young (Under age 40 or first eight years of practice) ^	49	56	-	22	27,193	224,043
Established (Age 40-64) ^	298	172	13	69	59,495	551,790
Senior (Age 65 or more)^	244	88	5	41	62,502	415,797
Present Employment						
Self-employed solo practice	80	33	3	18	16,927	110,247
Two physician practice	11	8	1	2	3,631	25,396
Group practice	263	151	9	58	66,043	577,636
Non-government hospital	51	28	2	11	8,164	59,397
State or local government hospital	68	38	1	12	9,935	86,655
HMO	7	2	0	2	650	2,250
Medical School	26	11	2	6	2,450	20,076
U.S. Government	20	8	0	6	2,279	22,607
Locum Tenens	2	1	0	2	365	2,589
Retired/Inactive	51	18	0	11	31,308	183,396
Resident/Intern/ Fellow	38	34	1	19	71,984	147,487
Student	32	41	1	16	53,542	116,060
Other/Unknown	12	18	0	4	7,438	101,381
Self-designated specialty						
Family Medicine	73	43	1	18	24,050	164,511
Internal Medicine	144	59	4	37	56,630	331,181
Surgery	146	68	6	26	36,839	193,274
Pediatrics	23	21	0	12	14,681	126,906
OB/GYN	39	31	3	16	13,549	65,941
Radiology	38	20	1	4	9,809	64,423

[8] Students and residents are so categorized without regard to age.
^ Reflects section/group definition of its membership.

Psychiatry	25	22	0	8	12,014	75,523
Anesthesiology	25	12	1	4	10,798	71,625
Pathology	13	15	0	0	4,748	31,777
Other specialty	103	59	3	26	38,056	213,956
Student	32	41	1	16	53,542	116,060

See Appendix B for a listing of specialty classifications.

Table 5. Demographic Characteristic Cross Sections of AMA Members, December 2022

	White non-Hispanic	Black non-Hispanic	Hispanic	Asian/Asian American	Native American	Other[9]
Mean age[10]	51.8	42.0	45.2	41.4	40.4	43.1
Count	134,244	13,379	12.234	42,310	470	72,079
Age distribution						
Under age 40	42.0%	55.6%	49.7%	58.6%	52.1%	64.3%
40-49 years	10.4%	15.6%	16.2%	15.4%	22.3%	8.5%
50-59 years	10.8%	12.9%	12.8%	11.9%	20.4%	5.4%
60-69 years	12.4%	8.9%	9.4%	5.5%	4.0%	7.1%
70 or more	24.4%	6.9%	11.9%	8.6%	1.1%	14.6%
Gender						
Male	65.5%	44.3%	58.9%	53.3%	52.1%	56.9%
Female	34.5%	55.7%	41.1%	46.7%	47.9%	41.1%
Unknown	0.0%	0.0%	0.1%	0.1%	0.0%	2.1%
Life Stage						
Student[11]	15.5%	24.1%	20.4%	21.5%	21.7%	24.6%
Resident[4]	19.9%	25.6%	26.3%	27.8%	27.2%	37.1%
Young (Under age 40 or first eight years of practice) ^	9.8%	12.9%	5.2%	14.1%	10.0%	7.8%
Established (Age 40-64) ^	24.0%	26.8%	32.0%	25.6%	39.2%	12.2%
Senior (Age 65 or more)^	30.8%	10.8%	16.1%	11.0%	1.9%	18.2%
Education						
US or Canada	92.2%	85.6%	73.5%	67.8%	93.8%	71.6%
IMG	7.8%	14.4%	26.5%	32.2%	6.2%	28.4%

[9] Includes other self-reported racial and ethnic groups.
[10] Age as of December 31. Mean age is the arithmetic average.
[11] Numbers include medical students and residents endorsed by their states for delegate and alternate delegate positions.
^ Reflects section/group definition of its membership.

Table 6. Demographic Characteristics of AMA Section Governing Councils, December 2022

	APS	IPPS	IMGS	MSS	MAS	OMSS	PPPS	RFS	SPS	WPS	YPS
Mean Age	62.4	57.7	42.6	27.3	45.9	65.4	54.9	30.9	71.9	46.3	37.1
Life Stage											
Student	-	-	-	9	-	-	-	-	-	-	-
Resident	-	-	-	-	2	-	-	8	-	1	-
Young (Under age 40 or first eight years of practice) ^	-	-	6	-	1	-	2	-	-	2	7
Established (Age 40-64)^	5	6	1	-	3	3	3	-	1	3	-
Senior (Age 65 or over)^	3	1		-	1	4	2	-	6	1	-
Gender											
Male	4	6	3	4	2	4	3	4	5	-	4
Female	4	1	4	5	5	3	4	4	2	7	3
Unknown	-	-	-	-	-	-	-	-	-	-	-
Race/ethnicity											
White non-Hispanic	4	5	3	4	1	5	5	3	5	3	6
Black non-Hispanic	1	-	-	1	3	-	-	-	-	1	-
Hispanic	1	-	-	1	2	1	-	-	-	-	-
Asian/Asian American	1	1	2	2	-	1	1	1	2	2	-
Native American	-	-	-	-	-	-	-	-	-	-	-
Other[1]	-	-	2	1	1	-	-	3	-	-	1
Unknown	1	1	-	-	-	-	1	1	-	1	-
Education											
US or Canada	7	5	-	9	7	6	6	8	6	7	7
IMG	1	2	7	-	-	1	1	-	1	-	-

^ Reflects section/group definition of its membership.

[1] Includes other self-reported racial and ethnic groups.

Table 7. Characteristics of Specialty Society Delegations, December 2022

	Mean Age	% Female	% IMG	% Resident
AMA Members (n =274,716)	47.1	39.5%	18.1%	26.2%
Specialty Society Delegates and Alternates (n =418)	55.3	38.5%	7.9%	2.9%
Family Medicine Delegations (n =30)	52.9	50.0%	6.7%	3.3%
Internal Medicine Delegations (n =92)	57.1	38.0%	13.0%	4.4%
Surgery Delegations (n = 90)	56.0	23.3%	7.8%	2.2%
Pediatrics Delegations (n = 12)	52.3	83.3%	0.0%	0.0%
OB/GYN Delegations (n = 28)	54.8	71.4%	7.1%	3.6%
Radiology Delegations (n = 34)	56.1	35.3%	5.9%	0.0%
Psychiatry Delegations (n =22)	54.1	45.5%	9.1%	0.0%
Anesthesiology Delegations (n =13)	56.2	15.4%	0.0%	0.0%
Pathology Delegations (n =20)	54.5	30.0%	5.0%	0.0%
Other specialty Delegations (n =77)	53.7	39.0%	6.5%	5.2%

Table 8. Mean Age of AMA Members and Delegations by State, December 2022

State	Total AMA Members in State	Mean Age of AMA Members	Total Number of Delegates and Alternate Delegates	Mean Age of AMA Delegates and Alternate Delegates
Alabama	3,073	51.9	8	58.6
Alaska	349	56.2	2	†
Arizona	4,632	54.7	10	61.1
Arkansas	1,948	52.3	5	63.4
California	31,743	55.0	62	54.3
Colorado	5,486	53.0	8	56.1
Connecticut	3,072	53.4	8	62.8
Delaware	835	55.6	2	†
District of Columbia	1,957	45.6	3	†
Florida	16,122	55.9	30	59.1
Georgia	5,901	52.6	11	59.3
Guam	20	59.3		
Hawaii	997	56.8	3	†
Idaho	774	55.9	2	†
Illinois	11,329	51.9	23	63.3
Indiana	4,646	52.5	9	65.2
Iowa	3,162	52.6	6	54.0
Kansas	2,251	52.5	7	63.1
Kentucky	3,999	51.5	8	62.5
Louisiana	5,906	50.0	7	52.1
Maine	1,144	55.4	2	†
Maryland	5,084	54.5	10	59.1
Massachusetts	12,481	51.2	19	57.0
Michigan	13,192	50.5	26	57.7
Minnesota	4,681	52.8	10	59.2
Mississippi	2,728	51.4	6	56.5
Missouri	4,900	49.3	9	59.9
Montana	684	57.1	2	†
Nebraska	1,654	49.0	4	47.8
Nevada	1,683	54.1	4	71.8
New Hampshire	893	54.9	3	†
New Jersey	7,603	54.6	12	67.1
New Mexico	1,187	55.7	4	55.0
New York	19,600	52.4	22	56.8
North Carolina	5,259	51.9	6	61.2
North Dakota	722	51.0	2	†
Ohio	10,214	50.7	18	51.3
Oklahoma	3,314	52.0	7	63.1
Oregon	3,145	54.9	5	58.4
Other	793	67.9	1	†
Pennsylvania	11,663	51.7	23	59.5
Puerto Rico	1,440	55.8	1	†
Rhode Island	1,030	50.4	5	61.8
South Carolina	3,683	51.7	10	64.3
South Dakota	975	52.2	5	63.6

† To protect the privacy of these individuals, data for three or fewer persons are not presented in the table, although the data are included in the overall total.

State	Total AMA Members in State	Mean Age of AMA Members	Total Number of Delegates and Alternate Delegates	Mean Age of AMA Delegates and Alternate Delegates
Tennessee	5,422	52.0	11	62.4
Texas	19,908	50.9	35	59.9
Utah	1,799	50.5	4	52.5
Vermont	460	53.0	1	†
Virgin Islands	29	65.2		
Virginia	7,000	53.0	10	60.4
Washington	5,445	54.8	10	49.7
West Virginia	1,872	50.1		
Wisconsin	4,621	52.8	7	62.0
Wyoming	206	59.1	2	†
TOTAL	274,716	53.1	510	59.1

Table 9. Women and International Medical Graduates on State Association Delegations, December 2022

State	Total AMA Members in State	Total Number of Delegates and Alternate Delegates	Percentage of female AMA Members in State	Number of Female Delegates and Alternate Delegates	Percentage of IMG Members in State	Number of IMG Delegates and Alternate Delegates
Alabama	3,073	8	34.0%	3	12.6%	-
Alaska	349	2	40.4%	1	10.0%	-
Arizona	4,632	10	36.0%	4	15.0%	-
Arkansas	1,948	5	37.2%	1	13.1%	1
California	31,743	62	41.0%	20	18.2%	3
Colorado	5,486	8	43.8%	5	5.9%	-
Connecticut	3,072	8	40.1%	4	21.2%	2
Delaware	835	2	34.6%	2	28.9%	-
District of Columbia	1,957	3	51.3%	-	12.1%	-
Florida	16,122	30	35.2%	9	29.4%	4
Georgia	5,901	11	40.8%	3	17.9%	1
Guam	20	-	15.0%	-	60.0%	-
Hawaii	997	3	34.0%	1	12.7%	-
Idaho	774	2	29.5%	1	5.8%	-
Illinois	11,329	23	39.6%	8	21.6%	6
Indiana	4,646	9	36.4%	2	16.0%	2
Iowa	3,162	6	36.1%	3	16.1%	-
Kansas	2,251	7	34.3%	2	12.8%	1
Kentucky	3,999	8	37.9%	1	14.3%	-
Louisiana	5,906	7	41.5%	-	15.5%	1
Maine	1,144	2	44.8%	1	8.4%	-
Maryland	5,084	10	43.0%	5	23.6%	3
Massachusetts	12,481	19	48.3%	7	15.0%	1
Michigan	13,192	26	38.6%	8	22.5%	4
Minnesota	4,681	10	38.9%	5	14.8%	-
Mississippi	2,728	6	33.7%	2	10.5%	1
Missouri	4,900	9	39.6%	3	10.4%	2
Montana	684	2	42.3%	1	4.5%	-
Nebraska	1,654	4	39.4%	1	8.0%	-
Nevada	1,683	4	35.8%	1	19.4%	1
New Hampshire	893	3	37.1%	1	16.9%	-
New Jersey	7,603	12	37.1%	4	29.2%	2
New Mexico	1,187	4	38.6%	2	14.2%	-
New York	19,600	22	40.7%	3	27.2%	2
North Carolina	5,259	6	36.1%	4	13.4%	-
North Dakota	722	2	38.6%	-	15.2%	1
Ohio	10,214	18	39.7%	6	15.8%	1
Oklahoma	3,314	7	36.6%	2	11.1%	-
Oregon	3,145	5	41.9%	1	8.7%	-
Other	793	1	16.3%	1	56.0%	-
Pennsylvania	11,663	23	37.1%	1	15.5%	4
Puerto Rico	1,440	1	43.3%	-	20.1%	-
Rhode Island	1,030	5	43.7%	2	16.3%	-

State	Total AMA Members in State	Total Number of Delegates and Alternate Delegates	Percentage of female AMA Members in State	Number of Female Delegates and Alternate Delegates	Percentage of IMG Members in State	Number of IMG Delegates and Alternate Delegates
South Carolina	3,683	10	39.6%	1	8.9%	-
South Dakota	975	5	37.2%	1	10.1%	1
Tennessee	5,422	11	38.8%	3	10.3%	2
Texas	19,908	35	40.8%	11	17.6%	4
Utah	1,799	4	26.6%	2	5.5%	-
Vermont	460	1	39.8%	-	9.3%	-
Virgin Islands	29	-	27.6%	-	31.0%	-
Virginia	7,000	10	41.5%	5	17.4%	1
Washington	5,445	10	39.6%	5	15.1%	1
West Virginia	1,872	-	36.7%	-	22.8%	-
Wisconsin	4,621	7	36.8%	3	16.7%	1
Wyoming	206	2	28.2%	-	11.2%	-
TOTAL	274,716	510	39.4%	162	18.1%	53

Table 10. Medical Students and Resident Physicians on State Association Delegations, December 2022

State	Total AMA Members in State	Number of State Delegates and Alternate Delegates	Total Medical Student AMA Members in State	Number of Medical Student Delegates and Alternate Delegates	Number of Regional Medical Student Delegates and Alternate Delegates[1]	Total Resident Physician AMA Members in State	Number of Resident Delegates and Alternate Delegates	Number of Sectional Resident Delegates and Alternate Delegates[2]
Alabama	3,073	8	501	1	1	879	1	1
Alaska	349	2	5	-	-	33	-	-
Arizona	4,632	9	833	1	1	1,505	2	-
Arkansas	1,948	5	570	1	1	376	-	-
California	31,743	61	3,416	7	5	6,642	7	2
Colorado	5,486	8	1,651	1	1	691	-	-
Connecticut	3,072	6	689	3	3	665	-	-
Delaware	835	2	22	-	-	107	-	-
District of Columbia	1,957	2	678	-	-	526	2	2
Florida	16,122	30	2,598	3	3	4,460	-	-
Georgia	5,901	11	1,058	2	2	1,149	-	-
Guam	20	-	-	-	-	2	-	-
Hawaii	997	3	156	-	-	118	-	-
Idaho	774	2	112	-	-	66	-	-
Illinois	11,329	23	2,727	2	1	2,522	5	1
Indiana	4,646	9	626	3	3	1,644	-	-
Iowa	3,162	6	386	-	-	769	-	-
Kansas	2,251	7	537	-	-	409	-	-
Kentucky	3,999	8	917	1	1	846	1	1
Louisiana	5,906	7	1,107	2	2	2,068	2	-
Maine	1,144	2	382	-	-	201	-	-
Maryland	5,084	10	610	1	1	935	1	-
Massachusetts	12,481	19	3,396	6	5	5,344	5	2
Michigan	13,192	25	1,847	2	1	5,085	1	-
Minnesota	4,681	10	634	1	1	1,428	-	-

Table 10. Medical Students and Resident Physicians on State Association Delegations, December 2022

State	Total AMA Members in State	Number of State Delegates and Alternate Delegates	Total Medical Student AMA Members in State	Number of Medical Student Delegates and Alternate Delegates	Number of Regional Medical Student Delegates and Alternate Delegates[1]	Total Resident Physician AMA Members in State	Number of Resident Delegates and Alternate Delegates	Number of Sectional Resident Delegates and Alternate Delegates[2]
Mississippi	2,728	6	626	1	1	740	1	1
Missouri	4,900	8	1,523	1	1	1,286	1	1
Montana	684	2	273	-	-	38	-	-
Nebraska	1,654	3	644	1	1	234	1	1
Nevada	1,683	4	328	-	-	491	2	2
New Hampshire	893	3	140	-	-	166	-	-
New Jersey	7,603	12	1,231	2	2	1,561	-	-
New Mexico	1,187	4	231	-	-	170	-	-
New York	19,600	18	4,029	4	3	6,231	-	-
North Carolina	5,259	6	815	-	-	1,288	1	-
North Dakota	722	2	340	-	-	84	-	-
Ohio	10,214	17	2,792	4	3	2,617	2	1
Oklahoma	3,314	5	1,030	-	-	849	-	-
Oregon	3,145	5	311	-	-	464	-	-
Other	793	1	22	-	-	66	-	-
Pennsylvania	11,663	22	2,210	3	2	3,007	2	-
Puerto Rico	1,440	1	578	-	-	280	-	-
Rhode Island	1,030	5	265	-	-	262	-	-
South Carolina	3,683	10	1,114	2	2	827	-	-
South Dakota	975	5	350	-	-	130	-	-
Tennessee	5,422	11	1,324	-	-	1,632	1	-
Texas	19,908	32	4,346	5	4	6,497	5	4
Utah	1,799	3	337	-	-	325	-	-
Vermont	460	1	98	-	-	97	-	-
Virgin Islands	29	-	-	-	-	-	-	-
Virginia	7,000	10	1,642	2	2	1,423	1	-
Washington	5,445	9	440	-	-	676	-	-

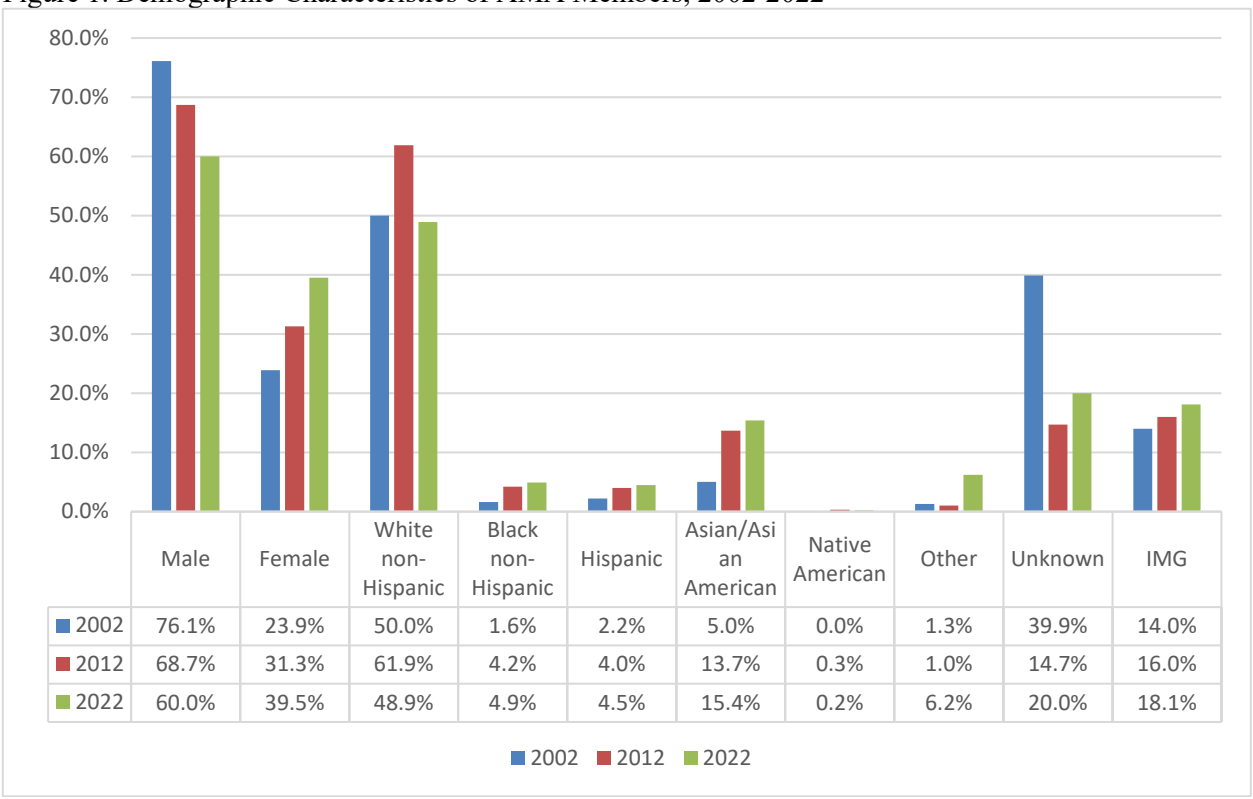
Table 10. Medical Students and Resident Physicians on State Association Delegations, December 2022

State	Total AMA Members in State	Number of State Delegates and Alternate Delegates	Total Medical Student AMA Members in State	Number of Medical Student Delegates and Alternate Delegates	Number of Regional Medical Student Delegates and Alternate Delegates[1]	Total Resident Physician AMA Members in State	Number of Resident Delegates and Alternate Delegates	Number of Sectional Resident Delegates and Alternate Delegates[2]
West Virginia	1,872	-	371	-	-	774	-	-
Wisconsin	4,621	6	671	1	1	1,273	1	1
Wyoming	206	2	3	-	-	18	-	-
TOTAL	274,716	488	53,542	63	54	71,976	45	20

[1] The Medical Student Section elects AMA delegates and alternate delegates from Medical Student Regions. There are seven Medical Student Regions defined for the purposes of electing AMA Delegates from Medical Student Regions. Each Region is entitled to delegate and alternate delegate representation based on the number of seats allocated to it by apportionment. A delegate is seated with the state delegation in which his or her medical school resides.

[2] Resident sectional delegates and alternate delegates endorsed by specialty societies were not included in this table. The following specialty societies endorsed sectional resident delegates and alternate delegates: American Academy of Family Physicians, American Academy of Neurology, American Academy of Pediatrics, American Association of Neurological Surgeons, American Association of Public Health Physicians, American College of Emergency Physicians, American Geriatrics Society, American Psychiatric Association, American Urological Association, Infectious Diseases Society of America, and Society of Critical Care Medicine. This table reflects information available as of January 31, 2023, and is subject to change. Information on alternate delegates was not available.

Figure 1. Demographic Characteristics of AMA Members, 2002-2022



	Male	Female	White non-Hispanic	Black non-Hispanic	Hispanic	Asian/Asian American	Native American	Other	Unknown	IMG
2002	76.1%	23.9%	50.0%	1.6%	2.2%	5.0%	0.0%	1.3%	39.9%	14.0%
2012	68.7%	31.3%	61.9%	4.2%	4.0%	13.7%	0.3%	1.0%	14.7%	16.0%
2022	60.0%	39.5%	48.9%	4.9%	4.5%	15.4%	0.2%	6.2%	20.0%	18.1%

Figure 2. Self-Identified Race/Ethnicity of Delegates and Alternate Delegates, 2002-2022

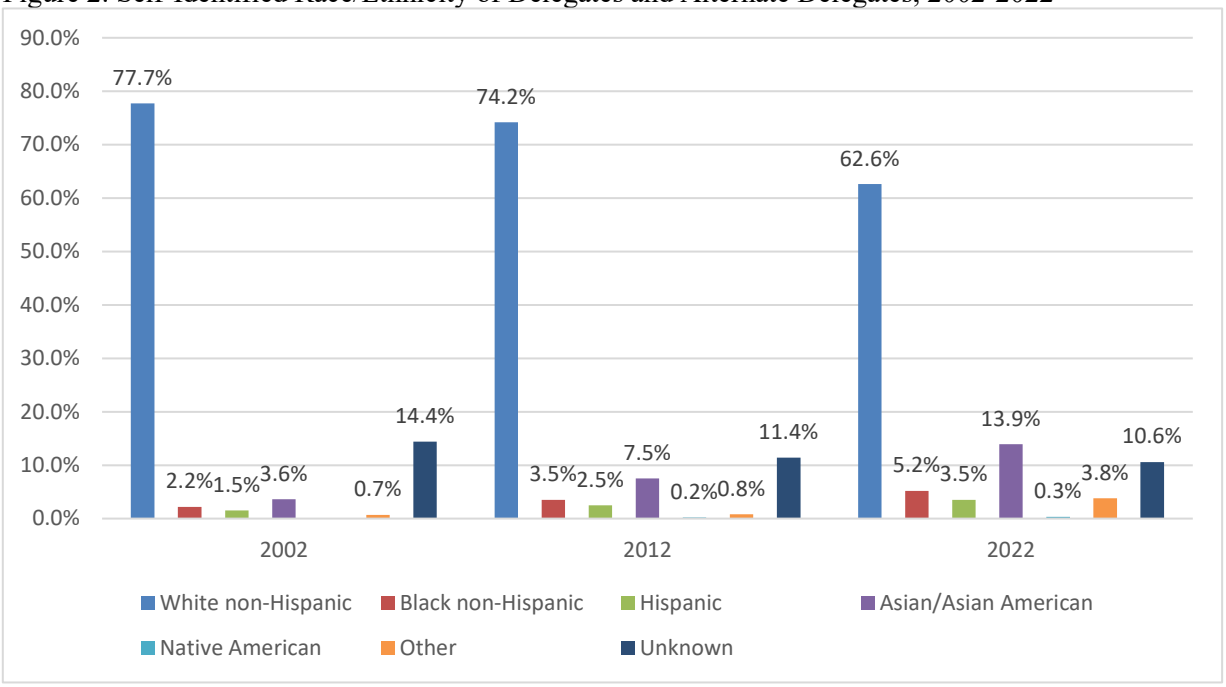


Figure 3. Self-Identified Race/Ethnicity of AMA Board of Trustees, 2002-2022

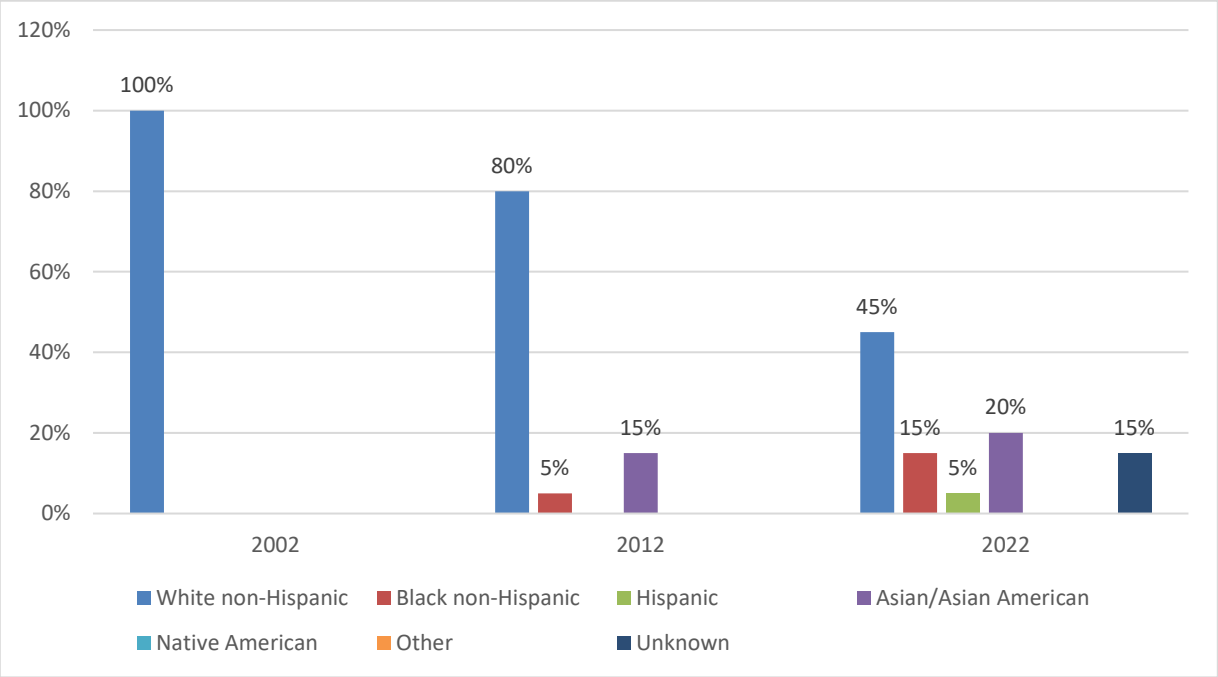


Figure 4. Self-Identified Race/Ethnicity of Councils and Section and Special Group Leadership, 2012-2022

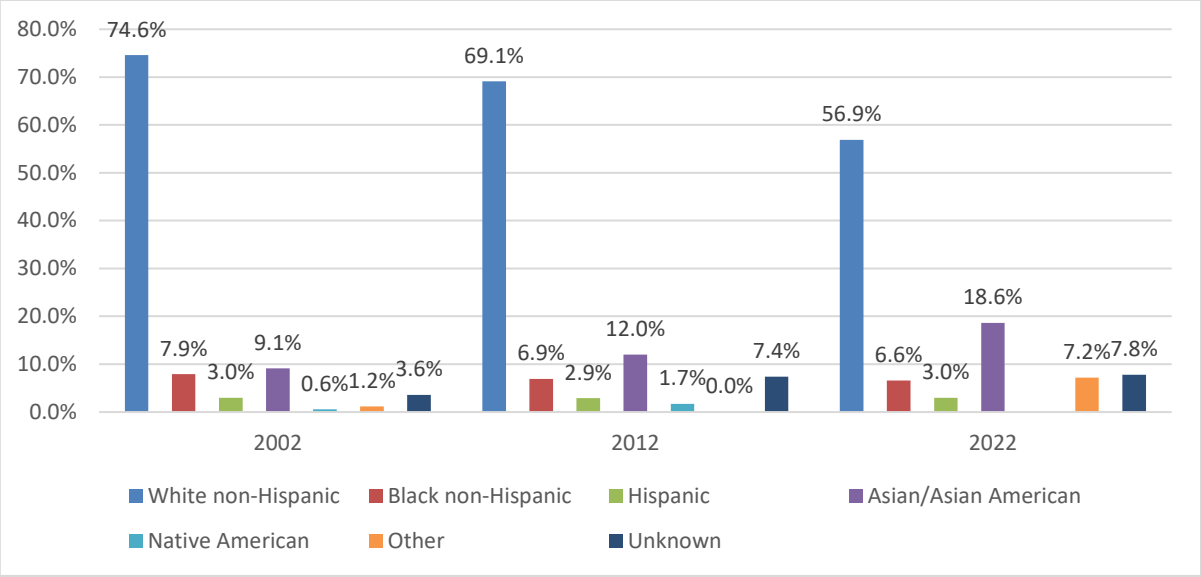
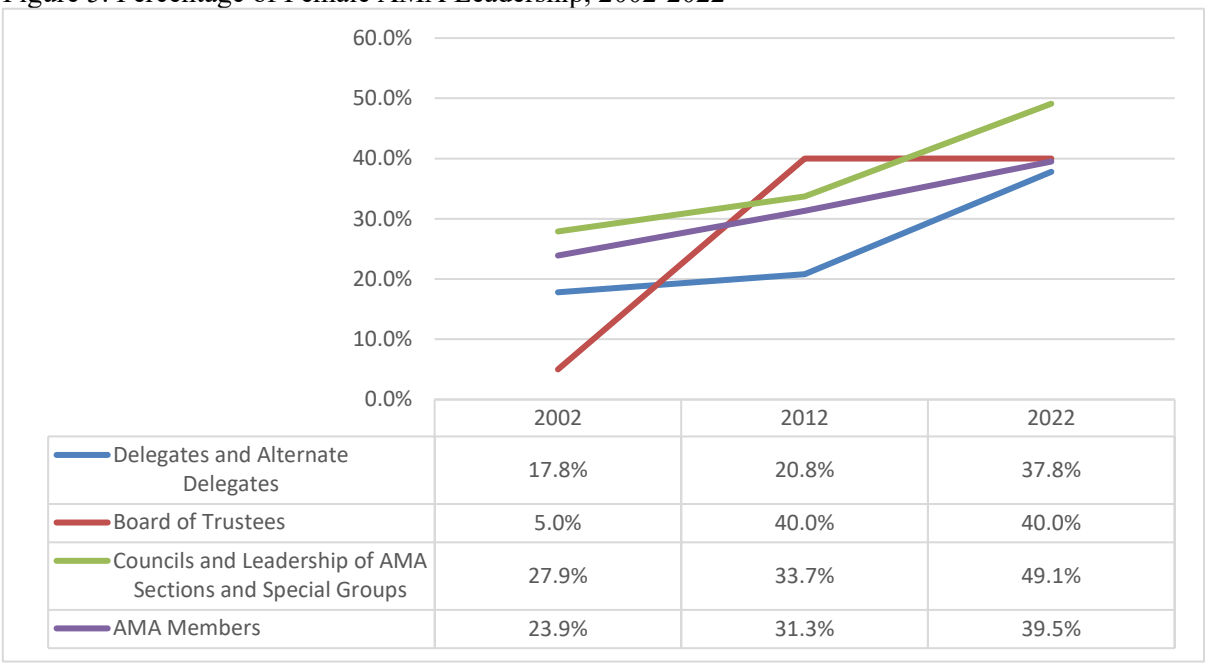
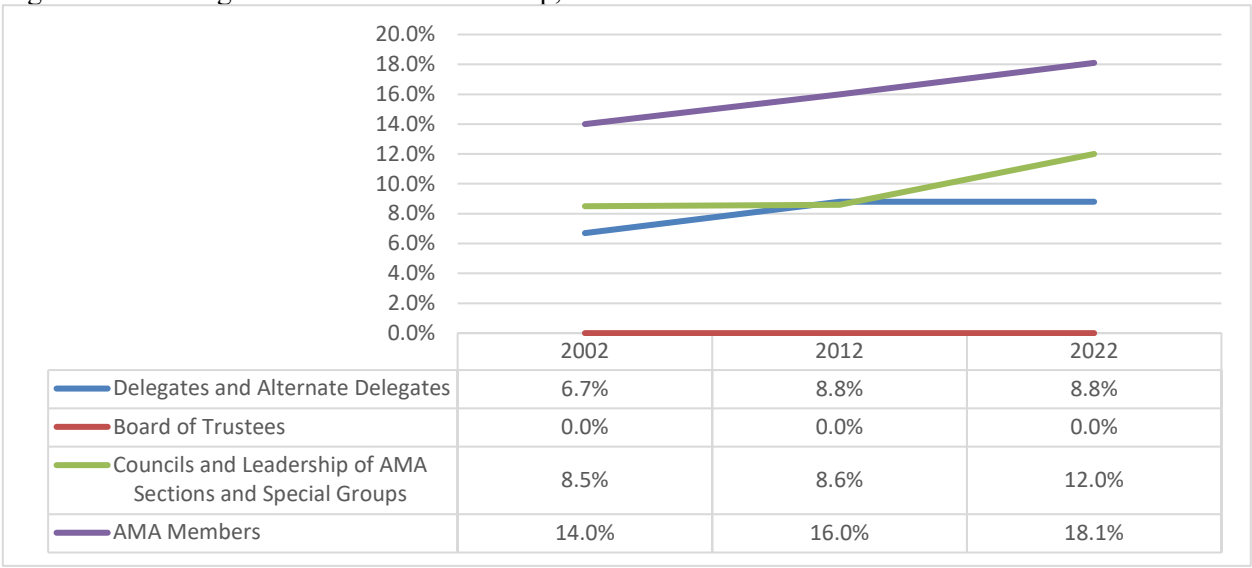


Figure 5. Percentage of Female AMA Leadership, 2002-2022



	2002	2012	2022
Delegates and Alternate Delegates	17.8%	20.8%	37.8%
Board of Trustees	5.0%	40.0%	40.0%
Councils and Leadership of AMA Sections and Special Groups	27.9%	33.7%	49.1%
AMA Members	23.9%	31.3%	39.5%

Figure 6. Percentage of IMG AMA Leadership, 2002-2022



	2002	2012	2022
Delegates and Alternate Delegates	6.7%	8.8%	8.8%
Board of Trustees	0.0%	0.0%	0.0%
Councils and Leadership of AMA Sections and Special Groups	8.5%	8.6%	12.0%
AMA Members	14.0%	16.0%	18.1%

APPENDIX B

Specialty classification using physicians' self-designated specialties

Major Specialty Classification	AMA Physician Masterfile Classification
Family Practice	General Practice, Family Practice
Internal Medicine	Internal Medicine, Allergy, Allergy and Immunology, Cardiovascular Diseases, Diabetes, Diagnostic Laboratory Immunology, Endocrinology, Gastroenterology, Geriatrics, Hematology, Immunology, Infectious Diseases, Nephrology, Nutrition, Medical Oncology, Pulmonary Disease, Rheumatology
Surgery	General Surgery, Otolaryngology, Ophthalmology, Neurological Surgery, Orthopedic Surgery, Plastic Surgery, Colon and Rectal Surgery, Thoracic Surgery, Urological Surgery
Pediatrics	Pediatrics, Pediatric Allergy, Pediatric Cardiology
Obstetrics/Gynecology	Obstetrics and Gynecology
Radiology	Diagnostic Radiology, Radiology, Radiation Oncology
Psychiatry	Psychiatry, Child Psychiatry
Anesthesiology	Anesthesiology
Pathology	Forensic Pathology, Pathology
Other Specialty	Aerospace Medicine, Dermatology, Emergency Medicine, General Preventive Medicine, Neurology, Nuclear Medicine, Occupational Medicine, Physical Medicine and Rehabilitation, Public Health, Other Specialty, Unspecified

American Medical Association Councils, Sections and Special Groups

COUNCILS

- American Medical Political Action Committee
- Council on Constitution and Bylaws
- Council on Ethical and Judicial Affairs
- Council on Legislation
- Council on Long Range Planning and Development
- Council on Medical Education
- Council on Medical Service
- Council on Science and Public Health

SECTIONS

- Academic Physicians Section
- Integrated Physician Practice Section
- International Medical Graduates Section
- Medical Student Section
- Minority Affairs Section
- Organized Medical Staff Section
- Private Practice Physicians Section
- Resident and Fellow Section

- Senior Physicians Section
- Young Physicians Section
- Women Physicians Section

SPECIAL GROUPS

- Advisory Committee on LGBTQ Issues

APPENDIX B

Specialty classification using physicians' self-designated specialties

Major Specialty Classification	AMA Physician Masterfile Classification
Family Practice	General Practice, Family Practice
Internal Medicine	Internal Medicine, Allergy, Allergy and Immunology, Cardiovascular Diseases, Diabetes, Diagnostic Laboratory Immunology, Endocrinology, Gastroenterology, Geriatrics, Hematology, Immunology, Infectious Diseases, Nephrology, Nutrition, Medical Oncology, Pulmonary Disease, Rheumatology
Surgery	General Surgery, Otolaryngology, Ophthalmology, Neurological Surgery, Orthopedic Surgery, Plastic Surgery, Colon and Rectal Surgery, Thoracic Surgery, Urological Surgery
Pediatrics	Pediatrics, Pediatric Allergy, Pediatric Cardiology
Obstetrics/Gynecology	Obstetrics and Gynecology
Radiology	Diagnostic Radiology, Radiology, Radiation Oncology
Psychiatry	Psychiatry, Child Psychiatry
Anesthesiology	Anesthesiology
Pathology	Forensic Pathology, Pathology
Other Specialty	Aerospace Medicine, Dermatology, Emergency Medicine, General Preventive Medicine, Neurology, Nuclear Medicine, Occupational Medicine, Physical Medicine and Rehabilitation, Public Health, Other Specialty, Unspecified

REPORT 02 OF THE COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT
(A-23) A Primer on the Medical Supply Chain

EXECUTIVE SUMMARY

The medical supply chain is an extensive network of systems, components, and processes that collectively work to ensure medicines and other health care supplies are manufactured, distributed, and provided to patients. In the broadest sense, a supply chain includes all activities related to manufacturing, the extraction of raw materials, processing, warehousing, and transportation. Hence, for large multinational companies that manufacture complex products, supply chains are highly complex socioeconomic systems. To strengthen and stabilize the medical supply chain, it is important to understand the various aspects of the medical supply chain, to identify the challenges that resulted in supply chain disruptions during the pandemic, and to consider several strategies to mitigate medical supply chain disruptions for the future.

Over decades, the medical supply chain has assembled substantial global networks; however, the pandemic has exposed structural weaknesses and cracks within these networks. Many medical supply distributors and health systems had adopted a "just-in-time" approach to supplies, by which they stocked only what they immediately needed and trusted supply chains to deliver other items quickly. At the same time, much of America's manufacturing capacity shifted abroad, where products could be made inexpensively with low labor and energy costs. While American manufacturing's share of overall output remained constant, its labor share declined as firms automated production lines and relied upon emerging technologies. That production and distribution system worked as planned until difficulties in the global supply chain disrupted those practices and created problems in supply, safety, and security. Today's problems include a wide array of medical supply and equipment shortages that can be traced to component scarcities, factory closures, backlogged ports, and transportation glitches.

The disruptions caused by the "just-in-time" approach have led to calls for greater domestic manufacturing capability through onshoring or reshoring (bringing production back to the United States) or nearshoring (bringing production back to friendly countries not far from the U.S., such as Canada and Mexico). One of the key areas affected by the pandemic was the manufacturing facilities making active pharmaceutical ingredients (APIs) for the U.S. market—72% of the medical supplies and APIs for making drugs found in the United States have resulted from outsourcing to other countries. While locally sourced API production will likely become an increasingly important part of government policy and pharmaceutical company commercial strategy, diversifying supply chains is expensive, and the cost of reconfiguring them will fall on consumers or governments.

Factors that disrupt medical supply chains include infectious disease outbreaks, geopolitical conflict, economic conditions, and quality-related issues at production sites. These factors can impact daily health care, as well as the profitability of manufacturing companies. In 2021, virtually all U.S. hospitals and health care systems (99%) reported challenges in procuring needed supplies, including shortages of key items and significant price increases.

Most experts agree that stakeholders must come together to develop consistent, meaningful metrics that reflect a sophisticated approach to managing and preventing shortages that pose risks to health care systems and patients. There are several automated technologies available that health care systems can use to quickly access data and projections: cloud-based, radio-frequency identification

(RFID) technology allows for real-time tracking that prevents shortages while enabling health care professionals to view their inventory quickly and accurately; internet-connected medical devices and equipment enable different systems in health care organizations to speak to one another and ensure information is updated across departments, rather than being held up in siloes; and analytics platforms, powered by artificial intelligence (AI), can be embedded in an electronic health record (EHR) to allow users to access benchmarking data so they can analyze their overall performance.

In a recent McKinsey survey of U.S. health system and supply chain executives, three themes emerged as critical to a high-performing medical supply chain function:

- *Engage front-line physicians in supply decisions,*
- *Jointly set goals across facilities and functions, and*
- *Invest in accurate, actionable data and analytics.*

While the pandemic caused major disruptions in health care with severe consequences, it also spurred medical and technological innovations. Telemedicine has become common, medical professionals have urged adoption of new models of care, shifting from cost-efficiency to long-term planning, and public-private partnerships have been formed to deal with current and future crises. Patient care has historically been limited to a person's ability to arrive at a hospital or care facility and restricted by the supply chain's capacity to swiftly provide the correct product for that patient's individual need. Technology has recently enhanced treatment products to allow patients to receive care outside of a traditional care facility. The use of 3D printing and new forms of diagnostics allow for more personalized treatment to be provided while saving manufacturing costs.

Artificial Intelligence (AI) and predictive analytics—while being used nominally right now by physicians and health care organizations—can, should, and will be used to ensure the right items, from the right sources, at the right prices for the right outcomes are ordered at the right times and in the right quantities to prevent shortages and price gouging. This will help to ensure financial stability of medical practices and health care organizations while mitigating patient risk. Although technology is a crucial enabler of resilience through supply chain digitalization, using it as the tip of the spear to address weaknesses may only partially fix the issues. Comprehensive solutions that position technology as a component alongside people and processes can help make the medical supply chain more resilient. Several large health care organizations have developed partnerships with shared goals and vision between physicians and hospital administrations. What is necessary to further these efforts is an investment in evidence tools and the creation of a physician role in the supply chain, which is becoming more common.

The future of the medical supply chain entails transparent communication of supply chain issues and patient needs between suppliers and health care professionals who can work together to create methods that enhance situational awareness. The medical supply chain can gain physician trust by communicating regularly and providing insight into the inner workings of logistics. Physicians can articulate needs, and medical supply chain professionals can provide information about the prices of products and transportation, outcomes, and alternative options for their products. Addressing these issues can improve the relationship between the supply chain, physicians, and health care organizations. Effective supply chain performance directly links to patient outcomes and clinical safety, influencing much more than personal protective equipment (PPE).

REPORT OF THE COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT

CLRPD Report 02-A-23

Subject: A Primer on the Medical Supply Chain

Presented by: Edmond Cabbabe, MD, Chair

The critical medical shortages that resulted from COVID-19 hampered the pandemic response and cascaded into defaults of other aspects of U.S. health care delivery. This informational report was developed to provide members of the House of Delegates (HOD) with some history of medical supply chain shortages, the structure of the medical supply chain, globalization of the U.S. medical supply chain, causes and consequences of failures, U.S. governmental actions to mitigate issues, and onshoring and nearshoring strategies for the U.S. medical supply chain. It also identifies opportunities for physicians and health systems to improve medical supply chain resilience and performance.

BRIEF HISTORY OF U.S. MEDICAL SUPPLY CHAIN SHORTAGES

Shortages of medical supplies in the United States due to supply chain issues are not new.

- During War II, the supply of quinine that was primarily sourced in the Japanese-occupied East Indies, was cut off. The United States suddenly found itself facing malaria across the globe without sufficient treatment, which resulted in major hospitalizations from malarial infections throughout different battles and theaters.[1]
- In September 2017, Hurricane Maria devastated the territory of Puerto Rico—producer of 50% of America's supply of intravenous saline—catapulting hospitals nationwide into a shortage.[2]
- In late 2019, SARS-CoV-2 emerged from China and rapidly evolved into a pandemic, resulting in disrupted production and export of medications and personal protective equipment (PPE) around the world.

The critical medical shortages that resulted from COVID-19 hampered the pandemic response and cascaded into defaults of other aspects of U.S. health care delivery. What differentiates COVID-19 from prior supply chain disruptions is the level of uncertainty and the length of the disruption, as well as its simultaneous global impact. Additionally, unlike most other disruptions, COVID-19 has affected not only the supply of, but also the demand for products and services.

MEDICAL SUPPLY CHAIN STRUCTURE

The medical supply chain is an extensive network of systems, components, and processes that collectively work to ensure medicines and other health care supplies are manufactured, distributed, and provided to patients. In the broadest sense, a supply chain includes all activities related to manufacturing, the extraction of raw materials, processing, warehousing, and transportation. Hence, for large multinational companies that manufacture complex products supply chains are

highly complex socioeconomic systems. There are many players in the medical supply chain; however, manufacturers and distributors are particularly prominent.

- Manufacturers are the first link in the supply chain and make the medicines and health care supplies patients and physicians rely on. Manufacturers acquire raw materials for production of approved products; conduct research, develop, and process medicines and products; identify what product(s) is needed and if enough supply will be available based on demand; conduct safety trial testing; and package approved products for distribution.
- Distributors are the second link in the medical supply chain. Distributors repackage, relabel, and ensure special handling for unique products; obtain medicines and products from manufacturing facilities and distribute to providers, health care facilities or other general areas of need; and manage temperature and climate conditions for safe transportation of medicines and products. Distributors purchase drugs and medical products in bulk from manufacturers and maintain large stocks in strategic locations across the country. Some wholesalers specialize in dealing with a particular range of products, such as biologics or to specific types of customers.
- Providers (hospitals, pharmacies, dialysis centers, urgent care, assisted living, and long-term care facilities) submit orders to distributors; refill prescriptions for patients; and identify shortages in inventory and potential distribution challenges.
- Patients and communities with unique medical needs that require specific products influence the demand for medicines and products.

To strengthen and stabilize the medical supply chain, it is important to understand the various aspects of the medical supply chain, to identify the challenges that resulted in supply chain disruptions during the pandemic, and to consider several strategies to mitigate medical supply chain disruptions for the future.

GLOBALIZATION OF U.S. MEDICAL SUPPLY CHAIN

Over decades, the medical supply chain has assembled substantial global networks; however, the COVID-19 pandemic has exposed structural weaknesses and cracks within these networks. Many medical supply distributors and health systems had adopted a “just-in-time” approach to supplies, by which they stocked only what they immediately needed and trusted supply chains to deliver other items quickly. That approach saved money because firms and hospitals did not need to build extended storage facilities or keep full inventories. Rather, they kept their stocks low and refreshed on an “as needed” basis.[3] At the same time, much of America’s manufacturing capacity shifted abroad, where products could be made inexpensively with low labor and energy costs.[4] Further, while American manufacturing’s share of overall output remained constant, its labor share declined as firms automated production lines and relied upon emerging technologies.[5] That production and distribution system worked as planned until issues in the global supply chain disrupted those practices, creating problems in terms of supply, safety, and security.

The National Academies of Sciences, Engineering, and Medicine (NASEM) reported that only 28% of the manufacturing facilities making active pharmaceutical ingredients (APIs) for the U.S. market were in the United States as of August 2019. This means that 72% of the medical supplies and APIs for making drugs found in the United States had resulted from outsourcing to other countries. A previous shortfall occurred with the anticoagulant heparin, made using pig intestines: China makes 80% of the world’s heparin and 60% of the U.S. supply. In 2007, an infectious disease outbreak in Asia decimated pig herds, pushing heparin into short supply and doubling prices. Seeking a rapid, practical solution, the U.S. Food and Drug Administration (FDA)

suggested using U.S. bovine heparin and asked manufacturers to submit applications that demonstrated safety, efficacy, quality, and purity. Although the FDA cannot eliminate all possible risk, it can enforce requirements, controls, and best practices to detect problems early while ensuring the availability of safe and effective medications.[6]

As COVID-19 became a pandemic, different countries took steps to protect their local supplies by limiting or stopping exports entirely. For example, China, which produces roughly 50% of the global supply of masks at 10 million masks daily, ramped up production to 115 million daily during the early phases of COVID-19, yet simultaneously terminated all mask exports, leading to a gradual depletion of global stockpiles. Additionally, Germany banned the export of most of its PPE supplies. In other areas where local production was not significant, essential equipment procurement became vulnerable.

Virus mitigation measures continue to affect production and limit efforts to return the supply chain to pre-pandemic levels. Several industry players have reduced worker levels due to fears of the further spread of COVID-19 within the workplaces. In China, port terminals temporarily closed because of the country's COVID-19 zero-tolerance policy, creating lengthy shipping backlogs at some of the world's largest ports. While consumer demand can increase in months, more time is required to increase port capacity, build warehouses, and hire employees so that shipping can meet the needs of the demand.

Problems include a wide array of medical supply and equipment shortages that can be traced to component scarcities, factory closures, backlogged ports, transportation glitches, and COVID-19 lockdowns across the global supply chain. According to the FDA, the list of persistently scarce items is long and includes latex and vinyl examination gloves, surgical gowns, laboratory reagents, specimen-collection testing supplies, saline-flush syringes, and dialysis-related products.[7]

CAUSES AND CONSEQUENCES OF MEDICAL SUPPLY CHAIN FAILURES

Factors that disrupt medical supply chains include infectious disease outbreaks, geopolitical conflict, economic conditions, and quality-related issues at production sites. These factors can impact daily health care, as well as the profitability of manufacturing companies. Once there is an infectious outbreak, it may be difficult to access treatment and other health services, especially if the outbreak comes with harsh control measures such as quarantines and lockdowns. Such measures may generate an acute surge in the demand for critical medical supplies and equipment, which exceeds supply, leading to shortages and protocols for prioritized use. A disruptive event can cause a mismatch between supply and demand in medical product supply chains in three ways:

1. Demand surge: An event drives demand for a medical product well above the normal level for an extended period. For example, a major natural disaster, such as a tornado or earthquake, can spike regional demand for certain medical products if these events result in a significant number of casualties requiring medical care. As seen during COVID-19, a pandemic can drive up global demand for many medical products.
2. Capacity reduction: One or more production or transport processes are impeded by lack of assets, power, or people. For example, a natural disaster could cause a factory to lose power and halt production, or regulatory barriers or manufacturing quality problems could restrict the output of a supplier or producer and could even eliminate inventory stock if a product is recalled. As seen during the COVID-19 pandemic, production of some products decreased because of lockdown measures, as well as acute loss of workers to quarantine and illness.

3. Coordination failure: Events that prevent coordination of supply to meet demand can cause shortages of medical products even when total supply is sufficient to meet total demand. For example, geopolitical issues or communication system failures during a hurricane or other natural disaster can reduce or obstruct the delivery of emergency supplies into a city or region.[8]

The COVID-19 pandemic led to such shortages in medical supplies as a combination of all three ways, leading to gaps in medical supplies for routine health care (e.g., dialysis-related products) and pandemic response (e.g., PPE, lab testing supplies and equipment, and ventilation-related products) in most health care facilities around the world.

The medical supply chain may be influenced by U.S. insurance companies, hospitals, physicians, employers, and regulatory agencies, with differing objectives among them. Demand for services is determined by both available treatments and insurance coverage for those treatments. Decisions made by one party often affect the options available to other parties, as well as the costs of these options, in ways that are not well understood. Most of these complicated factors are also present, to varying degrees, in industrial supply chains.

In 2021, virtually all U.S. hospitals and health care systems (99%) reported challenges in procuring needed supplies, including shortages of key items and significant price increases. A Kaufman Hall report noted that 80% of hospitals had significant supply shortages and had to seek new vendors for supplies during the pandemic. Shortages in raw materials and components hampered the production of both drugs and sophisticated medical devices. Manufacturing facilities struggled to keep up as COVID-19 swept through the workplace. Labor shortages prevented medical products from being transported to the places where they were needed most.[9]

Helium, a nonrenewable element found deep within the earth's crust, is essential for keeping magnetic resonance imaging (MRI) machines cool enough to work. With a boiling point of minus 452 degrees Fahrenheit, liquid helium is the coldest element on Earth. Pumped inside an MRI magnet, helium lets the current travel resistance-free. However, the supply of helium is running low leaving hospitals wondering how to plan with a much scarcer supply. Currently, four of five major U.S. helium suppliers are rationing the element.[10] Shortages in aluminum, semiconductors, wood and paper pulp, and resin are disrupting supplies of medical devices, with different business sectors competing for the same raw materials. Those shortages have led to uneven supplies of medical monitors, CT scan devices, packaging for medical supplies, and gloves. While only a fraction of the world's semiconductors is in medical equipment compared with cars and consumer electronics, the components are key to a range of medical devices such as MRI machines, pacemakers, glucose monitors, CT scanners, defibrillators, multiparameter monitors, and ultrasound machines. As a result, hospitals are experiencing long order delays for equipment because of the semiconductor shortage.[11]

Drugs used in the United States involve raw materials from all over the world. Many chemical inputs are manufactured in India and China and then shipped to the United States. Regardless of the root cause, drug shortages can lead to substitutions for available medications that are costlier and/or less effective. In some instances, hospital pharmacies must compound and modify products, which adds workload and potential error.[12] The American Medical Association (AMA) Council on Science and Public Health (CSAPH) has issued eleven reports on drug shortages. AMA Policy H-100.956, "National Drug Shortages," directs the CSAPH to continue to evaluate the drug shortage issue and report back at least annually to the House of Delegates on progress made in addressing drug shortages in the United States. CSAPH Report 01-I-22 provides an update on continuing

trends in national drug shortages and ongoing efforts to further evaluate and address this critical public health issue.[13]

The United States recently experienced a surge in respiratory illnesses, a potential "tripledemic" of three viruses: respiratory syncytial virus the influenza virus, and the COVID-19 coronavirus. While antibiotics like amoxicillin typically are not effective against such respiratory viruses, they can be important treatments for secondary bacterial infections that may occur when respiratory tract defenses and the immune system in general are battling a viral infection. Despite the best efforts to address root causes of drug shortages, the United States has a dysfunctional, opaque medical supply chain. There is still no easy way to scale up production to meet excess demand. Moreover, there remains a limited profit motive to do better, particularly for low-cost medications such as amoxicillin.

U.S. GOVERNMENT ACTIONS TO MITIGATE MEDICAL SUPPLY CHAIN ISSUES

During the COVID-19 public health emergency, the FDA took many actions to ensure that health care professionals had timely and continued access to high-quality medical devices. These actions included *Emergency Use Authorizations)* and guidance permits to expand available resources for diagnostic, therapeutic, and medical devices in high demand. Further, President Trump invoked the *Defense Production Act* and released government funds to help American companies build facilities and expand production capabilities for medical equipment.[14]

In October 2020, in response to Executive Order 1394410, the FDA published a *List of Essential Medicines, Medical Countermeasures, and Critical Inputs* (described herein as EM). This executive order sought to ensure sufficient, reliable, and long-term domestic production of these products and minimize potential shortages. The published EM list contained 227 drug and biological product essential medicines and countermeasures, including analgesics, antivirals, anticoagulants, antihypertensives, and antimicrobials.[15] The *Center for Drug Evaluation and Research (CDER) Site Catalog* includes approximately 1,100 locations that manufacture at least one product on the EM list. There are 1,686 sites that manufacture an active pharmaceutical ingredient (API), of which 354 manufacture API for EM products. Currently, 23% of API manufacturing sites are in the United States; for EM, this drops to 19%. These data illustrate that only a minority of drug manufacturing sites are domestic. Overall, API and finish dose form manufacturing are heavily dependent on foreign manufacturing sites.

Since early 2020, the United States has made progress in strengthening the health care supply chain by addressing concerns regarding domestic manufacturing and supply chain surge capabilities. In 2021, President Biden issued Executive Order (EO) 14017, *On America's Supply Chains*. The 100-Day Review under this order directed the U.S. Department of Health and Human Services (HHS) to identify products for which onshoring (bringing production back to the U.S.) may be advisable. HHS subsequently issued a 2022 report that identifies successes and practical strategies to further U.S. goals for America's supply chain and industrial base. Particular efforts should be directed at expanding the public health industrial base by working across government agencies, academia, and the private sector, and strengthening capabilities to monitor and manage supply chain bottlenecks.[16] Note that Section 510(j)(3) of *the Food, Drug and Cosmetic (FD&C) Act*, which was added by the recent *CARES Act,* requires FDA registered sites to report annually the amounts of drugs manufactured for U.S. commercial distribution. Combined with FDA information about the location of manufacturing sites, these data should enable the FDA to perform better manufacturing site surveillance.[17]

In 2020, the FDA reported 43 new drug shortages after a peak of 251 shortages in 2011.[18] On the surface, this looks like tremendous progress; however, this measurement does not consider the scope, scale, or severity of the shortage. The FDA metric measures every shortage the same way, whether a drug is dispensed 20 times or 20,000 times a month. Moreover, not every shortage is the same. In response to the public health crisis, some U.S. hospital groups, startups, and nonprofits began making their own sterile injectables and other medicines as a short-term workaround to combat persistent drug shortages.[19] Experts anticipate that efforts by hospitals to have more direct control over their critical drug supply chains will continue to evolve as they work to find a sustainable, cost-effective, and safe model. Joint public-private sector efforts, such as the creation of a *Strategic Active Pharmaceutical Ingredient Reserve (SAPIR),* will be instrumental in defining how these products are supplied in the future.[20]

The 2013 *Drug Supply Chain Security Act (DSCSA)* outlines steps to build an electronic, interoperable system to track and trace prescription drugs.[21] The original aim of the DSCSA was to enhance the ability of the FDA to regulate drug safety and help protect patients. However, this system could improve the management of drug product shortages as well.[22] Serialization (assignment of a unique serial number to each suppliable prescription product) in the drug supply chain could vastly improve an organization's ability to manage inventory. A pilot DSCSA program with the FDA showed the potential for using IBM blockchain technology to connect disparate data for tracking and tracing prescription medications and vaccines in the United States.[23]

In 2022, the NASEM published the congressionally mandated report, *Building Resilience into the Nation's Medical Product Supply Chains*. The report called for the FDA to track sourcing, quality, volume, and capacity information, and to establish a public database for health systems, inclusive of failure-to-supply penalties in contracts. In addition, the report recommended that the federal government optimize inventory stockpiling to respond to medical product shortages.[24]

While the federal government can generate greater economies of scale for the procurement of health care supplies during a pandemic, local governments can identify lower socioeconomic groups and minorities that are particularly vulnerable to both the health and economic aspects of a pandemic. As a result, they can employ resources more efficiently for a rise or fall in cases and hospitalizations.

ONSHORING AND NEARSHORING STRATEGIES

Concerns unleashed by the pandemic and dependence on foreign manufacturers combined to increase risks and raise doubts regarding "just-in-time" practices.[25] The disruptions caused by this approach have led to calls for greater domestic manufacturing capability through onshoring or reshoring (bringing production back to the United States) or nearshoring (bringing production back to friendly countries not far from the United States, such as Canada and Mexico). A European Parliament report found modest benefits to reshoring in the United Kingdom, United States and Japan and argued that reshoring should be primarily focused on specific critical sectors and products with pronounced supply bottlenecks, rather than across-the-board. Targeted reshoring was advised because host countries often do not have the production facilities and/or workforce required for wholesale reshoring.[26] Both onshoring and nearshoring should consider the ownership of the manufacturing: a foreign company can own domestic manufacturing facilities and still monopolize production.

One of the key areas affected by the pandemic was the API market. Research by McKinsey shows that supply chains in the pharmaceutical industry are more global than in other sectors, and there is a tendency to source certain materials from a particular region. For instance, 86% of the

streptomycin in North America and 96% of the chloramphenicol in the European Union come from China. Diversifying supply chain materials is an option that pharmaceutical companies could pursue to reduce their exposure through onshoring. McKinsey estimates that 38% to 60% of the international pharmaceutical trade, worth $236 billion to $377 billion in 2018, could be considered for onshoring. Locally sourced API production will likely become an increasingly important part of government policy and pharmaceutical company commercial strategy. However, diversifying supply chains is expensive, and the cost of reconfiguring them will fall on consumers or governments. Further, the risk from regional domestic disasters in the vicinity of manufacturing and distribution facilities must be assessed. [27]

The United States once led the world in semiconductor manufacturing yet has fallen behind. Other countries, especially in Asia, made deliberate investments to build powerful chipmakers in their own countries. Foreign state subsidies created a ~30% cost advantage for foreign chipmaking plants, and the resulting advantage is startling: in 1990, the United States supplied 37% of the world's chips, but now only 11%. This outcome has undermined U.S. technology leadership with significant economic and national security implications: a recent White House study concluded that "our reliance on imported chips introduces new vulnerabilities into the critical semiconductor supply chain."[28]

In 2019, the U.S. medical end-use market accounted for $5.6 billion in total semiconductor sales—roughly 11% of the global industrial semiconductor market and 1.3% of the total semiconductor market. However, 47% of the chips sold worldwide are designed in the United States. Meanwhile, the medical semiconductor segment is growing faster than the overall industrial semiconductor market, which is driven by long-term trends of an aging population, the rise of telehealth, the move to portable and wearable devices, and the applications of artificial intelligence.[29] Despite being a small percentage of the overall semiconductor chip market, there is an urgent need for chips in medical device manufacturing.[30]

Recognition of chip vulnerabilities led Congress to pass and President Biden to sign the *CHIPS and Science Act* in August 2022. This law provides $52.7 billion in aid to the semiconductor industry along with other incentives to build new semiconductor production facilities in the United States.[31]

OPPORTUNITIES TO IMPROVE MEDICAL SUPPLY CHAIN PERFORMANCE

Since disruptions in medical supply chains have the potential to seriously impact patient care and safety, health care systems need the capacity to proactively foresee, absorb, and adapt to shocks and structural changes in a way that allows them to sustain required operations, resume optimal performance as quickly as possible, transform their structure and functions, and reduce their vulnerability to similar shocks and structural changes in the future.[32] Most experts agree that stakeholders must come together to develop consistent, meaningful metrics that reflect a sophisticated approach to managing and preventing shortages that pose risks to health care systems and patients.

There are several automated technologies available that health care systems can use to quickly access data and projections:

- Cloud-based, radio-frequency identification (RFID) technology allows for real-time tracking that prevents shortages while enabling health care professionals to view their inventory quickly and accurately.

- By tapping into the Internet of Things, internet-connected medical devices and equipment enable different systems in health care organizations to speak to one another and ensure information is updated across departments rather than being held up in siloes.
- A third option are analytics platforms, powered by artificial intelligence (AI), e.g., an electronic health record (EHR) embedded in an AI platform. On these platforms, cataloging allows users to distribute and curate all analytics in a single web-based action. Users may also have access to benchmarking data so they can analyze their overall performance.[33]

In a recent McKinsey survey of U.S. health system and supply chain executives, nearly three-quarters of survey respondents agreed that "the supply chain stands to assume an even more strategic role." Three themes emerged as critical to a high-performing supply chain function:

- *Engage front-line physicians in supply decisions.* In high-performing organizations, physicians play an integral role in supply chain initiatives: they provide input on supplier selection and contracting strategies, including their financial impact; they support compliance with contract terms (for example, by committing to give a supplier a negotiated share of business); they manage the use of supplies; and they contribute to achieving financial, quality, or other goals.
- *Jointly set goals across facilities and functions.* Supply chain initiatives may require meaningful changes in behavior by some clinicians, including shifting away from their suppliers of choice to clinically similar suppliers used by their peers. To assist this change, systems may consider providing incentives, which can be financial or nonfinancial and may include a commitment to reinvest a percentage of savings in priorities of physicians.
- *Invest in accurate, actionable data and analytics.* Analytical tools are only useful if they provide relevant insights to their users, which may require individual customization and, for convenience, accessibility on multiple devices. For example, a supplies cost-per-case tool, which shows the cost of all supplies for a given operating-room procedure, should provide the relevant views for physicians so that they can see the supplies they use, cost compared to supplies used by peers, alternative supply options, and quality outcomes.[34]

At the 2019 Association for Health Care Resource & Materials Managementconference of the American Hospital Association, speakers emphasized eight points to strengthen relationships between physicians and PURE (Physicians Understanding, Respecting, and Engaging Supply Chain) professionals:

- *Share meaningful data with physicians*. Physicians are empiricists, motivated by data. As a result, health systems should provide meaningful data at a consistent cadence to physicians, perhaps quarterly.
- *Welcome partnerships in achieving the strategic goals of the organization*. Hospital systems that work with independent physicians should bring them into supply chain decision-making to include clinical perspectives.
- *Use evidence-based principles to guide decision making.*
- *Place some restriction on the number of vendors used.* However, be mindful not to limit physician preference items completely or force surgeons to use specific or substandard products.
- *Provide context for supply chain decision making.* Organizations should be very transparent regarding what relationships drive their supply chain decision-making, to include the use of group purchasing organizations (GPOs). Physicians understand

economies of scale, price sensitivity and market trends, and want to play a role in finding solutions.

- *Include practicing physicians as part of the decision-making team*. Many hospital administrators do not have clinical backgrounds or currency, so it is important to have physicians with clinical experience on supply chain leadership teams. Physicians can share clinical insights to inform supply chain discussions, translate clinical and supply chain languages, and provide credibility for communication with physicians.
- *Update clinical pathways to include product categories that support evidence-based medicine and minimize clinical variation.* Data should be used to create algorithms and care pathways for high-volume procedures.
- *Emphasize that supply chain sustainment needs logisticians and physicians.* Collaboration is essential to anticipate and fulfill supply needs with timeliness and realism.[35]

FUTURE OF THE MEDICAL SUPPLY CHAIN: IMPROVED TECHNOLOGY AND PROCESSES, AND SITUATIONAL AWARENESS

While the pandemic caused major disruptions in health care with severe consequences, it also spurred medical and technological innovations. Telemedicine has become common, medical professionals have urged adoption of new models of care, shifting from cost-efficiency to long-term planning, and public-private partnerships have been formed to deal with current and future crises. One of the highest priorities for the medical supply chain is expansion, which includes more than the expansion of infrastructure and transportation in areas that have less accessibility. Patient care has historically been limited to a person's ability to arrive at a hospital or care facility and restricted by the supply chain's capacity to provide swiftly the correct product for that patient's individual need. Technology has recently enhanced treatment products to allow patients to receive care outside of a traditional care facility. A patient's treatment can now follow them outside of a hospital or medical practice with the use of telehealth communication, at-home testing kits, and at-home treatment that can be sent right to the patient's door. This requires the medical supply chain to extend past hospitals and include last-mile transportation to patients so that they do not have to return to the hospital. At-home patient care also requires more treatments to become personalized. The use of 3D printing and new forms of diagnostics allow for more personalized treatment to be provided while saving manufacturing costs.

As physicians and health care organizations adapt to newer data processing capabilities, they can more readily keep their information correct and consistent. Predictability is a must as we continue to move towards standardizing patient experience and more at-home care. The medical supply chain will need to implement strategies that help it become more predictable to physicians and health care organizations who need high visibility on their needed products. Currently, medical supply chain management lacks a unified, well-adopted data standard. The Global Trade Item Number (GTIN) standard is available, but adoption rates remain low compared to the universal product code (UPC) fully adopted in other industries. Clinical and regulatory requirements necessitate tracking of device information through the supply chain and in clinical EHR systems. Supply chain intermediaries bear responsibility for efficient supply chain integration.

Data will be utilized to anticipate product demand. Clean data will also help supply chains stay agile and not allow disruptions to hold up the services they are working to provide. Discontinued or back-ordered products can greatly disrupt a supply chain, though when such things can be more easily resolved with data analysis, the supply chain can become much more predictable. Data usage is one strategy that will help supply chain predictability, and several strategies can help a supply chain stay consistent and save costs. Some strategies for resilience include expanding domestic

supply chain production, making product allocation needs-based, and increasing trust. The medical supply chain will have data that, if it is fully captured and analyzed, will be essential for decision making. Organized collection of data can greatly impact every stage of the supply chain, as each segment can make predictions based on past data and optimize processes.

Data can greatly enhance a company's capacity to be proactive, and predictive analytics can amplify that capability. Predictive analytics will help the supply chain with decision-making and offer a clear way to see the ebb and flow of supply and demand. Companies can use predictive analytics in new ways that help bring visibility to inventory and ensure the right products are being ordered and priced correctly and that there are enough items to meet demand. Predictive analytics can also help companies be more proactive in situations that significantly impact the medical supply chain. The COVID-19 pandemic created new aspects of health care to predict, like the number of COVID-19 cases, and the number of patients needing treatment. Predictive analytics can help companies prepare for these unforeseen circumstances and prepare the supply chain for future unknowns.

The use of artificial and augmented intelligence (AI) is growing throughout the health care industry: AI is being used to clean data and promote efficient human effort. There are even more ways that AI can be used to enhance health care and save costs. AI and predictive analytics—while being used nominally right now by physicians and health care organizations—can, should and will be used to ensure the right items, from the right sources, at the right prices for the right outcomes are ordered at the right times and in the right quantities to prevent shortages and price gouging. This will help to ensure financial stability of medical practices and health care organizations, while mitigating patient risk. AI can help supply chains keep up demand, by recommending stand-in products if the preferred product is not available. AI algorithms can be used to fill the gap between supply and demand while saving costs and eliminating human error.

Many health care organizations are addressing supply chain challenges with holistic solutions that pair technology with other changes. For the supply chain to function efficiently, physicians need to be involved in decision-making. Increasing supply chain resilience requires fostering an organization-wide commitment from leaders to staff members and by investing time and resources necessary to identify and address the root causes of supply chain challenges. Although technology is a crucial enabler of resilience through supply chain digitalization, using it as the tip of the spear to address weaknesses may only partially fix the issues. Comprehensive solutions that position technology as a component alongside people and processes can help make the medical supply chain more resilient. Several large health care organizations across the country have developed partnerships with shared goals and vision between physicians and hospital administrations. What is necessary to further these efforts is an investment in evidence tools and the creation of a physician role in the supply chain, which is becoming more common.

Some disruptions in a patient's care can be attributed to limited situational awareness between physicians and the supply chain. When physicians do not have knowledge of the products in the supply chain, they cannot provide the best treatment possible. When the supply chain lacks clear communication with physicians, medical practices, and health care facilities, it is difficult to know the demand for products and when they should arrive. The future of the medical supply chain entails transparent communication of supply chain issues and patient needs between suppliers and health care professionals. Supply chain professionals and physicians can work together to create methods that enhance situational awareness. Physicians can articulate needs, and medical supply chain professionals can provide information about the prices of products and transportation, outcomes, and alternative options for their products. Addressing these issues can improve the relationship between the supply chain and physicians and health care organizations. The medical

supply chain can gain physician trust by communicating regularly and providing insight into the inner workings of logistics.

Adaptability and efficiency are crucial in today's health care supply chain environment. If a company's methods are too rigid, it will not be able to adapt quickly to unexpected changes. Furthering relationships between clinicians and suppliers will help a supply chain boost its robustness. Having trusting relationships between distributors and manufacturers, as well as effective contracting models, will create a strong network within the health care supply chain that can adapt smoothly while providing the most efficient services possible. Effective supply chain performance directly links to patient outcomes and clinical safety, influencing much more than PPE. Prior to the COVID epidemic, many physician leaders recognized the value of supply chain excellence; that value is now apparent to all physicians.

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REPORT 06 OF THE COUNCIL ON MEDICAL SERVICE (A-23)
Health Care Marketplace Plan Selection
Informational Report

EXECUTIVE SUMMARY

At the 2022 Interim Meeting, the House of Delegates adopted Policy D-165.933, "Health Care Marketplace Plan Selection." This policy directs the American Medical Association (AMA) to re-evaluate and study the effectiveness of the current plan options in the health care marketplace to adequately provide choice and competition, especially in communities in close proximity to multiple states (insurance markets) and submit a report to the AMA House of Delegates at the 2023 Annual Meeting. This report, which is presented for information to the House of Delegates, provides updated information on insurer competition in health insurance exchanges, insurer concentration in exchange markets, and policies impacting the marketplace in 2023. Additionally, the report summarizes key AMA policies that strongly support competition and choice in the health insurance marketplace.

Insurer participation in the Affordable Care Act (ACA) marketplace has increased for five consecutive years, enrollment has surpassed 16 million people, and the exchanges are generally functioning well. Still, the Council recognizes that insurer participation in the marketplace remains lower today than in 2015, when it was at its highest, and the share of plans offered by large insurers has been steadily growing in recent years. Many insurer exchange markets remain highly concentrated, as evidenced by data compiled in the AMA's most recent edition of *Competition in Health Insurance: A Comprehensive Study of U.S. Markets*. The Council shares the sentiment of many physicians that insufficient competition in the ACA marketplace remains concerning in many areas. Importantly, health insurance markets are local; across states, there is significant variation in the number of insurers and plans offered in ACA exchanges and, within states, there may be differences in insurer participation in rural and urban regions.

The Council finds that the concerns raised in Policy D-165.933 are addressed by Policies H-165.825, H-165.839, H-165.838, H-165.846, H-180.946, H-165.856, and H-180.947. We identify no gaps in existing AMA policy and make no recommendations at this time. However, the Council believes network adequacy, which is key to maintaining healthy competition and choice in the marketplace, remains problematic and is worthy of additional study. The Council has begun looking at the need for stronger network adequacy standards for ACA, Medicare Advantage, and Medicaid plans and will present a report on this topic at the 2023 Interim Meeting.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 06-A-23

Subject: Health Care Marketplace Plan Selection

Presented by: Lynn Jeffers, MD, Chair

At the 2022 Interim Meeting, the House of Delegates adopted Policy D-165.933, "Health Care Marketplace Plan Selection." This policy directs the American Medical Association (AMA) to re-evaluate and study the effectiveness of the current plan options in the health care marketplace to adequately provide choice and competition, especially in communities in close proximity to multiple states (insurance markets) and submit a report to the AMA House of Delegates at the 2023 Annual Meeting. This report, which is presented for information to the House of Delegates, provides updated information on insurer competition in health insurance exchanges, insurer concentration in exchange markets, and policies impacting the marketplace in 2023. Additionally, the report summarizes AMA policy that strongly supports competition and choice in the health insurance marketplace.

BACKGROUND

The intent of individual health insurance exchanges required under the Affordable Care Act (ACA) is to broaden coverage through a patient-friendly market and ensure healthy competition among plans. Products sold in the ACA marketplace are required to be certified as qualified health plans (QHPs); and as a condition of QHP certification, insurers—or issuers—must meet certain standards and requirements designed to protect patients while encouraging health plan competition and choice. Robust competition among issuers participating in the insurance exchanges is essential to health plan affordability and choice, as evidenced by research showing that the participation of additional insurers on an exchange is associated with lower premiums and, conversely, regions with fewer insurers have higher premiums.[1] Across states, there is significant variation in the number of insurers and plans offered in ACA exchanges and, within states, there may be differences in insurer participation in rural and urban areas.

INSURER PARTICIPATION IN HEALTH INSURANCE EXCHANGES

Insurer participation in the marketplace has been an ongoing concern since the ACA exchanges began operating and have gone up and down in the ensuing years in response to marketplace regulations and insurers entering and exiting the market. After a period of decreasing insurer participation between 2016 and 2018 (participation was at its highest in 2015), 2023 marks the fifth consecutive year of increases in the number of insurers offering ACA marketplace plans. In fact, most people shopping for coverage on an exchange must navigate through scores of offerings before choosing a health plan that best meets their needs and budget, a process that can be both daunting and confusing. This year, consumers using the federal exchange through HealthCare.gov will have, on average, more than 113 QHPs to choose from, up from over 60 plan options in 2021 and just over 25 options in 2019.[2] An issue brief released by the Office of Health Policy for the Assistant Secretary for Planning and Evaluation (ASPE) showed that, in 2021, nearly three-quarters of HealthCare.gov users had more than 60 plan options to choose from, and over a quarter selected from more than 160 plans.[3] Within a specific metal tier (i.e., bronze, silver, gold, or

platinum), or even within a particular metal tier and a specific issuer, consumers in many areas can still have an abundance of plan options from which to choose.

In the 33 marketplaces using the HealthCare.gov platform, the Centers for Medicare & Medicaid Services (CMS) has announced that there is greater choice of insurers in 2023 with only one percent of enrollees having access to a single QHP issuer, the lowest in marketplace history.[4] The Center for Consumer Information and Insurance Oversight (CCIIO) has reported that, in HealthCare.gov states, 92 percent of enrollees have three or more insurers from which to choose this year compared to 89 percent of enrollees in 2022. There are 220 total insurers participating in HealthCare.gov states, an increase of seven from 2022, and the average enrollee has access to between six and seven issuers, and over 113 QHPs.[5] A CCIIO map (https://www.cms.gov/files/document/py2023-county-coverage-map.pdf) of Plan Year 2023 exchange insurers, which includes federally-facilitated exchange data as well as self-reported data (updated as of October 2022) from the 18 states operating their own exchanges, shows that only three percent of counties (93) have a single insurer while 25 percent (771) have two insurers and remaining counties have three or more insurers on the exchange. This contrasts with 2018 when over half (51.3 percent) of counties had a single carrier, a percentage that decreased to just over 35 percent of counties in 2019, 24 percent in 2020, nine percent in 2021, five percent in 2022, and three percent in 2023 (see appendix). County level data is important to measuring competition in the ACA marketplace because many insurers offer plans in some parts of a state but not others, and because health plans are priced and offered locally.

A brief from the Robert Wood Johnson Foundation explains that although insurer participation in the ACA marketplace increased significantly between 2019 and 2021, such increases were more moderate in 2022 and relatively small in 2023.[6] This year, large increases in insurer participation were seen in only a small number of states, including a few non-expansion states, as insurers continue to focus on areas where more uninsured people live. Although Georgia had a large increase in new plan offerings in 2022, the increase in that state was much smaller in 2023 when Texas had the most new offerings.[7] Importantly, the share of plans offered by large health insurers, including Blues plans, UnitedHealthcare, Cigna, CVS/Aetna, Centene, and Molina, increased in the marketplace while the share of smaller insurers, such as regional and provider-sponsored plans, decreased from 45 percent in 2022 to 40 percent in 2023.[8] Furthermore, the large national insurers have tended to take over where smaller companies, including Bright Health and Oscar Health, have exited markets. It is also notable that the Medicaid managed care companies Centene and Molina have been steadily increasing their footprints on the exchanges.

INSURER CONCENTRATION IN EXCHANGE MARKETS

The 2022 edition of the AMA's *Competition in Health Insurance: A Comprehensive Study of U.S. Markets* notes that there have been large changes over time in exchange market concentration and some volatility in exchange insurers' market shares and rankings. According to the study's analysis, there were large increases in average market concentration in the exchanges between 2015 and 2018, annual decreases thereafter, and a notably large decrease between 2020 and 2021 that was widespread across metropolitan statistical areas (MSAs). The AMA study found that, at the MSA level in 2021, at least one insurer had a market share of 30 percent in 98 percent of exchange markets; in 73 percent of markets, one insurer had a market share of 50 percent; and in 39 percent of markets, an insurer had a market share of 70 percent.[9] Turning to the national level, Anthem had the largest share of the exchange market in 2014 and 2015 but fell to sixth largest in 2021 while Centene, which had a smaller share of the exchange market in earlier years, had the largest market share (15 percent) in 2021.[10]

Concerns over the years regarding insufficient competition in the individual health care marketplace have led some thought leaders, as well as state and federal policy makers, to put forward a range of proposals to ensure marketplace coverage options, including the creation of a public option. Concerns with public option proposals have previously been addressed at length by the Council on Medical Service in Council Report 3-A-18 and Council Report 1-Nov.-20. Policy experts have also suggested leveraging Federal Employees Health Benefits Program (FEHBP) health plan participation as a solution to prevent bare counties in the marketplaces, which is consistent with Policy H-165.825. In addition to discussing a public option and establishing policy that supports requiring the largest two FEHBP insurers in counties that lack a marketplace plan to offer at least one silver-level marketplace plan as a condition of FEHBP participation, Policy H-165.825—established via Council on Medical Service Report 3-A-18—supports health plans offering coverage options for individuals and small groups competing on a level playing field, including providing coverage for pre-existing conditions and essential health benefits. This policy also opposes the sale of health insurance plans in the individual and small group markets that do not guarantee: (a) pre-existing condition protections and (b) coverage of essential health benefits and their associated protections against annual and lifetime limits, and out-of-pocket expenses, except in the limited circumstance of short-term limited-duration insurance offered for no more than three months.

A primary purpose of regulations governing the health insurance marketplace has been to help ensure that insurers are competing and operating on an even playing field in which all insurers and plans must play by the same rules. The AMA advocates that exchanges need to offer choices to patients to spur competition and that mechanisms to facilitate competition in health insurance should ensure that critical patient protections remain in place, including the ban on pre-existing condition exclusions as well as critical cost protections guaranteed in the ACA (e.g., annual cap on out-of-pocket expenses). The AMA strongly believes that an important federal role remains to ensure that proposals to foster competition in health insurance also promote ACA marketplace stability and a balanced risk pool and do not lead to adverse selection in the marketplace.[11]

NETWORK ADEQUACY

AMA policy and advocacy also underscores that a plan's provider network is an important factor in maintaining healthy competition and choice and, as such, the AMA consistently advocates for stronger network adequacy standards for QHPs, including those offered through federally facilitated exchanges. The AMA believes that state regulators should have flexibility to regulate their provider networks but also maintains that there is a critical need for a minimum federal network adequacy standard that includes quantifiable standards, especially in light of inaction in many states to update network adequacy requirements. The AMA has also advocated that CMS implement additional qualitative standards to measure network adequacy and better evaluate access to timely and appropriate care for enrollees in QHP plans.[12]

In response to CMS' proposed rulemaking on benefits and payment parameters under the ACA for 2024, the AMA strongly supported CMS' inclusion of wait time requirements into the measurement of network adequacy. The AMA believes this, and other quantitative standards are critical to determining if a network can serve the needs of its enrollees. Often network physicians may appear to be available but may not be accepting new patients at all or have a lengthy wait time for obtaining an appointment that makes it impossible to see them in a timely manner. Wait time requirements could help address these issues. The AMA also urged CMS to consider additional tools to measure compliance beyond insurer attestation, including audits, secret shopper programs, and patient surveys.[13]

SALE OF HEALTH INSURANCE ACROSS STATE LINES

The issue of permitting the sale of health insurance across state lines has been debated by the House of Delegates several times over the years, with proponents arguing that this would spur competition, choice, and affordability and others maintaining that any such allowances could motivate insurers to incorporate in states with less insurance regulation, putting important patient and provider protections at risk. Under AMA Policy H-180.946, established in 2017, the AMA would support the sale of health insurance across state lines, including multistate compacts, when patient and provider protection laws are consistent with and enforceable under the laws of the state in which the patient resides. These protections include not weakening any state's laws or regulations involving network adequacy and transparency; fair contracting and claims handling; prompt payment for physicians; regulation of unfair health insurance market products and activities; rating and underwriting rules; grievance and appeals procedures; and fraud. The sentiment of AMA policy is that patients purchasing an out-of-state policy should retain the right to bring a claim against an insurer in a state court in the state in which the patient resides.

Because a state's insurance regulator cannot enforce another state's laws or regulate beyond its borders, consumer protections and other regulations must be clearly defined when interstate health insurance sales are permitted. It is unclear whether insurers would even be interested in selling products in new markets across state lines where other carriers are already competing. When interstate health insurance sales were debated at the federal level in 2017, a handful of states had laws allowing such sales; however, out-of-state issuers were not drawn to these markets, primarily due to the costs and other challenges associated with developing provider networks in another state. Some stakeholders, including the American Academy of Actuaries and the National Association of Insurance Commissioners, have cautioned that interstate sales will neither increase competition nor decrease premium pricing but could have unintended consequences related to consumer protections and adverse selection.[14]

ADDITIONAL POLICIES IMPACTING THE MARKETPLACE IN 2023

Extension of Enhanced Premium Tax Credit Subsidies: The Inflation Reduction Act, signed into law in August 2022, extends through 2025 the enhanced premium tax credits that were made available to eligible consumers under the American Rescue Plan Act of 2021. This advanceable and refundable credit, which the AMA supports, reduces the premium contribution for families with incomes between 100 and 150 percent of the federal poverty level (FPL) to zero and provides subsidies to 90 percent of consumers selecting marketplace plans. Partly as a result, enrollment in marketplace plans has reached record highs, surpassing 16 million during the open enrollment period that ran until mid-January 2023 for most exchanges.[15] Additionally, the enhanced subsidies significantly increase affordability of marketplace plans and will improve the stability of the exchange market if healthier people enroll.[16]

Special Enrollment Opportunity (SEP) for Consumers Losing Medicaid/CHIP Coverage: The Consolidated Appropriations Act of 2023 decoupled the Medicaid continuous enrollment requirement from the public health emergency (PHE) end date and permitted state eligibility redeterminations of Medicaid/CHIP enrollees to begin as early as March 2023. Although it is not yet known how many individuals will be disenrolled as states undertake these mass redeterminations, major disruptions in coverage are anticipated and many people could become uninsured. Importantly, CMS established a SEP for consumers losing Medicaid/CHIP coverage due to the unwinding of the continuous enrollment requirement. This SEP, which allows individuals and families to enroll in marketplace plans, if eligible, outside of the annual open enrollment period, runs between March 31, 2023 and July 31, 2024 and presents a significant enrollment

opportunity for the exchanges.[17] The Council addressed the mass redeterminations and strategies for preventing coverage losses in Council Report 03-A-22.

Fixing the "Family Glitch:" The AMA long supported fixing the "family glitch" and was accomplished this year by regulations allowing family members of workers offered affordable self-only coverage to gain access to subsidized ACA marketplace coverage. Under the new rule, it was anticipated that nearly one million Americans would see their coverage become more affordable.[18]

Requiring Standardized Plan Options: To address "choice overload" and increase transparency, in 2023, CMS began requiring issuers offering QHPs on HealthCare.gov to offer standardized benefit plans for every product, metal level, and geographic area. In comment letters to CMS, the AMA has supported this change which will help highlight clear and meaningful differences between plans, simplify consumer choice, and improve the plan selection process.[19]

AMA POLICY

As previously noted, Council on Medical Service Report 3-A-18 established Policy H-165.825, which added to the AMA's strong body of policy on marketplace competition and health plan choice. Policy H-165.839 outlines principles for the operation of health insurance exchanges, including that: health insurance exchanges should maximize health plan choice for individuals and families purchasing coverage; health plans participating in the exchange should provide an array of choices, in terms of benefits covered, cost-sharing levels, and other features; and federal authority or oversight of health insurance exchanges must respect the role of state insurance commissioners with regard to ensuring protections for patients and physicians. Additionally, this policy supports using the open marketplace model for any health insurance exchange to increase competition and maximize patient choice of health plans.

Policy H-165.838 supports health reform initiatives that are consistent with long-standing AMA policies on pluralism, freedom of choice, freedom of practice, and universal access for patients. This policy also states 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. Support for fixing the ACA's "family glitch" is addressed by Policy H-165.828, which also supports efforts to ensure clear and meaningful differences between plans offered on health insurance exchanges.

Principles to guide in the evaluation of the adequacy of health insurance coverage options are outlined in Policy H-165.846, including that: any insurance pool or similar structure designed to enable access to age-appropriate health insurance coverage must include a wide variety of coverage options from which to choose; existing federal guidelines regarding types of health insurance coverage should be used as a reference when considering if a given plan would provide meaningful coverage; and mechanisms must be in place to educate patients and assist them in making informed choices. This policy also opposes waivers of essential health benefits (EHB) requirements that lead to the elimination of EHB categories and their associated protections. Policy H-165.865 states that in order to qualify for a tax credit for the purchase of individual health insurance, the health insurance purchased must provide coverage for hospital care, surgical and medical care, and catastrophic coverage of medical expenses as defined by Title 26 Section 9832 of the U.S. Code.

Network adequacy is addressed in Policy H-285.908, which supports state regulators as the primary enforcer of network adequacy requirements. This policy supports requiring health insurers to

submit and make publicly available, at least quarterly, reports to state regulators that provide data on several measures of network adequacy. Policy H-180.946 supports the selling of insurance across state lines that ensure that certain patient and provider protection laws are consistent with and enforceable under the laws of the state in which the patient resides. Additionally, Policy H-180.946 states that patients purchasing an out-of-state policy should retain the right to bring a claim in a state court in the state in which the patient resides.

Policy H-165.856 supports greater national uniformity of market regulation across health insurance markets, geographic location, or type of health plan. Under this policy, state variation in market regulation is permissible so long as states demonstrate that departures from national regulations would not drive up the number of uninsured, and so long as variations do not hamper the development of multi-state group purchasing alliances or create adverse selection. Under Policy D-165.971, the AMA will support an association health plan that safeguards state and federal patient protection laws, including those state regulations regarding fiscal soundness and prompt payment. Policy D-180.986 encourages local, state, and federal regulatory authorities to aggressively pursue action against "sham" health insurers.

Policy H-180.947 opposes consolidation in the health insurance industry that may result in anticompetitive markets. Antitrust reform is an AMA priority under Policy D-383.990, which directs the AMA to continue to: aggressively advocate for a level playing field for negotiations between physicians and health insurers; advocate to the Federal Trade Commission and Department of Justice for more flexible and fair treatment of physicians and for greater scrutiny for insurers; continue to develop and publish objective evidence of the dominance of health insurers through its study, Competition in Health Insurance; and identify consequences of the concentration of market power by health plans.

DISCUSSION

Insurer participation in the ACA marketplace has increased for five consecutive years, although a smaller increase was seen in 2023. Additionally, record numbers of individuals have signed up for coverage in the exchanges, which seem to be functioning well. Enrollment is likely being influenced this year by 1) the Inflation Reduction Act's extension of enhanced premium tax credit subsidies for marketplace plans, through 2025, and 2) the disenrollment of individuals no longer eligible for Medicaid/CHIP, some of whom may be eligible for subsidized ACA plans. Still, the Council recognizes that insurer participation in the marketplace remains lower today than in 2015, when it was at its highest, and the share of plans offered by large insurers has been steadily growing in recent years. Additionally, many insurer exchange markets remain highly concentrated, as evidenced by data compiled in the AMA's most recent edition of *Competition in Health Insurance: A Comprehensive Study of U.S. Markets*. Importantly, health insurance markets are local; across states, there is significant variation in the number of insurers and plans offered in ACA exchanges and, within states, there may be differences in insurer participation in rural and urban regions. The Council shares the sentiment of many physicians that insufficient competition in the ACA marketplace remains concerning in many areas.

The Council also recognizes that the AMA has been a longstanding advocate for health insurance coverage for all Americans, as well as pluralism, freedom of choice, freedom of practice and universal access for patients. The AMA's plan to cover the uninsured, updated annually with new policy and metrics on the uninsured, lays out key calls for action to not only maintain, but build upon, the coverage gains that have been achieved under the ACA. This plan guides ongoing AMA federal and state advocacy on health reform policy priorities. Importantly, increasing insurer competition, maximizing health plan choice, and strengthening and ensuring the sustainability of

the ACA marketplace remain key AMA priorities. The Council has presented several reports in recent years to establish and update AMA policy on these issues, including:

- Council on Medical Service Report 4-I-17, Health Insurance Affordability: Essential Health Benefits and Subsidizing the Coverage of High-Risk Patients;
- Council on Medical Service Report 3-A-18, Ensuring Marketplace Competition and Health Plan Choice;
- Council on Medical Service Report 2-A-18, Improving Affordability in the Health Insurance Exchanges;
- Council on Medical Service Report 2-A-19, Covering the Uninsured under the AMA Proposal for Reform;
- Council on Medical Service Report 1-Nov.-20, Options to Maximize Coverage under the AMA Proposal for Reform; and
- Council on Medical Service Report 3-Nov.-21, Covering the Remaining Uninsured.

Additionally, the Council highlights the following AMA policies addressing the issues raised in Policy D-165.933 and exemplifying the AMA's strong support for insurer competition and health plan choice:

- Policy H-165.825, which offers solutions to ensuring marketplace competition and health plan choice;
- Policy H-165.839, which supports using the open marketplace model for any health insurance exchange and states that exchanges should maximize health plan choice;
- Policy H-165.838, under which insurance coverage options offered in an exchange should be self-supporting and have uniform solvency and other requirements;
- Policy H-165.846, which outlines principles to guide in the evaluation of health insurance coverage options;
- Policy H-180.946, which supports the selling of insurance across state lines, including multistate compacts, when patient and provider protection laws are consistent with and enforceable under the laws of the state in which the patient resides;
- Policy H-165.856, which supports greater uniformity of market regulation across health insurance markets, geographic location, or type of health plan; and
- Policy H-180.947, which opposes consolidation in the health insurance industry that may result in anticompetitive markets.

CONCLUSION

During the development of this report, the Council did not identify gaps in existing AMA policy on competition and choice and, therefore, makes no policy recommendations at this time. However, the Council believes network adequacy, which is key to maintaining healthy competition and choice in the exchanges, is an issue that remains problematic and is worthy of additional study. Relatedly, the Council is concerned about the ability of patients to see certain physicians who are listed by plans as in-network but for whom, in reality, access is limited. Accordingly, the Council has begun looking at the need for stronger network adequacy standards for ACA, Medicare Advantage, and Medicaid plans and will present a report on this topic at the 2023 Interim Meeting.

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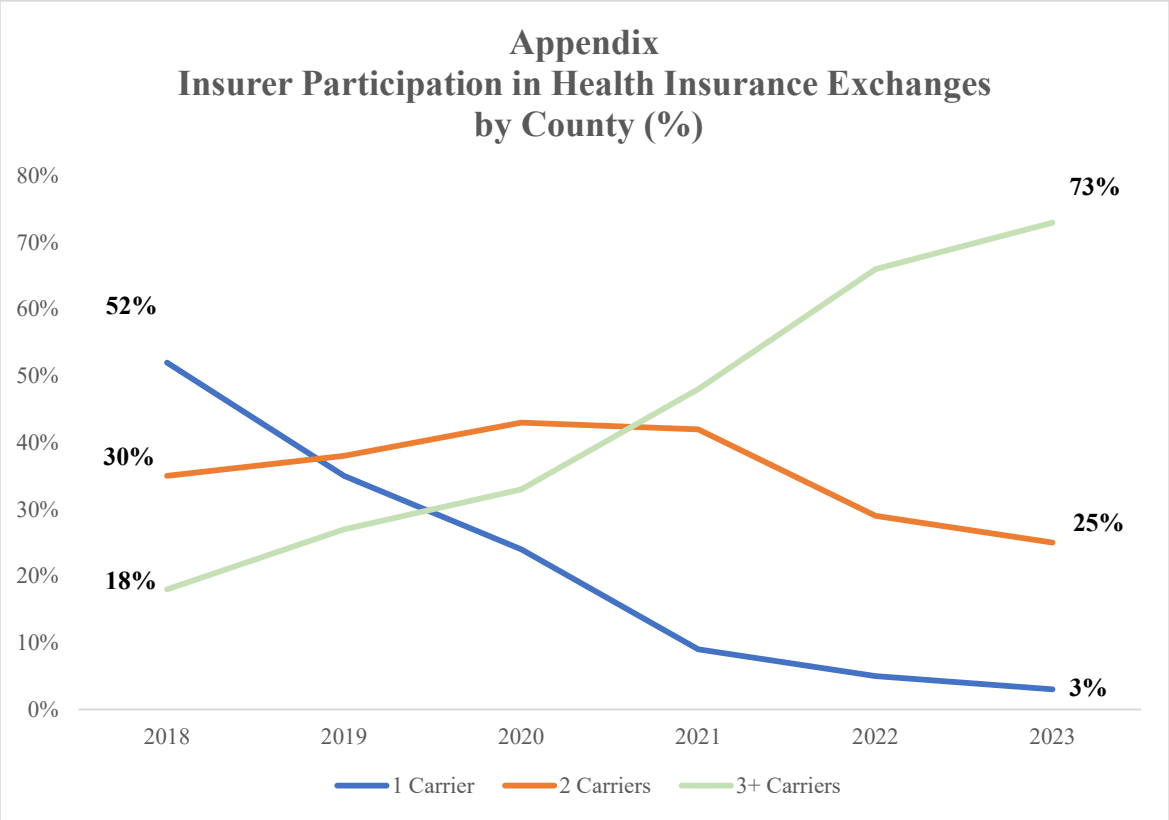

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Values may not add up to 100% due to rounding.