Reference Committee F

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Contained in the Handbook Addendum

REPORT OF THE BOARD OF TRUSTEES

B of T Report 01-A-23

Subject: Annual Report

Presented by: Sandra Adamson Fryhofer, MD, Chair

Referred to: Reference Committee F

The Consolidated Financial Statements for the years ended December 31, 2022 and 2021 and the Independent Auditor's report have been included in a separate booklet, titled "2022 Annual Report." This booklet is included in the Handbook mailing to members of the House of Delegates and will be discussed at the Reference Committee F hearing.

AMA
AMERICAN MEDICAL ASSOCIATION

2022 ANNUAL REPORT

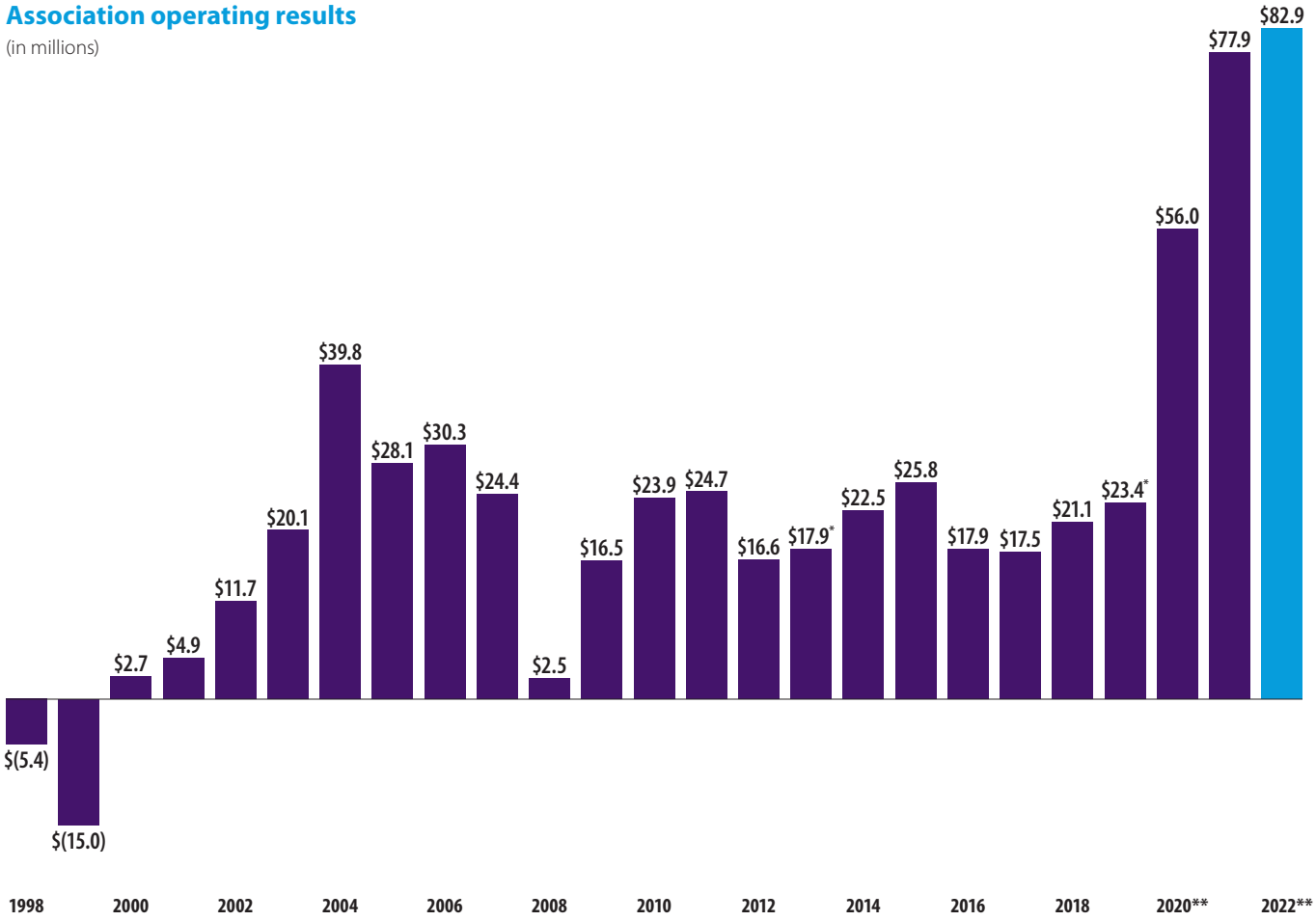
Fighting for physicians

Financial highlights

(Dollars in millions)	2022	2021
Revenues	$ 493.4	$ 459.7
Cost of products sold and selling expense	30.6	25.9
General and administrative expenses	375.5	352.3
Operating results	82.9	77.9
Non-operating items	(117.9)	79.5
Changes in defined benefit postretirement plans, other than periodic expense, net of tax	29.4	5.6
Change in unrestricted equity	(5.6)	163.0
Change in donor restricted equity	0.1	(0.1)
Change in association equity	(5.5)	162.9
Association equity at year-end	$ 889.4	$ 894.9
Employees at year-end	1,267	1,206

Association operating results

(in millions)



** Pro forma operating results: 1) 2013 excludes $33 million in nonrecurring charges relating to AMA's headquarters relocation and 2) 2019 excludes $36.2 million noncash pension termination expense reclassification from non-operating results.*

*** 2020 through 2022 results were impacted by a lack of travel due to the pandemic, as well as a hiring freeze and subsequent tight labor market. These savings are temporary in nature.*

Letter to stakeholders

It's been more than three years since the pandemic took hold of our nation and placed unrelenting pressure upon America's physicians and patients. While the number of deaths slowed and the cases trended downward through much of 2022, the pandemic underscored the urgent need to better support physicians who take care of this nation—and fix what's broken in health care. And the AMA answered.

The AMA met the challenge by introducing its Recovery Plan for America's Physicians. The strategy laid out specific actions needed to strengthen our nation's physician workforce, improve access to necessary care and rebuild our health system to more effectively respond to the next health crisis—whatever it may be.

In its first year the Recovery Plan delivered promising results, as AMA advocacy helped secure significant wins that locked in important telehealth expansions and protected physicians by limiting Medicare payment cuts. But this progress is not nearly enough. Much more is needed in 2023 and beyond to help physicians and their practices recover from the trauma of the pandemic and to help eliminate the pain points that continue to threaten patient care and drive physician dissatisfaction and burnout.

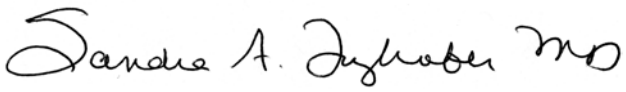
In a year that marked the organization's 175th anniversary, the AMA in 2022 continued to fight relentlessly—through the courts, in the halls of Congress and in state legislatures across the country—on behalf of physicians and patients. We are proud that ours was among the nation's leading nonpartisan voices for science and vaccine efficacy, for advancing health equity, and in cutting through the fog of medical disinformation and misinformation.

And we are equally proud that our voice once again set new standards for physician engagement across multimedia platforms, from content offered on our ever-expanding AMA Ed Hub™ digital education platform to record numbers of media impressions and unique visitors to our flagship website, growth that surpassed the record-high numbers from the pandemic's first year.

Other aspects fundamental to the AMA's mission flourished as well. The AMA released a special 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, with eight ranking in the top three for their respective specialties. And finally, we expanded the AMA's social impact strategy while helping to improve the lives of residents in our home city with a $3 million multi-year investment in West Side United.

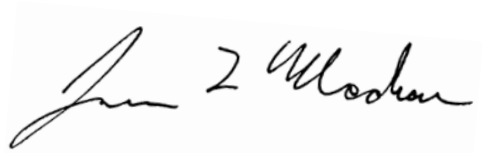
Following 11 consecutive years of membership growth, in 2022 the AMA experienced a small decrease in overall membership (mainly due to a drop in student numbers), but physician membership remained steady. Overall, the organization's advocacy efforts and mission activities were supported by another strong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

With unparalleled advocacy and engagement, strengthened by our industry-leading research, education and tools, the AMA continues to redefine what it means to be the physicians' powerful ally in patient care. Through challenges and change, in times of crisis and calm, the AMA is committed to physicians, patients and advancing medical practice—and we will never back down.

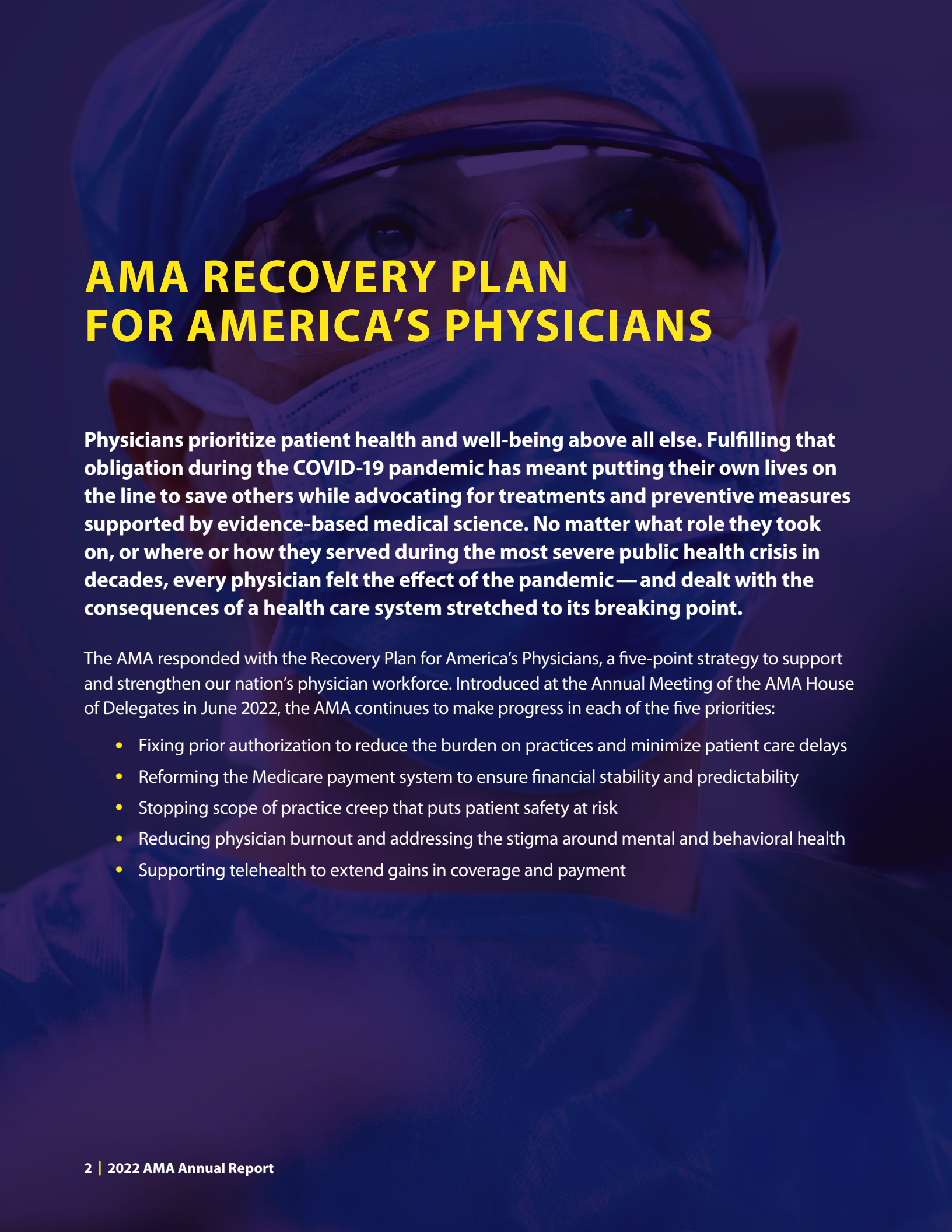


Sandra Adamson Fryhofer, MD
Chair, Board of Trustees

Michael Suk, MD, JD, MPH, MBA
Finance Committee Chair, Board of Trustees



James L. Madara, MD
CEO and Executive Vice President



AMA RECOVERY PLAN FOR AMERICA'S PHYSICIANS

Physicians prioritize patient health and well-being above all else. Fulfilling that obligation during the COVID-19 pandemic has meant putting their own lives on the line to save others while advocating for treatments and preventive measures supported by evidence-based medical science. No matter what role they took on, or where or how they served during the most severe public health crisis in decades, every physician felt the effect of the pandemic—and dealt with the consequences of a health care system stretched to its breaking point.

The AMA responded with the Recovery Plan for America's Physicians, a five-point strategy to support and strengthen our nation's physician workforce. Introduced at the Annual Meeting of the AMA House of Delegates in June 2022, the AMA continues to make progress in each of the five priorities:

- Fixing prior authorization to reduce the burden on practices and minimize patient care delays
- Reforming the Medicare payment system to ensure financial stability and predictability
- Stopping scope of practice creep that puts patient safety at risk
- Reducing physician burnout and addressing the stigma around mental and behavioral health
- Supporting telehealth to extend gains in coverage and payment

The AMA's progress on these goals in 2022 set the stage for even **greater success** in the future.

Fixing prior authorization

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 five states and laid the groundwork for 2023 reform efforts in dozens more states.

Reforming the Medicare payment system

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 succeeded in minimizing the 8.5% cuts slated for 2023.

The fight is far from over. Although physicians face a 2% reduction in Medicare payment in 2023, 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 continues to advocate for comprehensive Medicare payment reform and a rational system that is clinically relevant, less administratively burdensome, provides real opportunities for participation in new payment models, and provides stability and financial viability for large and small, as well as urban and rural, physician practices. Principles developed by the AMA to guide Medicare payment reform were endorsed by more than 120 medical societies.

Fighting scope creep

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.

Reducing physician burnout

The AMA helped secure 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. In addition, the AMA helped build coalitions to strip away stigmatizing questions about mental health and substance abuse disorders on licensure applications. Multiple medical boards and health systems made changes based on AMA recommendations. The AMA also continues to advance strategies organizations can employ to boost professional satisfaction and personal well-being. Finally, the AMA continues to provide tools to address the contributors to burnout in its STEPS Forward series, including a Saving Time Playbook, and a toolkit to address disproportionate impact on patients and physicians called Racial and Health Equity: Concrete STEPS for Health Systems.

Supporting telehealth gains

As evidenced by its tremendous growth during the COVID-19 pandemic, the AMA believes telehealth is a crucial element of effective health care delivery. That's why we continue to work to expand telehealth research, resources and policies while boosting the tools, support and expertise we offer physicians looking to integrate telehealth services into their practices without financial risks or penalties.

The AMA played a key role in securing passage of legislation to extend Medicare telehealth flexibilities through the end of 2024. We also launched model legislation that states can use to advance telehealth coverage and policies, and further supported telehealth expansion by producing curated webinars, hosting interactive information exchanges and virtual discussion sessions, and 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.

AMA highlights

The year 2022 was one of much progress across many meaningful initiatives led by the AMA, from advocacy to education and from health equity to blood pressure management. Here are some highlights of our organization's important work during 2022.

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. And 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.

30 million unique visitors

to our flagship website, a 10% increase from the record-setting performance the previous year.

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.

In the face of a worsening drug-related overdose and death epidemic, the AMA continued to fight to remove barriers to evidence-based care for people with substance use disorders, patients with pain and increase access to harm reduction initiatives. Thanks, in part, to AMA advocacy, Congress removed the federal "X-waiver" requirement to prescribe buprenorphine in-office for treating opioid use disorder; the Centers for Disease Control and Prevention (CDC) eliminated arbitrary, numeric thresholds from its revised 2022 opioid prescribing guidelines; and the U.S. Food and Drug Administration (FDA) removed barriers for harm reduction organizations to directly purchase and distribute naloxone. AMA advocacy also played a role in the National Association of Insurance Commissioners' efforts to increase health insurers' compliance with state and federal mental health and substance use disorder parity laws, as well as new laws being enacted in multiple states that decriminalized fentanyl test strips and other drug testing supplies and equipment.

The industry-leading AMA Ed Hub online education portal continued to expand its programs, affiliations and reach to support live broadcasts and enhance multimedia capabilities. The stable 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 educational modules published on the AMA Ed Hub learning platform that focus on strategies to advance equity through quality and safety improvements.

The AMA launched 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.

The AMA developed an 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 again collaborated on the annual bilingual "Get My Flu Shot/Vacunate Contra la Influenza" campaign, and kept physicians and the public up to date on the latest pandemic developments, including therapeutics and the importance of staying on track with COVID-19 vaccines.

6 million views on our AMA Ed Hub™

digital education platform.

The launch of the AMA's new Current Procedural Terminology (CPT®) Developer Program helped creators of health technology and services convert ideas and leverage AMA-published content into transformative innovations. A new self-service portal gave 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 also developed revised versions of an initial 20 illustrations for the 2023 CPT PRO Book, reflecting the diversity of our patients.

2.7 million YouTube views

2× the total from 2021.

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 state Medicaid programs increasing access for self-measured blood pressure by covering home-use devices and clinical support services. AMA added four more health care organizations to its growing list of AMA MAP BP™ implementation sites and announced exciting results of one implementation site, Cook County Health on Chicago's West Side, which reported that blood pressure control rates increased by 13 percentage points across 11 practice sites. Additionally, the AMA also trained more than 100 community health workers to help Chicago's West Side residents more accurately measure their blood pressure at home.

The AMA's community support included an additional $3 million multi-year commitment to West Side United, a community-based collaborative that is addressing determinants of health and reshaping economic vitality on Chicago's West Side.

First published in March 2022 as part of the AMA's MedEd Innovation Series, the "Coaching in Medical Education Handbook" 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 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.

In cases ranging from COVID-19 standards of care to firearm regulations, 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.

The AMA joined an Association of American Medical Colleges-led U.S. Supreme Court amicus brief in the *Students for Fair Admissions v. Harvard* and *Students for Fair Admissions v. University of North Carolina* cases in support of the consideration of race in higher education admissions. 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.

600,000 AMA podcast downloads

175 billion AMA media impressions

representing $1.6 billion in estimated advertising value to the organization.

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.

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.

Following up on extensive research that identified the benefits physicians valued most in a disability product, AMA Insurance launched two popular enhancements to this line, including a level-rated premium.

Management's discussion and analysis

Management's discussion and analysis

Introduction

The objective of this section is to help American Medical Association (AMA) members and other readers of our financial statements understand management's views on the AMA's financial condition and results of operations. This discussion should be read in conjunction with the audited consolidated financial statements and notes to the consolidated financial statements.

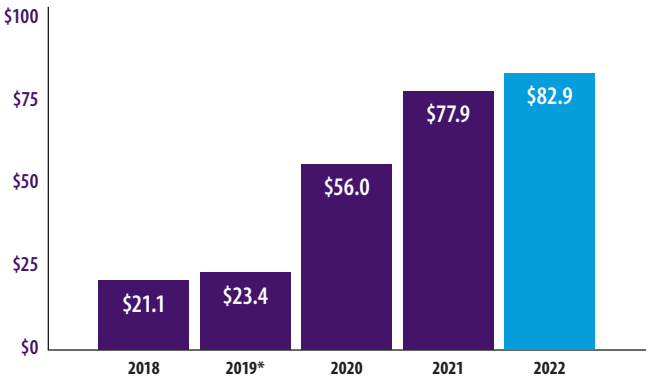
Improving the health of the nation is at the core of the AMA's work. As physicians' powerful ally in patient care, the AMA delivers on this goal by representing physicians with a unified voice in courts and legislative bodies across the nation, removing the largest governmental and private sector obstacles that interfere with optimal patient care, leading the charge to prevent chronic disease and confront public health crises, and driving the future of medicine to tackle the biggest challenges in health care and training the leaders of tomorrow. AMA's strategic arcs are supported by improving health outcomes, lifelong medical education and enhancing physician professional satisfaction and practice sustainability. Our advocacy, health equity and innovation initiatives act as accelerators across all arcs. AMA's foundation is built on science, membership, financial performance, talent and engagement.

2022 accomplishments were led by the launch of the AMA Recovery Plan for America's Physicians, an ambitious roadmap to renewing our country's commitment to physicians—and ensuring their needs are met—so patients can receive the high-quality care they deserve. The plan focuses on five key goals to re-build health care so that it works better for physicians and all those they serve: 1) fixing prior authorization to reduce the burden on practices and minimize care delays for patients; 2) reforming Medicare payment to promote thriving physician practices and innovation; 3) stopping scope creep that threatens patient safety; 4) reducing physician burnout and addressing the stigma around mental health; and 5) supporting telehealth to maintain coverage and payment. Advocacy results included achieving more than 35 state-level scope of practice victories in partnership with the Federation and extending telehealth coverage into 2024, as well as minimizing the impact of the scheduled 8.5 percent Medicare payment cuts. Professional Satisfaction and Practice Sustainability expanded its successful programs to reduce burnout in health systems, based on peer-reviewed studies and research.

The AMA, like all other organizations, recognized in early 2020 that there was substantial uncertainty about the effects and risk of COVID-19 on our funding, financial condition, and results of operations. As a result, AMA took steps to ensure that programmatic activities and employment levels would be protected during a sustained pandemic, knowing the potential for economic uncertainty, including a freeze on hiring and elimination of travel, among other measures. AMA lifted the freeze on hiring in the spring of 2021, but the level of open positions remained high through 2022 due to the very tight job market. The lower staffing levels and limited travel garnered substantial savings. These savings are temporary in nature and drove unusually high operating income for AMA during 2020 through 2022 but are not expected to recur after full return to normal activities in 2023.

Pro forma net operating results

(in millions)



**Excluding the $36.2 million non-cash pension termination charge*

AMA's 2023 budget assumes that these temporary savings will not recur, and coupled with expansion of certain programmatic areas, expenses will increase to normal levels, resulting in operating income at the board-approved policy level.

The AMA is committed to its responsibility of ensuring that the organization focuses its finite resources on core mission activities and strategic arcs while improving the quality and breadth of products and services for physicians and medical students. Our physicians' and medical students' voices are central to AMA's overall success.

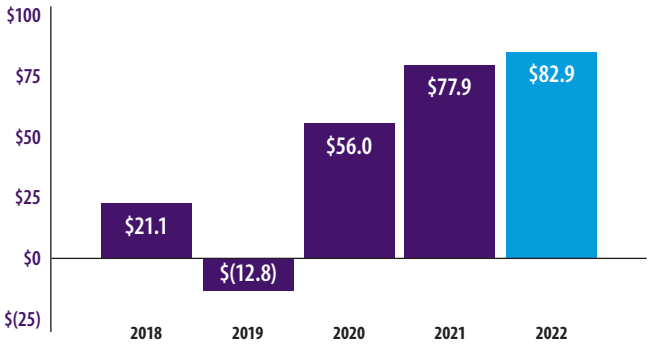
The following pages discuss the 2022 consolidated financial results as compared to 2021. Additional detailed discussion of operating unit results is included in the section titled "Group Operating Results."

Consolidated financial results

Results from operations

Net operating results

(in millions)



As noted above, the unusually tight labor market that adversely impacted hiring and limited travel and in-person meetings in the first half of 2022 were major factors in spending levels running $40 million less than budget. At the same time, recurring revenue rose by approximately $19 million. In addition, the liquidation of a subsidiary and recognition of one-time deferred revenue and costs added $11.6 million to the 2022 net results. Looking ahead to 2023, AMA does not expect to attain the same level of expense savings and future results are expected to be more modest.

In 2019, the AMA finalized termination of its defined benefit pension plan, providing lump sum payments to individuals that elected that option and purchasing a group annuity plan for participants that chose to remain in the plan. AMA recorded a $38.2 million noncash reclassification of prior actuarial losses from non-operating expense to operating expense, titled pension termination expense, as well as reclassifying a $2 million noncash tax benefit to income tax expense that was previously reported as a non-operating credit.

Excluding the $36.2 million noncash pension termination expense (net of the $2 million tax credit), AMA would have reported $23.4 million in net operating income for 2019.

Results discussed below reflect AMA's actual results from operations in 2022 as compared to 2021. Any pro forma charts exclude the impact of the pension termination on 2019 results.

Revenues

In 2022, total revenue improved by $33.7 million over the prior year, due to continued growth in AMA's royalties and a one-time recognition of $14.3 million in deferred revenue from a customer contract in a subsidiary company of Health2047, Inc. (Health2047) upon liquidation of the subsidiary. Most other revenue categories were either slightly down or unchanged for the year.

Consolidated investment income, which is dividend and interest income, net of management fees, increased in 2022, impacted in large part by higher interest rates. Market gains or losses are not included in investment income and are reported as non-operating results.

The number of AMA dues-paying members decreased slightly in 2022 by 0.9 percent, after 11 years of consecutive growth in membership. During that 11-year period, AMA dues-paying membership increased by more than 75,000.

Dues revenue decreased by 2.9 percent as growth in lower dues paying categories such as group memberships and sponsored memberships partially offset the decline in individual direct member categories.

Cost of products sold and selling expenses

All variable expenses related to the production, distribution and sale of periodicals, books, coding products and licensed products are included in the cost of products sold and selling expense categories. Examples include paper, sales commissions, promotional activities, distribution costs and third-party editorial costs.

In 2022, cost of products sold and selling expenses increased $4.7 million from the prior year, of which $2.7 million was for one-time recognition of deferred costs related to the Health2047 subsidiary's recognition of deferred revenue noted above. The remaining increase was largely a function of commodity price and postal rate increases for paper and distribution.

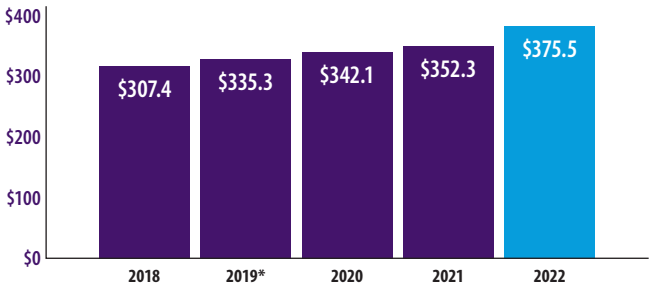
Contribution to general and administrative expenses

Cost of products sold and selling expenses are deducted from revenues to determine the amount of money available for the general and administrative expenses of the organization. Contribution to general and administrative expenses measures the gross margin derived from revenue-producing activities.

The contribution to general and administrative expenses increased $29 million to $462.8 million in 2022, with revenue improvements from royalties and the one-time recognition of the Health2047 subsidiary's deferred revenue and costs accounting for most of the change.

Pro forma general and administrative expenses

(in millions)



**Excluding the $38.2 million non-cash pension termination charge*

General and administrative expenses rose only $23.2 million in 2022, or 6.6 percent, when compared to 2021. This was substantially less than the budgeted increase for 2022, with nonrecurring savings related to staffing, professional services and travel.

Compensation and benefits were largely unchanged in 2022, increasing $1.4 million, or less than one percent. Compensation, including temporary help, was $5.8 million higher in 2022, a 3.6 percent increase which was mainly a function of annual merit increases. Fringe benefit costs increased $2.5 million in total primarily due to higher medical and payroll tax expenses, continuing a post-pandemic trend from 2021. Recruiting costs also increased as an unusually large number of open positions were under recruitment in 2022. Incentive compensation declined $7.8 million, offsetting most of the above increases, as some key performance indicators were not achieved in 2022 and others were met but not exceeded.

Occupancy costs were up slightly as operating costs rose with a return to office in late 2022 as well as the impact of higher property taxes. In late 2022, AMA exercised a contraction option in the main headquarters lease whereby AMA will relinquish one full floor of office space beginning in 2023 upon payment of a termination penalty. The cash savings over the remaining lease period, including operating expenses and property taxes and net of the penalty, are estimated to be in excess of $8 million.

Travel and meeting costs increased by $11.1 million in 2022, as AMA resumed in-person meetings and travel mid-year.

Technology costs were up $1.5 million in 2022, largely related to continued development of the AMA Ed Hub, JAMA Network initiatives and implementation of the Insurance Agency's new policy administration system.

Marketing and promotion costs rose $3.2 million in 2022, mainly for marketing and media costs related to the launch of AMA's Recovery Plan for America's Physicians and membership solicitation.

Outside professional services increased $0.5 million in 2022, due in part to Advocacy conducting a bi-annual Physician Practice Expense survey as well as costs for the "Stop Medicare Cuts" campaign early in 2022.

A $5.2 million increase in other operating expenses was driven by a $2.2 million increase in grants and contributions, of which a $1 million increase is for various grants sponsored by the Center for Health Equity and a $0.7 million increase is for the Accelerating Change in Medical Education (ACE) Consortium grants. Continued growth in the use of online solutions across a number of business units, as well as price increases, resulted in online product subscription costs increasing $1.7 million during 2022.

Operating results before income taxes

The AMA reported $87.3 million in pre-tax operating income in 2022 compared to $81.5 million in 2021. Both years reflect substantially reduced expenses due to pandemic restrictions on travel and meetings, staffing freezes and tight labor markets. A $33.7 million increase in revenue was only partially reduced by cost of products sold and general and administrative expense increases described above.

Income taxes

Taxes increased $0.8 million in 2022 when compared to 2021. The 2021 tax provision included a $1.2 million credit reflecting a reversal of a previously established reserve for taxes deemed unnecessary due to completion of tax audits. The absence of the credit in 2022 was partially offset by the effect of lower taxable income in one of the subsidiaries.

Net operating results

Net operating income was $82.9 million in 2022 compared to $77.9 million in 2021, driven mainly by improved revenues net of expense increases.

Non-operating items

The AMA reported a $115.1 million loss in the fair value of its portfolio during 2022 after an $82.8 million gain in 2021. Additional portfolio performance information is discussed in the group operating results section.

As a result of an accounting standard adopted in 2019 for postretirement benefit plans, non-operating results include $3.5 million and $3.9 million in postretirement plan interest expense and recognized actuarial losses and prior service credits for 2022 and 2021, respectively.

Revenue (less than) in excess of expenses

Expenses exceeded revenues by $35 million in 2022, a combination of $82.9 million in operating income, the $115.1 million loss in fair value in the portfolio and $2.8 million in other non-operating expenses. Revenues exceeded expenses by $157.4 million in 2021, a combination of $77.9 million in operating income, an $82.8 million gain in fair value in the portfolio and $3.3 million in other non-operating expenses.

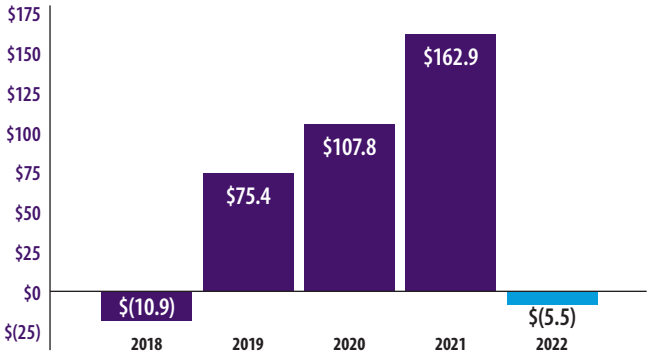
Accounting standards require organizations to recognize deferred actuarial losses and prior service credits or charges for defined benefit postretirement plans as a charge or credit to equity.

In 2022, AMA recorded a $29.4 million credit to equity reflecting an actuarial gain for the postretirement health care plan, net of a reclassification of actuarial losses for the plan to operating expense and income tax. The gain resulted primarily from higher interest rates reducing the present value of plan liabilities.

In 2021, AMA recorded a $5.6 million credit to equity reflecting an actuarial gain for the postretirement health care plan, net of a reclassification of actuarial losses and prior service credits for the plan to operating expense and income tax. The gain resulted from higher interest rates and changes in participants, offset by an increase in baseline claims costs.

Change in total association equity

(in millions)



The AMA reported a $5.5 million decrease in association equity in 2022. This reflects the amount by which expenses exceeded revenues, plus the credit to equity for changes in defined benefit postretirement plans discussed above, as well as a small increase in donor-restricted equity.

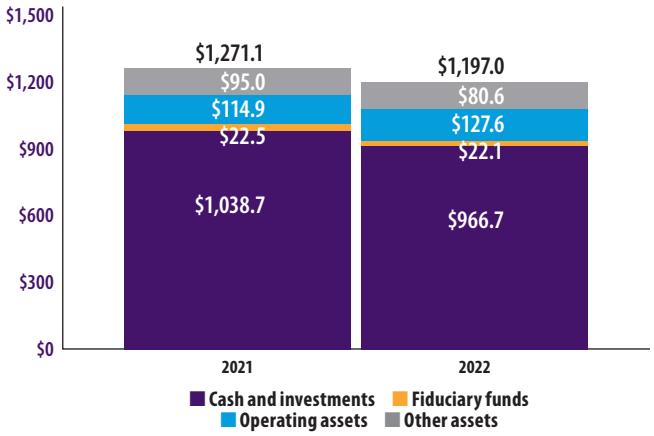
The AMA reported a $162.9 million increase in association equity in 2021. This reflects the amount by which revenues exceeded expenses, plus the credit to equity for changes in defined benefit postretirement plans discussed above, as well as a small decrease in donor-restricted equity.

Financial position and cash flows

The AMA's assets include cash, cash equivalents and investments; operating assets such as accounts receivable, inventory and prepaid expenses; fixed capital such as equipment, computer hardware and software; and other assets. AMA assets are supported by association equity, operating liabilities and deferred revenue.

Assets

(in millions)



The AMA's total assets decreased $74.1 million in 2022. This includes a $72 million decrease in cash and investments resulting from $45.4 million in free cash flow minus a $115.1 million loss in the fair value of investment securities and $2.3 million for investments in affiliates.

Fiduciary funds are premium payments from insurance customers not yet remitted to the carriers and funds held by the AMA for third parties for future use as approved by the third parties. This approximates the offsetting liability titled insurance premiums and other fiduciary funds payable.

Operating assets increased $12.7 million in 2022, primarily due to an increase in accounts receivable and prepaid expenses. Changes in operating assets from year to year are largely due to timing of cash flows.

Other assets includes operating lease right-of-use assets, property and equipment and investments in mutual funds maintained in separate accounts designated for various nonqualified benefit plans that are not available for operations. Operating lease right-of-use assets decreased due to amortization of the asset over the life of the lease as well as the impact from the headquarters' lease contraction noted above. Property and equipment net book value also decreased as new capital spending was exceeded by annual depreciation and amortization of existing capital assets.

Operating liabilities decreased $52.6 million in 2022, led by decreases in the postretirement health care plan liabilities, lease liability and accrued payroll. The postretirement health care plan liability decrease was a function of the impact of higher interest rates on the present value of plan liabilities. The lease liability change includes a $2.3 million reduction in the present value of the headquarters liability resulting from exercising the contraction option noted above.

Deferred revenue represents funds received during the year that will not be recognized as income until the following year or thereafter. These amounts vary, as well as accounts payable and accrued expenses, depending on the timing of cash receipts and payments.

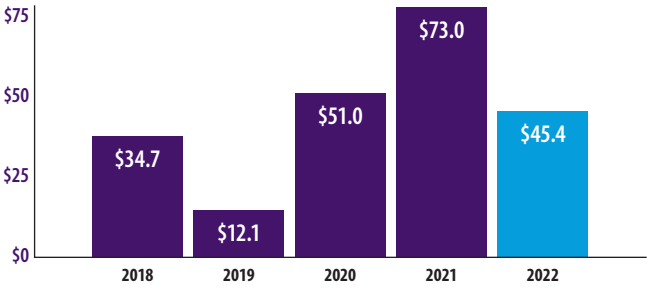
Cash flows

Cash, cash equivalents and donor-restricted cash increased $1.4 million in 2022 and decreased $2.9 million in 2021. This comparison may cause misleading conclusions, as the change in cash and cash equivalents includes reductions for amounts invested in marketable securities, as well as cash inflows from non-operating activities.

Free cash flow measures the AMA's ability to fund operations, capital expenses and major programmatic initiatives from funds generated from operations. This measure excludes non-operating gains and losses.

Free cash

(in millions)

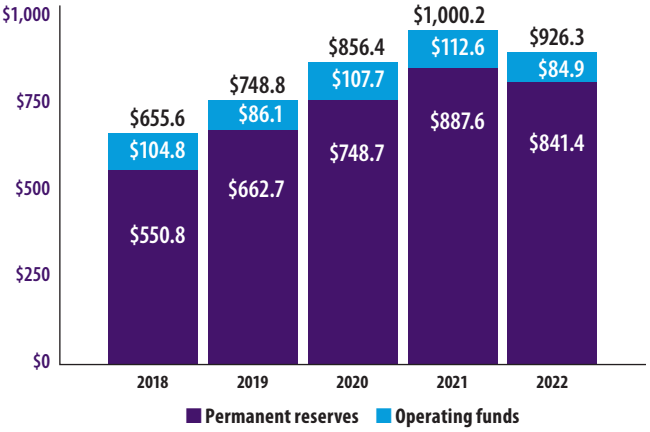


Free cash in 2022 totaled $45.4 million, substantially less than the 2021 results, driven mainly by changes in operating assets and liabilities.

Reserve portfolio

Reserves

(in millions)



The reserves and operating funds above do not include cash and investments in the for-profit subsidiaries and reflect only the not-for-profit entity's cash and investment portfolio values.

As of year-end 2022, the reserve portfolio's value was $841.4 million compared to $887.6 million in 2021, a $46.2 million decrease. That decrease was mainly the result of a $108.1 million loss in the fair value of the reserve portfolio offset by a $61.5 million transfer of 2021 excess operating funds to reserves. Operating funds totaled $84.9 million in 2022, down $27.7 million from 2021.

The AMA has established a required minimum reserve investment portfolio level that is adequate to cover 100 percent of annual general and administrative expenses (excluding grant expenses) plus an amount sufficient to pay long-term postretirement and lease liabilities (net of the right-of-use asset value). Operating funds, coupled with operating assets, are to be maintained at a level that allows payment of all current operating liabilities.

The minimum reserve portfolio level is designed to ensure that the AMA can always meet its long-term obligations, as well as provide that the AMA could continue operations for at least one year in the case of a catastrophic occurrence.

Reserve portfolio funds also provide the AMA with the ability to fund major strategic spending initiatives not within the operating budget. Spending from the reserve funds is limited to the amount by which reserves exceed the minimum requirement. The Board of Trustees must authorize any use of reserves.

Permanent reserves and minimum reserve requirement

(in millions)

Group operating results

The AMA is organized into various operating groups: Membership; Publishing, Health Solutions & Insurance; Strategic Arcs & Core Mission Activities; Administration and Operations; Affiliated Organizations; Unallocated Overhead; and Health2047 (including subsidiaries). Revenues and expenses directly attributed to those units are included in the group operating results. A financial summary of group operating results is presented at the end of this section. Prior year financial results have been restated to be consistent with the current year reported results for each group.

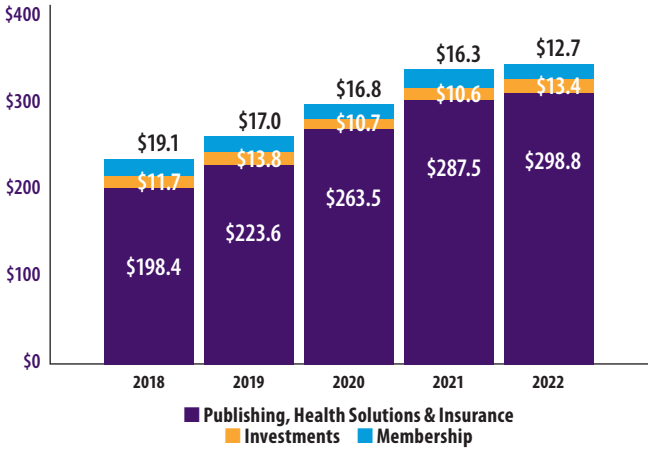
Contribution margin (net expenses)

Contribution margin equals individual group revenues minus cost of products sold, selling expenses, and direct general and administrative expenses such as compensation, occupancy, travel and meetings, technology costs and professional services.

Net expenses equals total spending, net of any revenue produced by the group, such as grants or other fee income. Total contribution margin and net expenses equals consolidated operating results before income taxes. The charts below separate groups with contribution margin from groups with net expenses.

Contribution margin

(in millions)



The contribution margin generated by Membership; Publishing, Health Solutions & Insurance; as well as Investments, provides the funding for all mission-related activities of the AMA as well as funding for all administration and support operations required to run the organization.

Membership

The Membership group's total revenue includes both net membership dues and interest expense on lifetime memberships. Net membership dues include the gross dues revenue collected, reduced by any commissions paid to state societies, and equal the membership dues revenue reported on the statement of activities.

After 11 consecutive years of increases in the number of dues-paying members, AMA experienced a small decrease in total membership in 2022, as the number of dues paying members declined by 0.9 percent. This was driven largely by a drop in student membership which was unfavorably impacted by limitations on in-person recruiting on campuses, while physician membership held steady. Membership continues to focus on expanding use of digital tools to engage physicians and retain them as lifelong members, group membership marketing, and more effectively reaching physicians through expanded programmatic activities.

Dues revenue was $33.8 million, a $1 million decrease from 2021. Although the number of physician memberships remained steady, growth in lower dues paying categories was only partially offset by the decline in individual direct member categories. Interest expense on lifetime memberships was $0.1 million in 2022 and zero in 2021. Membership substantially expanded its marketing and solicitation efforts during 2022, with a $1.9 million increase in marketing costs, accounting for most of the $2.5 million cost increase. Membership's contribution margin decreased $3.6 million in 2022, a combination of the revenue decline and cost increases.

Publishing, Health Solutions & Insurance

Publications in the JAMA Network include the *Journal of the American Medical Association (JAMA)* and the JAMA Network specialty journals. In recent years, the JAMA Network has launched four new journals: *JAMA Oncology* in 2015 and *JAMA Cardiology* in 2016, which are hybrid journals offering open access options for research articles; *JAMA Network Ope*n in 2018, a fully open access journal; and *JAMA Health Forum* in 2021, a peer-reviewed, open-access, online journal focused on health policy, health care systems, and global and public health.

Publishing revenues are derived from advertising, subscriptions, site licensing, reprints, electronic licensing, open access fees and royalties. Publishing revenues decreased $1.8 million in 2022, with declines in most revenue lines except open access fees. The prior year had included two large one-time purchases of reprints and journal backfiles totaling $2.4 million which accounted for most of the decline. Expenses rose $5.2 million during 2022, with approximately $1.3 million related to inflationary cost increases on paper, printing and distribution. The remaining cost increases occurred across most expense categories. The contribution margin thus declined by $7 million to $2.1 million.

Health Solutions includes two major lines: Database Products, and Books and Digital Content.

Database Products includes royalties from licensed data sales and credentialing products revenue. Revenues increased in 2022, up $3.5 million when compared to 2021, driven in large part by a major compliance effort to upgrade existing customer contracts from development contracts to full licenses. Expenses were up $1.1 million driven by higher compensation, increased technology costs and resumption of travel. The resulting contribution margin rose by $2.4 million in 2022 to $54.3 million.

AMA-published books and coding products, such as CPT® books, workshops and licensed data files, make up the Books and Digital Content unit. Revenues in this unit increased by $18.6 million. Royalties and digital content sales drove this increase, as the market for electronic use of digital coding products continues to expand. Phasing in previous pricing model changes was also a factor. Coding book sales declined slightly in 2022 as the move from print products to digital continues to adversely impact print product sales. Expenses were down slightly in 2022, driven by reduced use of outside professional services. The contribution margin increased by $19.4 million to $228.5 million.

The AMA has two active for-profit subsidiaries, the AMA Insurance Agency (Agency) and Health2047. The latter is discussed separately at the end of this discussion and analysis.

The Agency's revenues declined by $1.6 million in 2022, mainly due to a second decrease in commission rates to protect the viability of the plan, which allowed the Agency to avoid charging higher premiums to physician customers. The Agency, as broker, receives a commission on insurance policies sold. Expenses were up $0.6 million mainly due to technology costs related to development of a new customer facing platform. The contribution margin declined to $17.8 million from $20 million in the prior year.

Other business operations net expenses were up $1.3 million in 2022, which included $0.7 million in one-time costs.

In total, Publishing, Health Solutions & Insurance contribution margin was $298.8 million, up $11.3 million from 2021.

Investments (AMA-only)

AMA-only investment income includes dividend and interest earnings on the AMA's portfolio. Investment income in AMA's active subsidiaries is included as part of the group results for Publishing, Health Solutions & Insurance and Health2047.

Investments' revenue was $14.1 million in 2022, a $2.8 million increase over the prior year. Dividend and interest income continued to improve in 2022, impacted in part by higher interest rates. The contribution margin also increased by $2.8 million as expenses were unchanged.

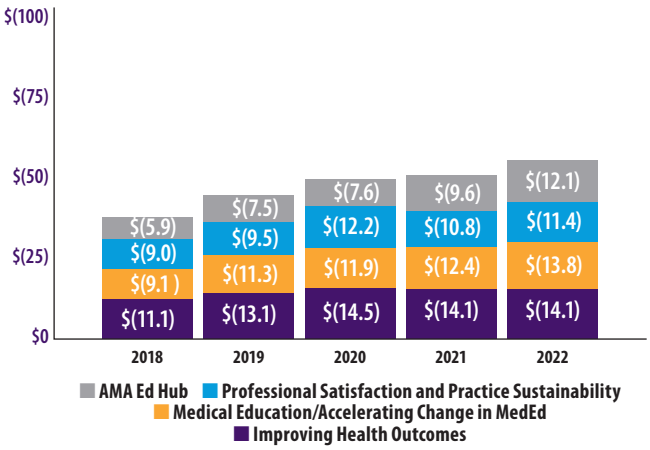
The net gain or loss on the market value of investments is not included in operating results but reported as a non-operating item. This amount is in addition to the investment income discussed above.

In 2022, AMA reported a net loss of $115.1 million, compared to an $82.8 million gain in 2021. The total investment return, including investment income, on the reserve portfolios was negative 10.5 percent, better than the 13.1 percent loss in the composite benchmark index.

Net expenses

Strategic Arcs

(in millions)



The Strategic Arcs include direct costs associated with the groups for Improving Health Outcomes (IHO), Medical Education including Accelerating Change in Medical Education (ACE), the AMA Ed Hub and Professional Satisfaction and Practice Sustainability (PS2).

IHO focuses on confronting two of the nation's most prevalent issues: cardiovascular disease and type-2 diabetes, setting a course of innovation and action aimed at reducing the disease and cost burden associated with these selected conditions.

To help prevent type-2 diabetes, the AMA and the Centers for Disease Control and Prevention (CDC) developed a toolkit to help health care teams screen, test and refer at-risk patients to in-person or online diabetes prevention programs (DPPs). In 2022, the AMA completed a six-year public awareness campaign with the CDC and the Ad Council, reaching 12.5 million individuals who took an online prediabetes risk test.

The AMA has developed online tools and resources using the latest evidence-based information to support physicians to help manage their patients' high blood pressure (BP). In 2022, to improve the identified gap in BP measurement training in medical schools, IHO developed a three-part e-learning series and hosted a grant program to help embed and monitor the success of the training.

The main focus during 2022 was on hypertension outcome goals as progress continues on implementation of cloud-based M.A.P. BP (a three-step program that works to diagnose and manage patients with hypertension) dashboards at health care organizations (HCOs), providing a visual representation of their performance on five key blood pressure metrics, including stratification by ethnicity, race, and gender. Since 2019, the AMA has worked with forty-six HCOs across 20 states to help them implement AMA M.A.P. BP. Additionally, the AMA is currently testing new ways to disseminate M.A.P. BP through population health channel partnerships to help serve health care organizations that care for historically marginalized and minoritized populations. Net expenses were unchanged in 2022.

Advancing Professional Development includes Medical Education/ACE and the AMA Ed Hub.

While the undergraduate medical school consortium grants successfully concluded in 2018, all 32 consortium schools have continued collaboration and new schools have been added to the ACE Consortium each year through focused innovation grants. The consortium of schools has been substantially expanded and now acts as a learning collaborative so that best practices can be developed, shared and implemented in medical schools across the country.

In 2019, the methods and learning from the undergraduate consortium initiative were extended to a new multi-year grant program on graduate medical education, designed to improve the transition from undergraduate to graduate medical education and to maintain and reinforce the positive changes initiated by the undergraduate consortium work.

One of the key outcomes of the ACE Consortium was the development of Health Systems Science, a foundational platform and framework for the study and understanding of how care is delivered, how health professionals work together to deliver that care, and how the health system can improve patient care and health care delivery.

In 2022, Medical Education convened its first Precision Education Summit with a goal of advancing a conceptual model of precision education to optimize lifelong learning for physicians. This will be the next phase of AMA's critical education transformation. Medical Education is also responsible for defining or influencing standards for undergraduate, graduate and continuing medical education and providing support for the Council on Medical Education. Net expenses increased $1.4 million in 2022 reflecting resumption of in-person meetings and travel as well as payment of ACE grants previously deferred during the pandemic.

The AMA Ed Hub, formally launched in 2018, is a platform providing physicians and other health care providers content and educational services that support lifelong professional development. The AMA Ed Hub has unified the AMA education portfolio and has piloted integration of external content providers, launched new content sets and established internal development plans enterprise-wide, including the Health Equity Education Center and the UME Curricular Enrichment Program. The AMA Ed Hub also gives doctors and other health professionals a streamlined way to earn, track and report continuing medical education activities spanning clinical,

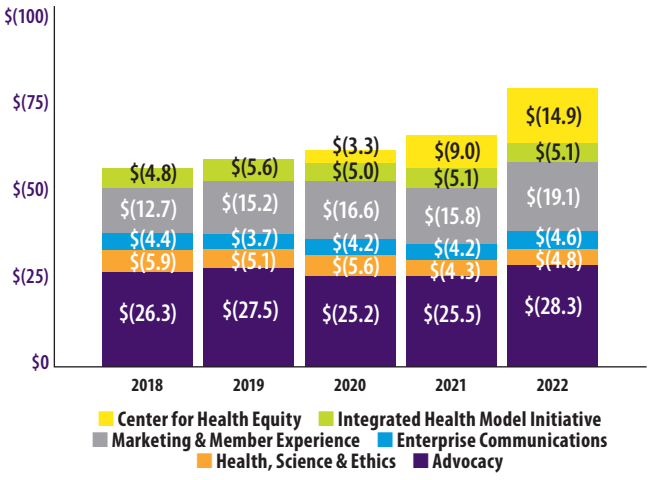
practice transformation and professionalism topics. The number of external education providers on the platform grew by ten organizations to 35 organizations in 2022. Net expenses were up $2.5 million in 2022 due largely to growth in staffing and enhancements to the technology platform, including features to support live broadcasting and advance multi-media, as well as expanding real-time credit submission to four additional medical boards.

PS2 includes three major streams of work: professional satisfaction/practice transformation, practice sustainability, and digital health all designed to improve the day-to-day practice and professional experience of physicians and remove obstacles to care. The goals of this group are to promote successful models in both the public and private sectors. This includes expanding research of credible practice science, creating tools and other solutions to help guide physicians, care teams and health system leaders on developing and implementing strategies to optimize practice efficiencies, reduce burnout and improve professional well-being; ensuring the physician perspective is represented in the design, implementation and evaluation of new health care technologies; and shaping the evolution of payment models for sustainability and satisfaction.

In 2022, 220,000 physicians were the direct beneficiaries of PS2 services/interventions, as measured by the number of physicians within participating HCOs utilizing organizational/burnout assessments; within participating HCOs in collaborative training and/or coaching efforts; and within HCOs recognized by the Joy in Medicine Health System Recognition Program. In addition, PS2 launched the Private Practice Simple Solutions Initiative and also led and funded the Behavioral Health Integration (BHI) Collaborative of Federation members to design and launch the BHI Immersion Program. In 2022, net expenses increased $0.6 million, driven almost entirely by staffing and travel costs.

Core Mission Activities

(in millions)



Core Mission Activities includes six groups: Advocacy; Health, Science & Ethics; Center for Health Equity; Integrated Health Model Initiative (IHMI); Enterprise Communications; and Marketing & Member Experience (MMX).

Advocacy includes federal and state level advocacy to enact laws and advance regulations on issues important to patients and physicians; economic, statistical and market research to support advocacy efforts; political education for physicians; grassroots advocacy; and maintaining relations with the federation of medicine. Advocacy led a campaign (Reforming Medicare Pay) joined by more than 150 other organizations that helped minimize the 8.5 percent in Medicare payment cuts originally slated for 2023, and continuing to urge Congress for long-term, systemic reform through the AMA's coalition. Other major initiatives included: supporting telehealth by extending Medicare telehealth coverage through 2024; fighting scope creep by achieving more than 35 state-level scope of practice victories in strong collaboration with Federation partners; reducing physician burnout by advocating in support of passage of the Dr. Lorna Breen Health Care Provider Protection Act, which provides essential physician wellness resources and by leading a national campaign that enacted multiple state laws, changed licensing and changed credentialing questions; and tackling prior authorization by successfully advocating for unanimous passage of a federal Medicare Advantage prior authorization reform bill in one chamber during the 117th Congress, and helping to enact prior authorization reform laws in Michigan, Georgia and Iowa. In 2022, Advocacy net spending increased $2.8 million, primarily compensation expenses, travel and meeting costs as in-person meetings resumed as well as campaign costs to stop Medicare cuts.

Health, Science & Ethics is involved in developing AMA policies on scientific, public health and ethical issues for the House of Delegates (HOD) providing leadership, subject matter expertise and scientifically sound content and evidence that underpins and informs both current and future AMA initiatives in areas such as infectious disease, drug policy and opioid prescribing; overseeing maintenance of the AMA Code of Medical Ethics and publication of the AMA Journal of Ethics, AMA's online ethics journal; and managing the United States Adopted Names (USAN) program, responsible for selecting generic names for drugs by establishing logical nomenclature classifications based on pharmacological or chemical relationships (reported separately in Group Operating Results). This group continued to lead the AMA's COVID-19 efforts during 2022 by providing subject matter expertise and content, and in conjunction with the Ad Council and CDC, updated and launched the annual campaign to get vaccinated against seasonal flu. Net expenses increased $0.5 million in 2022, due to limited staff expansion and higher costs in the grant administration unit.

The AMA recognized that a key to long-term success in our strategic arcs is increasing our efforts to reduce health and health care disparities. As a result of a 2018 task force report, the AMA sought leadership to embed health equity initiatives as relevant into all strategic priorities and areas of the organization, creating a new group, the Center for Health Equity (CHE). The focus of this group is to elevate AMA's public role and responsibilities to improve health equity. In 2022, CHE expanded its efforts to establish an AMA presence in the health equity research literature with the publication of seven Social Justice Education Ed Hub modules and the continuation of the Prioritizing Equity Series; launched the *In Full Health Learning and Action Community to Advance Equitable Health in Innovation* that prioritizes investment in health innovations developed by, with, and for historically marginalized communities; launched the Peer Network for Advancing Equity through quality and safety in collaboration with Brigham & Women's Hospital and The Joint Commission to help health systems apply an equity lens to all aspects of quality and safety practices; and announced Rise to Health, a national coalition for equity in health care, co-led with the Institute for Healthcare Improvement. CHE also established AMA as an anchor mission partner for a collaborative on Chicago's west side, West Side United, and continued building staff capacity to understand concepts surrounding health equity and to operationalize equity in goal and metric setting and developing structural competency learning tools. The continued planned growth of CHE resulted in a $5.9 million increase in net expenses in 2022.

IHMI brings together experts from patient care, medical terminology, and informatics around a common framework for defining and expressing health data. IHMI has been recognized as a leading authority on clinical content standards and is contributing to the development and use of clinical content through collaboration with Health Level 7 (HL7) Fast Healthcare Interoperability Resources (FHIR), the Gravity Project and others. In 2022, IHMI completed development of a Self-Measured Blood Pressure (SMBP) software and services solution and gathered baseline data from a pilot site related to pilot population. IHMI net expenses were largely unchanged in 2022.

MMX extends the reach and impact of AMA's mission and advocacy initiatives and strengthens the AMA brand. MMX continues to take on increased oversight for managing the quality, timing and relevance of the experience physicians have at each point of interaction through AMA's digital publishing, health system engagement and member programs. MMX creates or packages AMA's content into digital formats and distributes AMA resources and thought leadership to intended audiences through owned and paid channels, raising awareness of AMA initiatives, resources and accomplishments and elevating the voice of AMA and physicians. In 2022, more than 30 million unique individuals accessed AMA's website, a 20 percent increase over the record number of users in the prior year which was driven by AMA's COVID-19 Resource Center and other compelling editorial, video and social content. The launch of AMA's Recovery Plan for America's Physicians alone generated nearly five million website users. Net expenses increased $3.3 million in 2022, largely staffing and media marketing expenses for the recovery plan launch.

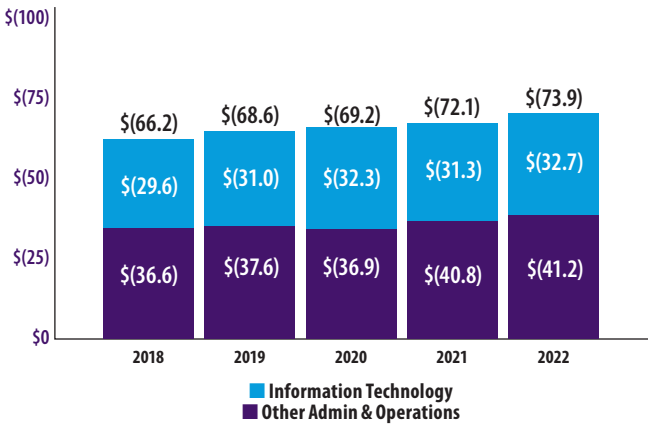
Ongoing responsibilities of the Enterprise Communications area include amplifying the work of individual operating units among their core audiences while providing consistency and alignment with the AMA narrative. Enterprise Communications distinctly communicates AMA's leading voice in science to embed equity, innovation and advocacy across the AMA's strategic work throughout health care. Net expenses were up $0.4 million in 2022, mainly related to activities celebrating AMA's 175th anniversary.

Governance

Governance includes the Board of Trustees and Board Operations, the HOD, Sections and Special Constituencies & International units. The Board of Trustees unit includes costs related to governance activities as well as expenses associated with support of the Strategic Arcs and Core Mission Activities. The HOD, Sections and Special Constituencies & International unit includes costs associated with annual and interim meetings, groups and sections and other HOD activities, as well as costs associated with AMA's involvement in the World Medical Association. In 2022, Governance net spending was up $5.6 million, mainly for resumption of in-person meeting and travel costs.

Administration and Operations

(in millions)



These units provide administrative and operational support for Publishing & Health Solutions, Membership, Strategic Arcs and Core Mission Activities, as well as other operating groups. Net expenses were up slightly in 2022, an increase of $1.8 million, or 2.5 percent, mainly inflationary cost increases.

Affiliated organizations

Affiliated Organizations represent either grant or in-kind service support provided by the AMA to other foundations and societies. In some cases, the AMA is reimbursed for services provided. No net expenses were reported in 2022.

Unallocated overhead

The net expenses in this area include costs not allocated back to operating units such as corporate insurance and actuarial services, employee incentive compensation, valuation allowances or other reserves. In 2022, these expenses totaled $20.5 million, down from $31.1 million in 2021. Lower incentive compensation was the main factor in the decrease.

Health2047 and subsidiaries

AMA owns a business formation and commercialization enterprise designed to enhance AMA's ability to define, create, develop and launch, with partners, a portfolio of products and technologies that will have a profound impact on many aspects of the U.S. health care system and population health, with a central goal of helping physicians in practice. The Board of Trustees approved the use of reserves to establish this subsidiary with plans to use third-party resources to assist in funding spinoffs with commercial potential in future years.

Health2047 funds initial projects and moves those that demonstrate commercial appeal into separate companies, along with necessary seed funding for the new companies. After the initial stage, it is expected that these companies should command additional investment from third parties to begin commercialization of the product, either through debt or equity financing. At some point in the future, the spinoffs will be sold or liquidated, at which time, AMA could expect to receive a financial return.

Since 2017, Health2047 has spun off or invested in 11 companies: Akiri, Inc. (Akiri), First Mile Care, Inc. (FMC), HXSquare, Inc. (HXS), Zing Health Enterprises, LP (Zing), Medcurio, Inc. (Medcurio), Phenomix Sciences, Inc. (Phenomix), Sitebridge Research, Inc. (Sitebridge), Emergence Healthcare Group, Inc. (Emergence), Heal Security, Inc. (Heal), Recovery Exploration Technologies, Inc. (RecoverX) and Scholar Rx, Inc. (Scholar Rx).

In 2022, Health2047 liquidated two of these companies, Akiri and HXS, as third-party financing efforts were unsuccessful. Upon liquidation of Akiri, there was an $11.6 million gain from recognizing deferred revenue and expense for a customer contract entered into and paid in 2017. There was no material gain or loss upon the HXS liquidation.

As of December 31, 2022, Health2047 has an ownership interest in nine companies, including a consolidated subsidiary, FMC, two companies accounted for using the equity method, Heal and Emergence, and six companies accounted for using the cost method, Zing, Medcurio, Phenomix, Sitebridge, RecoverX and Scholar Rx. The footnotes to AMA's financial statements include a detailed discussion on accounting for Health2047 spinoff companies.

Third-party financing is expected to cover most long-term future costs for many of these companies.

Health2047 revenue in 2022 was $14.3 million, compared to $1 million in 2021. In 2022, as a result of the Akiri liquidation, Health2047 recognized $14.3 million in revenue and $2.7 million in associated costs for creating a custom platform for a customer. Both revenue and expense had been received or incurred in prior years but were deferred until the project was completed or abandoned, which occurred in 2022.

Costs increased $3.4 million, of which $2.7 million was the recognition of deferred costs for the custom platform.

Net expenses declined by $9.9 million in 2022 to $1.4 million, primarily due to the net $11.6 million impact from recognizing the deferred revenue and expense discussed above.

The summary of group operating results is included on the following page.

American Medical Association group operating results

(in millions)	Revenues 2022	Revenues 2021	Margin (expenses) 2022	Margin (expenses) 2021
Membership	**$ 33.7**	$ 34.8	**$ 12.7**	$ 16.3
Publishing, Health Solutions & Insurance				
Publishing	**65.9**	67.7	**2.1**	9.1
Database Products	**66.9**	63.4	**54.3**	51.9
Books and Digital Content	**252.1**	233.5	**228.5**	209.1
Insurance Agency/Affinity Products	**36.4**	38.0	**17.8**	20.0
Other business operations	**-**	-	**(3.9)**	(2.6)
	421.3	402.6	**298.8**	287.5
Investments (AMA-only)	**14.1**	11.3	**13.4**	10.6
Strategic Arcs & Core Mission Activities				
Improving Health Outcomes	**-**	0.1	**(14.1)**	(14.1)
Medical Education/Accelerating Change in Medical Education	**0.3**	0.3	**(13.8)**	(12.4)
AMA Ed Hub	**0.4**	0.3	**(12.1)**	(9.6)
Professional Satisfaction and Practice Sustainability	**0.4**	0.4	**(11.4)**	(10.8)
Advocacy	**0.5**	0.5	**(28.3)**	(25.5)
Health, Science & Ethics	**2.7**	2.5	**(4.8)**	(4.3)
Center for Health Equity	**0.1**	-	**(14.9)**	(9.0)
Integrated Health Model Initiative	**-**	-	**(5.1)**	(5.1)
Marketing and Member Experience	**-**	-	**(19.1)**	(15.8)
Enterprise Communications	**-**	-	**(4.6)**	(4.2)
United States Adopted Names Program	**3.7**	4.0	**2.9**	3.3
	8.1	8.1	**(125.3)**	(107.5)
Governance				
Board of Trustees and Board Operations	**-**	-	**(6.5)**	(5.2)
House of Delegates, Sections, Special Constituencies & International	**0.1**	-	**(10.0)**	(5.7)
	0.1	-	**(16.5)**	(10.9)
Administration and Operations				
Information Technology	**-**	**-**	**(32.7)**	(31.3)
Senior Executive Management	**-**	**-**	**(5.6)**	(4.7)
General Counsel	**-**	**-**	**(6.9)**	(8.3)
Finance & Risk Management	**-**	**-**	**(7.7)**	(7.8)
Human Resources	**-**	**-**	**(8.1)**	(7.1)
Corporate Services	**-**	**-**	**(5.6)**	(5.4)
Customer Service	**-**	**-**	**(3.4)**	(3.4)
Strategic Insights and Planning	**-**	**-**	**(3.9)**	(4.1)
	-	-	**(73.9)**	(72.1)
Affiliated Organizations	**0.1**	0.1	**-**	-
Unallocated Overhead	**1.7**	1.8	**(20.5)**	(31.1)
Health2047 & Subsidiaries	**14.3**	1.0	**(1.4)**	(11.3)
Consolidated revenue and income before tax	**$ 493.4**	$ 459.7	**87.3**	81.5
Income taxes			**(4.4)**	(3.6)
Consolidated net operating income			**$ 82.9**	$ 77.9

Consolidated financial statements

American Medical Association and subsidiaries

Consolidated statements of activities

Years Ended December 31

(in millions)	2022	2021
Revenues		
Membership dues	$ 33.8	$ 34.8
Advertising	13.3	14.4
Journal print subscription revenues	2.9	3.3
Journal online revenues	30.8	31.2
Other publishing revenue	17.8	18.0
Books, newsletters and online product sales	24.7	25.5
Royalties and credentialing products	293.1	270.5
Insurance commissions	33.2	35.0
Investment income (Note 4)	15.1	11.6
Equity in losses of affiliates (Note 2)	(0.8)	(0.6)
Grants and other income	29.5	16.0
Total revenues	**493.4**	**459.7**
Expenses		
Cost of products sold and selling expenses	30.6	25.9
Contribution to general and administrative expenses	**462.8**	**433.8**
General and administrative expenses		
Compensation and benefits	234.7	233.3
Occupancy	21.4	21.1
Travel and meetings	14.7	3.6
Technology costs	29.5	28.0
Marketing and promotion	21.3	18.1
Professional services	29.2	28.7
Other operating expenses	24.7	19.5
Total general and administrative expenses	**375.5**	**352.3**
Operating results before income taxes	87.3	81.5
Income taxes (Note 9)	4.4	3.6
Net operating results	**82.9**	**77.9**
Non-operating items		
Net (loss) gain on investments (Note 4)	(115.1)	82.8
Defined benefit postretirement plan non-service periodic expense (Note 8)	(3.5)	(3.9)
Other non-operating income	0.7	0.6
Total non-operating items	**(117.9)**	**79.5**
Revenues (less than) in excess of expenses	**(35.0)**	**157.4**
Changes in defined benefit postretirement plans, other than periodic expense, net of tax (Notes 8 and 9)	29.4	5.6
Change in association equity	**(5.6)**	**163.0**
Change in donor restricted association equity		
Restricted contributions	0.4	0.3
Net assets released from restriction	(0.3)	(0.4)
Change in association equity – donor restricted	**0.1**	**(0.1)**
Change in total association equity	**(5.5)**	**162.9**
Total association equity at beginning of year	894.9	732.0
Total association equity at end of year	**$ 889.4**	**$ 894.9**

See accompanying notes to the consolidated financial statements.

American Medical Association and subsidiaries

Consolidated statements of financial position

As of December 31

(in millions)	2022	2021
Assets		
Cash, cash equivalents and donor-restricted cash	$ 33.5	$ 32.1
Fiduciary funds (Note 2)	22.1	22.5
Investments in affiliates (Note 2)	8.9	7.0
Accounts receivable and other receivables, net of an allowance for doubtful accounts of $0.3 in 2022 and $0.2 in 2021	101.5	88.5
Inventories	2.8	1.7
Prepaid expenses and deposits	11.7	13.0
Deferred income taxes (Note 9)	2.7	4.7
Investments (Note 4)	933.2	1,006.6
Property and equipment, net (Note 6)	33.3	39.6
Operating lease right-of-use assets (Note 10)	39.1	46.0
Other assets (Note 5)	8.2	9.4
	$ 1,197.0	**$ 1,271.1**
Liabilities, deferred revenue and association equity		
Liabilities		
Accounts payable, accrued expenses and other liabilities	$ 16.0	$ 18.6
Accrued payroll and employee benefits (Note 7)	45.7	54.6
Accrued postretirement healthcare benefits (Note 8)	88.1	117.5
Insurance premiums and other fiduciary funds payable	22.1	22.4
Operating lease liability (Note 10)	65.3	76.7
	237.2	289.8
Deferred revenue		
Membership dues	13.9	14.6
Subscriptions, licensing, insurance commissions and royalties	53.9	69.4
Grants and other	2.6	2.4
	70.4	86.4
Association equity	889.3	894.9
Donor-restricted association equity	0.1	-
Total association equity	889.4	894.9
	$ 1,197.0	**$ 1,271.1**

See accompanying notes to the consolidated financial statements.

American Medical Association and subsidiaries

Consolidated statements of cash flows

Years Ended December 31

(in millions)	2022	2021
Cash flows from operating activities		
Change in total association equity	$ (5.5)	$ 162.9
Adjustments to reconcile change in association equity to net cash provided by operating activities		
Depreciation and amortization	12.2	12.3
Postretirement health care expense	4.6	5.3
Noncash operating lease expense	9.7	10.1
Net loss (gain) on investments	115.1	(82.8)
Equity in losses of affiliates	0.8	0.6
Noncash credit for changes in defined benefit plans other than periodic expense net of tax	(29.4)	(5.6)
Noncash credit from recognition of deferred revenue and costs related to liquidation of subsidiary	(11.6)	-
Bad debt expense	0.1	(0.2)
Other	(1.3)	(1.1)
Changes in assets and liabilities		
Accounts receivable and other receivables	(13.1)	(5.5)
Inventories	(1.1)	0.6
Prepaid expenses and deposits	1.0	(1.8)
Accounts payable, accrued liabilities and income taxes	(22.5)	(9.4)
Accrued postretirement benefit costs	(2.7)	(2.4)
Deferred revenue	(1.7)	(1.4)
Net cash provided by operating activities	54.6	81.6
Cash flows from investing activities		
Purchase of property and equipment	(9.2)	(8.6)
Investment in affiliates	(2.3)	(6.3)
Purchase of investments	(538.3)	(662.6)
Proceeds from sale of investments	496.6	593.0
Net cash used in investing activities	(53.2)	(84.5)
Net change in cash, cash equivalents and donor restricted cash	**1.4**	**(2.9)**
Cash, cash equivalents and donor restricted cash at beginning of year	32.1	35.0
Cash, cash equivalents and donor restricted cash at end of year	**$ 33.5**	**$ 32.1**
Noncash operating activities		
Right-of-use assets obtained in exchange for lease obligation	$ 0.5	$ -
Noncash investing activities		
Accounts payable for property and equipment additions	$ 0.3	$ 0.9

See accompanying notes to the consolidated financial statements.

Notes to consolidated financial statements

For the years ended December 31, 2022 and 2021
(Columnar amounts in millions)

1. Nature of operations

The American Medical Association (AMA) is a national professional association of physicians with approximately 275 thousand members. The AMA serves the medical community and the public through standard setting and implementation in the areas of science, medical education, improving health outcomes, health equity, delivery and payment systems, ethics, representation and advocacy, policy development, and image and identity building. The AMA provides information and services to hundreds of thousands of physicians and includes journal and book publishing, physician credentialing, database licensing, insurance and other professional services for physicians.

The AMA classifies all operating results as revenues and expenses in the consolidated statements of activities. Non-operating items include net realized and unrealized gains and losses on investments, defined benefit postretirement plan non-service expense and other non-recurring income or expense.

Donor-restricted association equity includes contributions restricted for use for scope of practice program which are not available for general use by AMA.

2. Significant accounting policies

Consolidation policy

The accompanying consolidated financial statements include the accounts of the AMA and its subsidiaries, AMA Services, Inc., American Medical Assurance Company and Health2047 Inc. (collectively, the AMA).

AMA, through its wholly owned subsidiary, Health2047 Inc. (Health2047), has investments in nine companies or limited partnerships as of December 31, 2022. Health2047 controls and therefore consolidates the results of two companies, First Mile Care, Inc. as well as Akiri, Inc. (Akiri). Akiri was liquidated during 2022 resulting in recognition of $14.3 million of deferred revenue, in grants and other income, and $2.7 million of deferred costs, in cost of products sold and selling expenses, related to completion of a customer contract entered into during 2017.

The equity method of accounting is used to account for investments in companies or limited partnerships in which the AMA has significant influence but not overall control. The investments are initially recorded at the original amounts paid for common and convertible preferred stock, and subsequently adjusted for the AMA's share of undistributed earnings and losses from the underlying entities from the dates of formation. Each investment will be increased or reduced by any future additional contributions and distributions received, respectively. The cost method of accounting is used to account for investments in companies in which the AMA has neither significant influence nor overall control and where the fair value is not readily determinable.

The companies accounted for under the equity method of accounting during 2022 are: HXSquare, Inc. (formed in January 2019 and liquidated in February 2022), Emergence Healthcare Group, Inc. (formed in January 2021), Heal Security, Inc. (formed in February 2021), and Recovery Exploration Technologies, Inc. (formed in August 2021). During 2022, the AMA ceased application of the equity method to account for the investment in Recovery Exploration Technologies, Inc. as additional third-party investment resulted in AMA no longer exercising significant influence over this entity.

At December 31, 2022, AMA ownership interest is 20.1% in Emergence Healthcare Group, Inc. and 33.3% in Heal Security, Inc. The book value of the two investments accounted for under the equity method, net of convertible debt, at December 31, 2022 is $1.8 million.

In addition, at December 31, 2022, AMA has an ownership interest of 3.6% in Zing Health Enterprises, LP (formed in May 2020), 12.1% in Medcurio Inc., (formed in February 2020), 12.6% in Phenomix Sciences, Inc. (formed in August 2020), 11.3% in Recovery Exploration Technologies, Inc., 18.8% in Sitebridge Research, Inc. (formed January 2021), and 6.0% in Scholar Rx, Inc. (formed December 2022). The investments in these entities are accounted for using the cost method, as AMA holds less than a 20% ownership and does not exercise significant influence over the entities. The book value of the six investments carried at cost at December 31, 2022 is $7.1 million.

Health2047 had investments in ten companies or limited partnerships as of December 31, 2021, including two that were consolidated, First Mile Care, Inc. and Akiri, Inc. The companies accounted for under the equity method of accounting during 2021 were: HXSquare, Inc., Phenomix Sciences, Inc., Emergence Healthcare Group, Inc., Heal Security, Inc., and Recovery Exploration Technologies, Inc. During 2021, the AMA ceased application of the equity method to account for the investment in Phenomix Sciences, Inc. as additional third-party investment resulted in AMA no longer exercising significant influence over this entity.

At December 31, 2021 AMA ownership interest was 20% in HXSquare, Inc., 21.9% in Emergence Healthcare Group, Inc., 33.3% in Heal Security, Inc. and 22.6% in Recovery Exploration Technologies, Inc. The book value of the four investments accounted for under the equity method, net of convertible debt, at December 31, 2021 was $2.4 million.

In addition, at December 31, 2021, AMA had an ownership interest of 5.5% in Zing Health Enterprises, LP, 11.8% in Medcurio Inc., 14.4% in Phenomix Sciences, Inc. and 18.8% in Sitebridge Research, Inc. The investments in these entities were accounted for using the cost method, as AMA held less than a 20% ownership and did not exercise significant influence over the entities. The book value of the four investments carried at cost at December 31, 2021 was $4.6 million.

Use of estimates

Preparation of consolidated financial statements in conformity with accounting principles generally accepted (GAAP) in the United States of America requires management to make estimates and assumptions that affect reported amounts of assets, liabilities, revenues and expenses as reflected in the consolidated financial statements. Actual results could differ from estimates.

Cash equivalents

Cash equivalents consist of liquid investments with original maturities of three months or less and are recorded at cost, which approximates fair value.

Fiduciary funds

One of the AMA's subsidiaries, the AMA Insurance Agency, Inc., in its capacity as an insurance broker, collects premiums from the insured and, after deducting its commission, remits the premiums to the underwriter of the insurance coverage. Unremitted insurance premiums are invested on a short-term basis and are held in a fiduciary capacity. The AMA also collects and holds contributions on behalf of separate unincorporated entities with $2.3 million and $2.8 million held at December 31, 2022 and 2021, respectively.

Inventories

Inventories, consisting primarily of books and paper for publications, are valued at the lower of cost or net realizable value.

Property and equipment

Property and equipment are carried at cost, less accumulated depreciation and amortization. Depreciation and amortization are computed using the straight-line method over the estimated useful lives of the assets. Equipment and software are depreciated or amortized over three to 10 years. Leasehold improvements are depreciated over the shorter of the estimated useful lives or the remaining lease term.

Revenue recognition

Revenue is recognized upon transfer of control of promised products or services to customers in an amount that reflects the consideration that AMA expects to receive in exchange for those products or services. AMA enters into contracts that generally include only one product or service and as such, are distinct and accounted for as separate performance obligations. Revenue is recognized net of allowances for returns and any taxes collected from customers, which are subsequently remitted to governmental authorities.

Nature of products and services

Membership dues are deferred and recognized as revenue in equal monthly amounts during the applicable membership year, which is a calendar year. Dues from lifetime memberships are recognized as revenue over the approximate life of the member.

Licensing and subscriptions to scientific journals, site licenses, newsletters or other online products are recognized as revenue ratably over the terms of the subscriptions or service period. Advertising revenue and direct publication costs are recognized in the period the related journal is issued. Book and product sales are recognized at the time the book or product is shipped or otherwise delivered to the customer. Royalties are recognized as revenue over the royalty term. Insurance brokerage commissions on individual policies are recognized as revenue on the date they become effective or are renewed, to the extent services under the policies are complete. Brokerage commissions or plan rebates on the group products are recognized as revenue ratably over the term of the contract as services are rendered.

Contract balances

AMA records a receivable when the performance obligation is satisfied and revenue is recognized. For agreements covering subscription or service periods, AMA generally records a receivable related to revenue recognized for the subscription, license or royalty period. For sales of books and products, AMA records a receivable at the time the product is shipped or otherwise delivered to the customer. These amounts are included in accounts receivable on the consolidated statements of financial position and the balance, net of allowance for doubtful accounts, was $96.3 million and $85.1 million as of December 31, 2022 and 2021, respectively.

The allowance for doubtful accounts reflects AMA's best estimate of probable losses inherent in the accounts receivable balance. The allowance is based on historical experience and other currently available evidence.

Payment terms and conditions vary by contract type, although terms generally include a requirement of payment within 30 to 60 days. Some annual licensing agreements carry longer payment terms. In instances where the timing of revenue recognition differs from the timing of invoicing, AMA has determined that these contracts generally do not include a significant financing component.

Prepaid dues are included as deferred membership dues revenue in the consolidated statements of financial position. Prepayments by customers in advance of the subscription, royalty or insurance coverage period are recorded as deferred subscriptions, licensing, insurance commissions and royalty revenue in the consolidated statements of financial position.

Income taxes

The AMA is an exempt organization as defined by Section 501(c)(6) of the Internal Revenue Code and is subject to income taxes only on income determined to be unrelated business taxable income. The AMA's subsidiaries are taxable entities and are subject to income taxes.

3. New accounting standards update

In August 2020, Financial Accounting Standards Board (FASB) issued Accounting Standards Update No. 2020-06, *Debt — Debt with Conversion and Other Options (Subtopic 470-20) and Derivatives and Hedging — Contracts in Entity's Own Equity (Subtopic 815-40) — Accounting for Convertible Instruments and Contracts in an Entity's Own Equity*. The amendments in this update are expected to improve, simplify, and enhance the financial reporting requirements for convertible instruments and contracts in an entity's own equity for all entities, including private companies. The new guidance is effective for the AMA for the year ending December 31, 2024. AMA does not expect there to be a material impact on the consolidated financial statements upon adoption.

4. Investments

Investments include marketable securities, venture capital and private equity investments that are carried at fair value.

In determining fair value, the AMA uses various valuation approaches. The FASB's Accounting Standards Codification (ASC) Topic 820, *Fair Value Measurements and Disclosures*, establishes a hierarchy for inputs used in measuring fair value that maximizes the use of observable inputs and minimizes the use of unobservable inputs by requiring that the most observable inputs be used when available. Observable inputs are inputs that market participants would use in pricing the asset based on market data obtained from sources independent of the organization. Unobservable inputs are inputs that would reflect an organization's assumptions about the assumptions market participants would use in pricing the asset developed based on the best information available in the circumstances. The hierarchy is broken down into three levels based on the observability of inputs as follows:

Level 1 — Valuations based on quoted prices in active markets for identical assets that the organization has the ability to access. Since valuations are based on quoted prices that are readily and regularly available in an active market, valuation of these products does not entail a significant degree of judgment.

Level 2 — Valuations based on one or more quoted prices in markets that are not active or for which all significant inputs are observable, either directly or indirectly.

Level 3 — Valuations based on inputs that are unobservable and significant to the overall fair value measurement.

The availability of observable inputs can vary from instrument to instrument and is affected by a wide variety of factors, including, for example, the liquidity of markets and other characteristics particular to the transaction. To the extent that valuation is based on models or inputs that are less observable or unobservable in the market, the determination of fair value requires more judgment.

The AMA uses prices and inputs that are current as of the measurement date, obtained through a third-party custodian from independent pricing services.

A description of the valuation techniques applied to the major categories of investments measured at fair value is outlined below.

Exchange-traded equity securities are valued based on quoted prices from the exchange. To the extent these securities are actively traded, valuation adjustments are not applied and they are categorized in Level 1 of the fair value hierarchy.

Mutual funds are open-ended Securities and Exchange Commission (SEC) registered investment funds with a daily net asset value (NAV). The mutual funds allow investors to sell their interests to the fund at the published daily NAV, with no restrictions on redemptions. These mutual funds are categorized in Level 1 of the fair value hierarchy.

The fair value of corporate debt securities is estimated using recently executed transactions, market price quotations (where observable) or bond spreads. If the spread data does not reference the issuer, then data that reference a comparable issuer are used. Corporate debt securities are generally categorized in Level 2 of the fair value hierarchy.

U.S. government agency securities consist of two categories of agency issued debt. Non-callable agency issued debt securities are generally valued using dealer quotes. Callable agency issued debt securities are valued by benchmarking model-derived prices to quoted market prices and trade data for identical or comparable securities. Agency issued debt securities are categorized in Level 2 of the fair value hierarchy.

U.S. government securities are valued using quoted prices provided by a vendor or broker-dealer. These securities are categorized in Level 2 of the fair value hierarchy, as it is difficult for the custodian to accurately assess at a security level whether a quoted trade on a bond represents an active market.

Foreign and U.S. state government securities are valued using quoted prices in active markets when available. To the extent quoted prices are not available, fair value is determined based on interest rate yield curves, cross-currency basis index spreads, and country credit spreads for structures similar to the bond in terms of issuer, maturity and seniority. These investments are generally categorized in Level 2 of the fair value hierarchy.

Investments also include investments in a diversified closed end private equity fund with a focus on buyout and secondary market opportunities in the United States and the European Union, as well as investments in a venture capital fund focused on companies developing promising health care technologies that can be commercialized into revolutionary products and services that improve the practice of medicine and the delivery and management of health care. The investments are not redeemable and distributions are received through liquidation of the underlying assets of the funds. It is estimated that the underlying assets will be liquidated over the next four to ten years. The fair value estimates of these investments are based on NAV as provided by the investment manager. Unfunded commitments as of December 31, 2022, and 2021 totaled $80.1 million and $76.4 million, respectively.

The AMA manages its investments in accordance with Board-approved investment policies that establish investment objectives of real inflation-adjusted growth over the investment time horizon, with diversification to provide a balance between long-term growth objectives and potential liquidity needs.

The following table presents information about the AMA's investments measured at fair value as of December 31. In accordance with ASC Subtopic 820-10, investments that are measured at fair value using the NAV per share (or its equivalent) practical expedient have not been classified in the fair value hierarchy. The fair value amounts presented in this table are intended to permit reconciliation of the fair value hierarchy to the amounts presented in the consolidated statements of financial position.

	2022	2021
Level 1 – Quoted prices in active market for identical securities		
Equity securities	$ 419.9	$ 474.6
Fixed-income mutual funds	27.1	48.9
	447.0	523.5
Level 2 – Significant other observable inputs		
Debt securities		
Corporate	106.7	116.0
U.S. government and federal agency	264.8	269.1
Foreign government	24.7	28.7
U.S. state government	0.1	0.2
	396.3	414.0
Other investments measured at NAV – Private equity and venture capital funds	89.9	69.1
Investments	$ 933.2	$ 1,006.6

Interest and dividends are included in investment income as operating revenue while realized and unrealized gains and losses are included as a component of non-operating items.

Investment income consists of:

	2022	2021
Investment dividend and interest income	$ 18.3	$ 15.1
Management fees	(3.2)	(3.5)
	$ 15.1	$ 11.6

Investment non-operating items include:

	2022	2021
Realized gains on investments, net	$ 6.4	$ 74.8
Unrealized (losses) gains on investments, net	(121.5)	8.0
	$ (115.1)	$ 82.8

5. Other assets

Other assets include investments in mutual funds maintained in separate accounts designated for various nonqualified benefit plans that are not available for operations. Mutual funds are open-ended SEC registered investment funds with a daily NAV. The mutual funds allow investors to sell their interests to the fund at the published daily NAV, with no restrictions on redemptions. These mutual funds are categorized in Level 1 of the fair value hierarchy. The investments totaled $8.2 million and $9.4 million as of December 31, 2022 and 2021, respectively.

6. Property and equipment

Property and equipment at December 31 consists of:

	2022	2021
Leasehold improvements	$ 39.0	$ 38.7
Furniture and office equipment	19.9	19.7
Information technology		
Hardware	12.9	13.5
Software	94.4	97.6
	166.2	169.5
Accumulated depreciation and amortization	(132.9)	(129.9)
Property and equipment, net	$ 33.3	$ 39.6

7. Retirement savings plans

The AMA has a 401(k) retirement and savings plan, which allows eligible employees to contribute up to 75 percent of their compensation annually, subject to Internal Revenue Service (IRS) limits. The AMA matches 100 percent of the first three percent and 50 percent of the next two percent of employee contributions. The AMA may, at its discretion, make additional contributions for any year in an amount up to two percent of the compensation for each eligible employee. Compensation is subject to IRS limits and excludes bonuses and severance pay. AMA matching and discretionary contribution expense totaled $8.3 million and $7.9 million in 2022 and 2021, respectively.

8. Postretirement health care benefits

The AMA provides health care benefits to retired employees who were employed on or prior to December 31, 2010. After that date, no individual can become a participant in the plan. Generally, qualified employees become eligible for these benefits if they retire in accordance with the plan provisions and are participating in the AMA medical plan at the time of their retirement. The AMA shares the cost of the retiree health care payments with retirees, paying approximately 60 to 80 percent of the expected benefit payments. The AMA has the right to modify or terminate the postretirement benefit plan at any time. Other employers participate in this plan and liabilities are allocated between the AMA and the other employers.

The AMA has applied for and received the federal subsidy to sponsors of retiree health care benefit plans that provides a prescription drug benefit that is actuarially equivalent to Medicare Part D under the *Medicare Prescription Drug, Improvement and Modernization Act of 2003*. In accordance with ASC Topic 958-715, *Compensation-Retirement Benefits*, the AMA initially accounted for the subsidy as an actuarial experience gain to the accumulated postretirement benefit obligation.

The postretirement health care plan is unfunded. In accordance with ASC Topic 958-715, the AMA recognizes this liability in its consolidated statements of financial position.

The following reconciles the change in accumulated benefit obligation and the amounts included in the consolidated statements of financial position at December 31:

	2022	2021
Benefit obligation at beginning of year	$ 117.5	$ 120.5
Service cost	1.1	1.5
Interest cost	3.1	2.8
Benefits paid	(4.1)	(3.8)
Participant contributions	1.2	1.2
Federal subsidy	0.2	0.2
Actuarial gain	(30.9)	(4.9)
Accrued postretirement benefit costs	$ 88.1	$ 117.5

The postretirement health care plan accumulated losses not yet recognized as a component of periodic postretirement health care expense, but included as an accumulated charge or credit to equity as of December 31 are:

	2022	2021
Actuarial (gains) losses	$ (9.7)	$ 21.6

Actuarial assumptions used in determining the accumulated benefit obligation at December 31 are:

	2022	2021
Discount rate	5.2%	2.8%
Initial health care cost trend	7.0%	6.1%
Ultimate health care cost trend	4.0%	4.0%
Year that the rate reaches the ultimate trend rate	2046	2045

AMA recognizes postretirement health care expense in its consolidated statements of activities. The service cost component is included as part of compensation and benefits expense and the other components of expense are recognized as a non-operating item:

	2022	2021
Service cost	$ 1.1	$ 1.4
Interest cost	3.1	2.8
Amortization of prior service credit	-	(0.3)
Amortization of actuarial loss	0.4	1.4
	$ 4.6	$ 5.3

Postretirement health care-related changes, other than periodic expense, that have been included as a charge or credit to unrestricted equity consist of:

	2022	2021
Actuarial gains arising during period	$ 30.9	$ 4.8
Reclassification adjustment for recognition of actuarial loss	0.4	1.4
Reclassification adjustment for recognition of prior service credit	-	(0.3)
Change in unrestricted equity	$ 31.3	$ 5.9

Actuarial assumptions used in determining postretirement health care expense are the same assumptions noted in the table above for determining the accumulated benefit obligation, except as follows:

	2022	2021
Discount rate	2.8%	2.5%
Initial health care cost trend	6.1%	5.64%

The following postretirement health care benefit payments are expected to be paid by the AMA, net of contributions by retirees and federal subsidies:

2023	$ 3.6
2024	3.7
2025	4.1
2026	4.3
2027	4.6
2028 – 2032	26.0

9. Income taxes

The provision for income taxes includes:

	2022	2021
Operating		
Current	$ 4.3	$ 3.7
Deferred	(21.4)	0.1
Valuation allowance	21.5	(0.2)
	4.4	3.6
Tax expense related to credits or charges to equity		
Deferred	1.9	0.3
	$ 6.3	$ 3.9

As prescribed under ASC Topic 740, *Income Taxes*, the AMA determines its provision for income taxes using the asset and liability method. Under this method, deferred tax assets and liabilities are recognized for future tax effects of temporary differences between the consolidated financial statement carrying amounts of existing assets and liabilities and their respective tax basis.

The deferred tax benefit or charge from credits or charges to equity represents the estimated tax benefit from recording unrecognized actuarial losses and prior service credits for the postretirement health care plan, pursuant to ASC Topic 958-715.

Valuation allowances are provided to reduce deferred tax assets to an amount that is more likely than not to be realized. The AMA evaluates the likelihood of realizing its deferred tax assets by estimating sources of future taxable income and assessing whether or not it is likely that future taxable income will be adequate for the AMA to realize the deferred tax asset. The AMA established an initial valuation allowance in 2009 to reflect the fact that deferred tax assets include future expected benefits, largely related to retiree health care payments, that may not be deductible due to a projected lack of taxable advertising income in future years. Increases or decreases in deferred tax assets, where future benefits are considered unlikely, will result in an equal and offsetting change in the valuation reserve. If the AMA were to make a determination in future years that these deferred tax assets would be realized, the related valuation allowance would be reduced and a benefit to earnings recorded.

Deferred tax assets recognized in the consolidated statements of financial position at December 31 are:

	2022	2021
Net operating loss carryforward	$ 21.4	$ -
Benefit plans and compensation	5.2	7.3
Other	0.1	(0.1)
	26.7	7.2
Valuation allowance	(24.0)	(2.5)
	$ 2.7	$ 4.7

Cash payments for income taxes were $4 million and $6.2 million in 2022 and 2021, respectively, net of refunds.

10. Leases

AMA leases office space at a number of locations and the initial terms of the office leases range from five years to 15 years. Most leases have options to renew at then prevailing market rates, or, in one circumstance, early terminate with appropriate notice and termination payments. As any extension, renewal, or termination is at the sole discretion of AMA, and at this date is not certain, renewal and termination options are not included in the right-of-use (ROU) asset or lease liability.

AMA leases do not provide an implicit interest rate and as such, AMA calculates the lease liability at lease commencement or remeasurement date as the present value of unpaid lease payments using an estimated incremental borrowing rate. The incremental borrowing rate represents the rate of interest that AMA estimates it would have to pay to borrow an amount equal to the lease payments on a collateralized basis over a similar term, based on information available at the time of commencement or remeasurement.

AMA exercised a contraction option during 2022 reducing the square footage at the main headquarters by approximately 10%, with a contraction penalty. The ROU asset and lease liability were remeasured as of the lease modification date and the impact of the contraction is reflected in the ROU asset and lease liability as of December 31, 2022. ROU assets decreased $1.3 million, lease liabilities decreased $2.3 million, with the resulting net gain of $1 million included as a reduction to other operating expense. AMA also leases copiers and printers in several locations. The lease agreements do not contain variable lease payments, residual value guarantees or material restrictive covenants. All office and equipment leases are classified as operating leases.

Operating lease costs totaled $9.7 million in 2022 and $10.1 million in 2021. Cash paid for amounts included in the measurement of lease liabilities totaled $13.2 million in 2022 and $13.1 million in 2021.

The remaining weighted-average lease term is 6.3 years and 7.1 years as of December 31, 2022 and 2021, respectively. The weighted-average discount rate used for operating leases is 5% for both 2022 and 2021.

The maturity of lease liabilities as of December 31, 2022:

2023	$ 15.3
2024	11.4
2025	11.4
2026	11.6
2027	11.8
2028 and beyond	14.5
Total lease payments	76.0
Less imputed interest	(10.7)
Present value of lease obligations	$ 65.3

11. Financial asset availability and liquidity

AMA has a formal reserve policy that defines the reserve investment portfolios as pools of liquid net assets that can be accessed to mitigate the impact of undesirable financial events or to pursue opportunities of strategic importance that may arise, as well as provide a source of capital appreciation. The policy establishes minimum required dollar levels required to be held in the portfolios (defined as an amount equal to one-year's general and administrative operating expenses plus long-term liabilities). The policy also covers the use of dividend and interest income, establishes criteria for use of the funds and outlines the handling of excess operating funds on an annual basis.

Dividend and interest income generated from the reserve portfolios are transferred to operating funds monthly and used to fund operations. The formal reserve policy contemplates use of reserve portfolio funds for board approved time- or dollar-limited strategic outlays, to the extent that the reserve portfolio balances exceed the minimum amount established by policy. All surplus funds generated from operations annually (defined as operating cash plus other current assets minus current liabilities and deferred revenue at year end) are transferred to the reserve portfolios after year-end. The reserve policy does not cover the for-profit subsidiaries' activities.

AMA invests cash in excess of projected weekly requirements in short-term investments and money market funds. AMA does not maintain any credit facilities as the reserve portfolios provide ample protection against any liquidity needs.

The following reflects AMA's financial assets as of December 31 reduced by amounts not available for general use that have been set aside for long-term investing in the reserve investment portfolios or funds subject to donor restrictions. AMA's financial assets include cash, cash equivalents and donor restricted cash, short-term investments and long-term investments in the reserve portfolios.

	2022	2021
Financial assets	$ 966.7	$ 1,038.7
Less assets unavailable for general expenditures:		
Restricted by governing body primarily for long-term investing or for governing body approved outlays	(841.4)	(887.6)
Financial assets available to meet cash needs for general expenditures within one year	$ 125.3	$ 151.1

In addition to financial assets available to meet general expenditures over the next 12 months, the AMA operates under a policy that requires an annual budget surplus, excluding time- or dollar-limited strategic expenditures approved by the board, and anticipates generating sufficient revenue to cover general ongoing expenditures on an annual basis.

12. Contingencies

In the opinion of management, there are no pending legal actions for which the ultimate liability will have a material effect on the equity of the AMA.

13. Subsequent events

ASC Topic 855, *Subsequent Events,* establishes general standards of accounting for and disclosure of events that occur after the consolidated balance sheet date but before consolidated financial statements are issued or are available to be issued.

For the year ended December 31, 2022, the AMA has evaluated all subsequent events through February 10, 2023, which is the date the consolidated financial statements were available to be issued, and concluded no additional subsequent events have occurred that would require recognition or disclosure in these consolidated financial statements that have not already been accounted for.

14. Functional expenses

The costs of providing program and other activities have been summarized on a functional basis in the consolidated statements of activities. Certain costs have been allocated among the Strategic Arcs and Core Mission Activities, Publishing, Health Solutions and Insurance, Membership and other supporting services.

The expenses that are allocated and the method of allocation include the following: fringe benefits based on percentage of compensation and occupancy based on square footage. All other expenses are direct expenses of each functional area.

	Membership	Publishing, Health Solutions and Insurance	Investments (AMA only)	Strategic Arcs and Core Mission Activities	Governance, Administration and Operations	Health2047 and Subsidiaries	Total
Cost of products sold and selling expense	$ -	$ 27.9	$ -	$ -	$ -	$ 2.7	$ 30.6
Compensation and benefits	6.4	65.1	-	78.1	78.1	7.0	234.7
Occupancy	0.4	5.7	-	6.9	7.1	1.3	21.4
Travel and meetings	0.1	2.6	-	4.5	7.2	0.3	14.7
Technology costs	1.0	11.0	-	7.1	10.3	0.1	29.5
Marketing and promotion	11.7	0.1	-	7.3	1.6	0.6	21.3
Professional services	0.4	4.2	0.3	17.5	3.8	3.0	29.2
Other operating expense	1.0	5.9	0.4	12.0	4.7	0.7	24.7
2022 total expense	**$ 21.0**	**$ 122.5**	**$ 0.7**	**$ 133.4**	**$ 112.8**	**$ 15.7**	**$ 406.1**
Cost of products sold and selling expense	$ -	$ 25.9	$ -	$ -	$ -	$ -	$ 25.9
Compensation and benefits	5.8	62.4	-	70.1	88.5	6.5	233.3
Occupancy	0.5	5.6	-	6.7	6.8	1.5	21.1
Travel and meetings	-	0.6	-	1.1	1.8	0.1	3.6
Technology costs	1.6	10.4	-	6.3	9.7	-	28.0
Marketing and promotion	9.6	0.4	-	7.5	0.1	0.5	18.1
Professional services	0.1	4.5	0.3	16.6	4.7	2.5	28.7
Other operating expense	0.9	5.3	0.4	8.9	2.8	1.2	19.5
2021 total expense	**$ 18.5**	**$ 115.1**	**$ 0.7**	**$ 117.2**	**$ 114.4**	**$ 12.3**	**$ 378.2**

Independent auditor's report

The Board of Trustees of American Medical Association

Opinion

We have audited the consolidated financial statements of the American Medical Association (the "AMA") and subsidiaries, which comprise the consolidated statements of financial position as of December 31, 2022 and 2021, and the related consolidated statements of activities and cash flows for the years then ended, and the related notes to the consolidated financial statements (collectively referred to as the "financial statements").

In our opinion, the accompanying financial statements present fairly, in all material respects, the financial position of the AMA as of December 31, 2022 and 2021, and the results of its operations and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Basis for Opinion

We conducted our audits in accordance with auditing standards generally accepted in the United States of America (GAAS). Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of the AMA and to meet our other ethical responsibilities, in accordance with the relevant ethical requirements relating to our audits. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Responsibilities of Management for the Financial Statements

Management is responsible for the preparation and fair presentation of the financial statements in accordance with accounting principles generally accepted in the United States of America, and for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about the AMA's ability to continue as a going concern for one year after the date that the financial statements are available to be issued.

Auditor's Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with GAAS will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the financial statements.

In performing an audit in accordance with GAAS, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the AMA's internal control. Accordingly, no such opinion is expressed.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about the AMA's ability to continue as a going concern for a reasonable period of time.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control-related matters that we identified during the audit.

Deloitte & Touche LLP
Chicago, Illinois
February 10, 2023

Written statement of certification of chief executive officer and chief financial officer

The undersigned hereby certify that the information contained in the consolidated financial statements of the American Medical Association for the years ended December 31, 2022 and 2021 fairly present, in all material respects, the financial condition and the results of operations of the American Medical Association.

James L. Madara, MD
Executive Vice President and Chief Executive Officer

Denise M. Hagerty
Senior Vice President and Chief Financial Officer

February 10, 2023

2022–2023 Board of Trustees and Executive Leadership

Board of Trustees

Jack Resneck Jr., MD
President

Jesse M. Ehrenfeld, MD, MPH
President-elect

Gerald E. Harmon, MD
Immediate Past President

Bruce A. Scott, MD
Speaker, AMA House of Delegates

Lisa Bohman Egbert, MD
Vice Speaker, AMA House of Delegates

Sandra Adamson Fryhofer, MD
Chair

Willie Underwood III, MD, MSc, MPH
Chair-elect

Bobby Mukkamala, MD
Immediate Past Chair

Michael Suk, MD, JD, MPH, MBA
Secretary

David H. Aizuss, MD

Toluwalase A. Ajayi, MD

Madelyn E. Butler, MD

Alexander Ding, MD, MS, MBA

Willarda V. Edwards, MD, MBA

Scott Ferguson, MD

Drayton Charles Harvey

Marilyn J. Heine, MD

Pratistha Koirala, MD, PhD

Ilse R. Levin, DO, MPH & TM

Thomas J. Madejski, MD

Harris Pastides, PhD, MPH

Executive Management

James L. Madara, MD
CEO and Executive Vice President

Standing Committees

Executive Committee

Dr. Fryhofer, *chair*

Dr. Underwood

Dr. Resneck

Dr. Ehrenfeld

Dr. Harmon

Dr. Suk

Dr. Scott

Dr. Mukkamala

Audit Committee

Dr. Harmon, *chair*

Dr. Aizuss

Dr. Butler

Dr. Madejski

Dr. Pastides

Dr. Scott

Dr. Suk

Awards and Nominations

Dr. Madejski, *chair*

Dr. Ajayi, MD

Dr. Egbert

Mr. Harvey

Dr. Heine

Dr. Koirala

Dr. Levin

Compensation Committee

Dr. Ehrenfeld, *chair*

Dr. Ferguson

Dr. Fryhofer *(ex-officio w/vote)*

Dr. Mukkamala *(ex-officio w/vote)*

Dr. Scott

Dr. Suk

Dr. Underwood *(ex-officio w/vote)*

Finance Committee

Dr. Suk, *chair*

Dr. Aizuss

Dr. Butler

Dr. Ding

Dr. Edwards

Dr. Ehrenfeld

Dr. Ferguson

Governance and Self-Assessment Committee

Dr. Harmon, *chair*

Dr. Ehrenfeld

Dr. Fryhofer

Dr. Madejski

Dr. Suk

Note: Drs. Fryhofer, Underwood and Mukkamala serve on all committees, except where otherwise noted, as ex-officio members without vote. Dr. Resneck serves on all committees as an ex-officio member with vote.

Jack Resneck Jr., MD

Jesse M. Ehrenfeld, MD, MPH

Gerald E. Harmon, MD

Bruce A. Scott, MD

Lisa Bohman Egbert, MD

Sandra Adamson Fryhofer, MD

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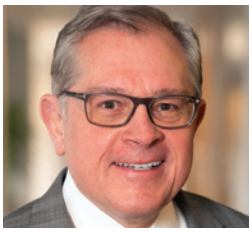


James L. Madara, MD

REPORT OF THE BOARD OF TRUSTEES

B of T Report 04-A-23

Subject: AMA 2024 Dues

Presented by: Sandra Adamson Fryhofer, MD, Chair

Referred to: Reference Committee F

Our American Medical Association (AMA) last raised its dues in 1994. AMA continues to invest in improving the value of membership. As our AMA's membership benefits portfolio is modified and enhanced, management will continuously evaluate dues pricing to ensure optimization of the membership value proposition.

RECOMMENDATION

2024 Membership Year

The Board of Trustees recommends no change to the dues levels for 2024, that the following be adopted and that the remainder of this report be filed:

Regular Members	$ 420
Physicians in Their Fourth Year of Practice	$ 315
Physicians in Their Third year of Practice	$ 210
Physicians in Their Second Year of Practice	$ 105
Physicians in Their First Year of Practice	$ 60
Physicians in Military Service	$ 280
Semi-Retired Physicians	$ 210
Fully Retired Physicians	$ 84
Physicians in Residency/Fellow Training	$ 45
Medical Students	$ 20

(Directive to Take Action)

Fiscal Note: No significant fiscal impact.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 13-A-23

Subject: Delegate Apportionment and Pending Members

Presented by: Sandra Adamson Fryhofer, MD, Chair

Referred to: Reference Committee F

At the November 2022 Interim Meeting, Board of Trustees Report 3, "Delegate Apportionment and Pending Members," was considered and referred.

BACKGROUND

At the 2018 Interim Meeting, policy was adopted calling for the inclusion of pending members in the delegate apportionment process. Per Board of Trustees Report 1-I-18 pending members are those who at the time they apply for AMA membership are not members and who pay dues for the following calendar year. This typically occurs in the last few weeks of one year, with the individual's membership becoming active on January 1 of the following year. The policy was refined in Board of Trustees Report 12-A-19 to address issues related to counting such members as well as distinctions between constituent and specialty societies, and the necessary bylaws amendments were adopted at the 2019 Interim Meeting in the Council on Constitution and Bylaws Report 3-I-19. This formed AMA Policy G-600.016, "Data Used to Apportion Delegates," which also called for an evaluation at A-22. Board of Trustees Report 20-A-22 provided a review on the effects of counting pending members and included six recommendations. One recommendation was adopted which defined the apportionment process for 2023 and was predicated on not counting pending members. (Policy G-600.959 paragraph 1). Recommendation 1 of BOT Report 20-A-22 was referred for decision and the remaining recommendations were referred.

In September 2022, your Board voted to adopt Recommendation 1 of Board Report 20-A-22, which had been referred for decision. By this action pending members would not be counted for apportionment purposes, which was subsequently recorded as paragraph 2 of Policy G-600.959, "Delegate Apportionment and Pending Members."

Board of Trustees Report 3-I-22 dealt with the remaining referred items from Board Report 20-A-22. The report included a recommendation to rescind Policy G-600.016. The House of Delegates (HOD) referred the report back to the Board. Also at I-22, the HOD considered Constitution & Bylaws Report 1-I-22 which recommended changes to Bylaw §2.1.1.1 specifying how apportionment would be accomplished for 2023 and recommended deletion of the following sentence, "*The December 31 count will include pending members for purposes of apportionment; however, pending members shall not be recounted the following year absent membership renewal."* The HOD adopted the bylaw amendment specifying the 2023 apportionment but referred the recommended deletion of the sentence reproduced above. Given the Board's September action, to no longer count pending members and the adopted bylaw which specifies the process to be used for 2023, the referred sentence although retained in Bylaw §2.1.1.1 has no impact. Furthermore, the amendment adopted by the House includes a sunset provision for the entirety of Bylaw §2.1.1.1 as of December 31, 2023.

DISCUSSION

The original policy adopted by the HOD regarding pending members called for a subsequent evaluation of the policy with recommendations regarding its continuation. This evaluation showed that the intended goals of counting pending members for apportionment of HOD Delegates had not been realized. In addition, your Board believes that counting pending members diminishes the role of active members themselves, devalues other benefits of membership and unnecessarily complicates the apportionment process.

There is little to no evidence that suggests that the offer to count pending members for apportionment purposes has led to membership gains. Virtually all the pending members identified in the initial adoption of the policy had already joined prior to the implementation of the experiment. Anecdotes suggesting that being counted toward representation in the House of Delegates is a motivation for members to join late in the membership cycle has not been confirmed with data over the trial years. Physicians consistently report valuing the advocacy that emerges from House of Delegates (HOD) policy, not representation in the House of Delegates itself *per se.*

There may be isolated instances where state delegations at risk for losing a seat in the House may be motivated to recruit pending members, but it would seem these efforts should be undertaken earlier in the membership year to recruit members for the actual year used for apportionment not the following year. In fact, our current bylaws (2.1.1.2.1) provide that if the membership information as recorded at the end of a year warrants a decrease in the number of delegates, the association is permitted to retain their delegate number, without decrease, for an additional year to intensify their recruitment of members. Counting pending members, those who pay dues not for that additional grace year but for the following year, in effect extends the grace period and creates an opportunity for members to join every third year while still being counted for apportionment.

The notion that pending members gain representation by being counted for apportionment purposes belies the fact that delegates represent the needs of not only members but patients, their sponsoring societies, and the profession, including nonmembers. This is explicitly stated in the HOD Reference Manual. Pending members are in fact NOT members. Individuals who join late in the year wishing to be represented in the HOD could join for the current year by paying half-year dues. It has been said that counting pending members more fairly apportions delegation count. On the contrary, since representation in HOD is based upon membership numbers, allowing certain societies to inflate their delegate numbers beyond their true proportional representation by including pending members diminishes the vote of other societies that have fulfilled their membership requirements and may be thought to disenfranchise the current members.

Some delegations hoped that including pending members would increase their number of delegates. Upon implementation virtually all the increase came in the first year of the experiment and few states actually gained delegates even in that initial year. Any increase was short lived as pending members provide a net membership increase only in their initial count. Ultimately, there is no evidence that pending members have any positive effect on apportionment numbers.

Others have argued that not counting pending members is tantamount to treating them as second-class members. As noted above, they are indeed not members, at least not initially, and once they are members they will be counted just like all other members in the year in which their membership dues apply. Decisions about apportionment need not be linked to more concrete member benefits. In fact, members do begin receiving most membership benefits shortly after the membership decision is made.

Although physicians and medical students make the membership decision throughout the year, AMA membership, similar to most every other medical society membership, is calendar year based. For example, medical students, particularly first year students, often join in July or August and most continuing members renew their membership for the following year in November and December. As such, the membership count varies from day to day. Determination of membership count and thus apportionment could theoretically be done on any date but has to be completed on a defined date. The date of December 31 is specified in multiple provisions within our bylaws. The AMA recognizes dues revenue in financial statements for the calendar membership year. Legally, members are listed as members for the calendar year membership designated on the membership application, regardless when submitted and paid.

Finally, as a practical matter, once someone becomes a pending member, the individual must be tracked across time in perpetuity solely for apportionment lest membership become an on-again, off-again process to game the system. The timing of one's dues payment and one's membership status at the time of that payment affect how and whether one is counted for apportionment purposes. These elements cannot be captured by AMA's membership accounting system across a potential 40- or 50-year career in medicine. To track the information would require an estimated quarter million dollar change to the membership accounting system.

CONCLUSION

While the composition of the House is the province of the HOD, your Board maintains that the long-standing policy of counting actual members for apportionment, including a one-year grace period for societies at risk of losing a delegate seat, has served our association, the House, and members well. There is no clear evidence that counting pending members increases membership or provides benefit to constituent societies. Counting pending members can be considered to diminish or discount actual members' value as much as it can be seen to enhance representation. In addition, it unnecessarily complicates the apportionment process and adds additional cost of tracking pending members over time. Your Board concludes that the trial of counting pending members for apportionment purposes should not be continued.

The adoption of the Policy G-600.959 [1] and the bylaw amendment from CC&B Report 1-I-22 specified the process that was followed for apportionment for 2023. The amended Bylaw §2.1.1.1includes a sunset provision for the entirety of the bylaw as of December 31, 2023. Given that the apportionment process for 2023 is complete, Policy G-600.959 [1] should be rescinded as it has been accomplished.

RECOMMENDATION

Therefore, your Board of Trustees recommends that paragraphs 2-4 of Policy G-600.016 and paragraph 1 of Policy G-600.959 be rescinded and the remainder of the report filed.

Fiscal Note: $150 to update PolicyFinder

RELEVANT AMA POLICY

Data Used to Apportion Delegates G-600.016
1. Our AMA shall issue an annual, mid-year report on or around June 30 to inform each state medical society and each national medical specialty society that is in the process of its 5-year review of its current AMA membership count.
2. "Pending members" (defined as individuals who at the time they apply for membership are not current in their dues and who pay dues for the following calendar year) will be added to the number of active AMA members in the December 31 count for the purposes of AMA delegate allocations to state medical societies for the following year and this total will be used to determine the number of national medical specialty delegates to maintain parity.
3. Our AMA will track “pending members” from a given year who are counted towards delegate allocation for the following year and these members will not be counted again for delegate allocation unless they renew their membership before the end of the following year.
4. Our AMA Board of Trustees will issue a report to the House of Delegates at the 2022 Annual Meeting on the impact of Policy G-600.016 and recommendations regarding continuation of this policy.

Delegate Apportionment and Pending Members G-600.959
1. Delegates will be apportioned to constituent societies for 2023 with each society getting the greatest of the following numbers:
- The number of delegates apportioned at the rate of 1 per 1000, or fraction thereof, AMA members;
- The number of delegates apportioned for 2022 so long as that figure is not greater than 2 more than the number apportioned at the rate of 1 per 1000, or fraction thereof, AMA members; or
- For societies that would lose more than five delegates from their 2022 apportionment, the number of delegates, apportioned at the rate of 1 per 1000, or fraction thereof, AMA members, plus 5.
2. Pending members will no longer be counted for delegate apportionment.
BOT Rep. 20, A-22; BOT Action in response to referred for decision: BOT Rep. 20, A-22

REPORT OF THE BOARD OF TRUSTEES

B of T Report 18-A-23

Subject: Making AMA Meetings Accessible

Presented by: Sandra Adamson Fryhofer, MD, Chair

Referred to: Reference Committee F

Policy G-630.140 [8], adopted by the American Medical Association House of Delegates (HOD) at the 2022 Annual Meeting, called for a report to the HOD by no later than the 2023 Annual Meeting with a plan on how to maximize meeting participation for members and invited attendees with disabilities. This report responds to G-630.140 [8].

BACKGROUND

AMA meeting venues are selected several years in advance to secure locations and begin meeting planning. Among the other considerations, management is directed by current AMA policy to choose hotels for its meetings, conferences, and conventions based on size, service, location, cost, and similar factors. For our Interim and Annual Meetings, efforts are made to locate the Section Assembly Meetings in the House of Delegates meeting hotel or in a hotel in proximity.

When planning an event, it is important to consider accessibility for individuals with disabilities, and AMA management takes this responsibility seriously by researching venues and assessing their accessibility features, considering unique needs, and providing necessary aids for optimal participation.

To ensure accessibility for individuals with disabilities, AMA management follows a thorough process. This includes researching venues that have necessary accessibility features and conducting in-person site visits to assess various features such as parking, entrances, elevators, ramps, restrooms, all gender restrooms, seating arrangements, and audiovisual capabilities. Additionally, AMA management considers unique needs such as sensory processing issues and provides options for individuals to retreat to quiet spaces as needed. To further enhance participation, AMA management offers various audio and visual aids to accommodate those who are sight or hearing impaired. For individuals with hearing impairments, options include sign language interpreters, assistive listening devices, and captioning. For individuals with visual impairments, options include audio descriptions, tactile maps and models, Braille and large-print materials, and accessible technology such as screen readers or magnification software.

For the hearing assistance device, management will work to ensure that the device is available and working properly during management meetings. Members who require this device can inform management in advance, and staff will make sure that the device is set up and ready for use. This information will be included in the registration form for the meeting, or members can contact management directly to request the device.

For an in-person interpreter, management will work to ensure that a qualified interpreter is available for members who require this service. The cost of the interpreter will be covered by the AMA, not by the member. Meeting services will coordinate with the interpreter and the member to ensure that the interpreter is available at the appropriate time and location. Members who require an interpreter can inform management in advance, and staff will make sure that an interpreter is available.

For members in wheelchairs, management will work to ensure that the meeting venue is accessible and that accommodations are made as needed. This may include providing accessible seating, ensuring that there are accessible paths of travel throughout the venue, and making sure that any equipment or materials needed by the member are available and accessible. Members who require accommodations for mobility issues can inform management in advance, and staff will work with the member to ensure that their needs are met.

Overall, management is committed to ensuring that all members are able to participate fully in meetings and that their needs are accommodated appropriately. Members who require special accommodations should inform management in advance, and staff will work to ensure that these accommodations are made.

Further, the House of Delegates (HOD) Affairs Office provides an opportunity for delegates and alternate delegates to request special accommodations thru the delegate credentialing process. Any requests are handled by the Director, HOD Affairs, in conjunction with meeting services. The HOD Office has been made aware of three instances where accommodations were needed. In those instances, the attendees provided their own accommodations and informed the HOD Office for awareness purposes.

CONCLUSION

Ensuring accessibility for all attendees, including those with disabilities, is an important aspect of event planning and management. Providing accommodations such as assistive technologies and sign language interpreters can help ensure that all attendees have an equal opportunity to participate fully in the conference and benefit from its content. It is also important to ensure that the accommodations are communicated clearly to attendees, so they know how to request them if needed. By taking these steps, the conference organizers are demonstrating their commitment to inclusion and creating a welcoming environment for all attendees.

AMA management considers that all the venues for the conference have taken steps to ensure that they are compliant with the Americans with Disabilities Act (ADA) requirements. This means that attendees with disabilities will have access to all areas of the venue, including entrances, restrooms, and meeting rooms.

RECOMMENDATION

The Board of Trustees recommends that Policy G-630.140 [8] be rescinded as being accomplished by this report, and the remainder of the report be filed.

Fiscal Note: No significant fiscal impact

REPORT OF THE BOARD OF TRUSTEES

B of T Report 20-A-23

Subject:	Surveillance Management System for Organized Medicine Policies and Reports (Resolution 609-A-22)
Presented by:	Sandra Adamson Fryhofer, MD, Chair
Referred to:	Reference Committee F

Resolution 609 A-22 "Surveillance Management System for Organized Medicine Policies and Reports," sponsored by Georgia Delegation, was referred to the Board of Trustees. Resolution 609 A-22 asked:

1. That our American Medical Association develop a prioritization matrix across both global and reference committee specific areas of interest (Directive to Take Action);
2. That our AMA develop a web-based surveillance management system, with pre-defined primary and/or secondary metrics, for resolutions and reports passed by their respective governance body (Directive to Take Action);
3. That our AMA share previously approved metrics and results from the surveillance management system at intervals deemed most appropriate to the state and local membership of organized medicine, including where and when appropriate to their patients. (Directive to Take Action)

BACKGROUND

Resolution 609 describes a need to have appropriate surveillance and dissemination system(s) in place that addresses the informational needs of physicians at the state and local levels including those who are members of House of Delegates within organized medicine. Further, the resolution asks that a prioritization matrix be created to aid delegates' and Federation societies' decision-making in submission of relevant and timely resolutions.

The role of prioritization matrices

Decision-making and prioritization frameworks are in common use across industries. Prioritization can be determined by any number of factors, but typical examples may include:

- Importance
- Urgency
- Relevancy
- Probability of Successful Outcome
- Risk

Matrices are used when executive decision-making is required to move forward. Typically, scoring values (e.g. Rank-Order, Likert Scales) must be captured in a consistent manner. Furthermore, the relative weighting of each factor is another important design element that must be determined.

Current resources within AMA

By nature of our AMA's councils, sections, and delegates structures, resolutions are shaped through a rigorous process of research, proposal, discussion, review and ultimately debate and voting.

Members of our House of Delegates today have access to a detailed House of Delegates microsite within *ama-assn.org*. The site provides a preliminary agenda that incorporates a "Bookmark" feature to allow delegates to be notified of changes over time.

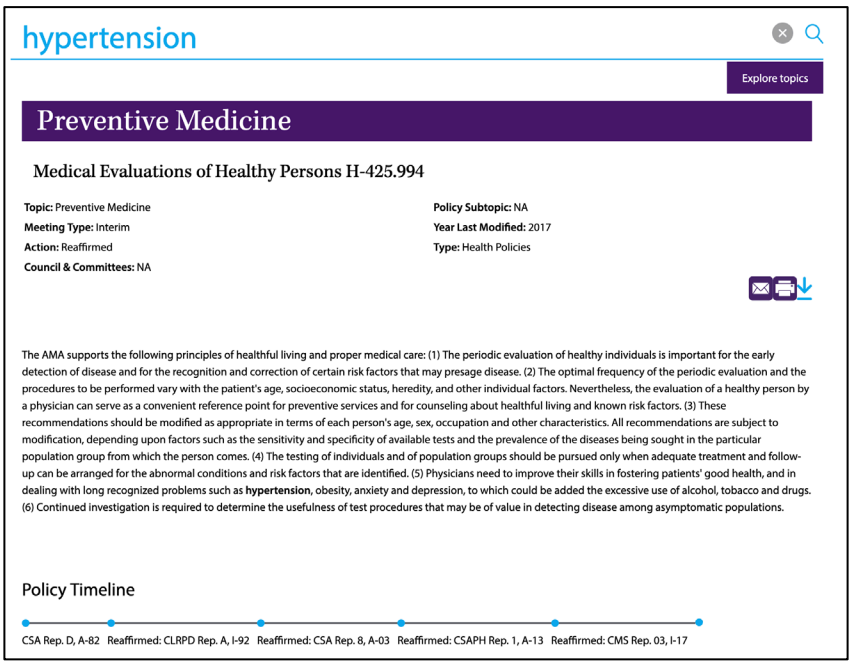
There are three primary database tools available to the public:

PolicyFinder	Council Reports Finder	AMA Archives

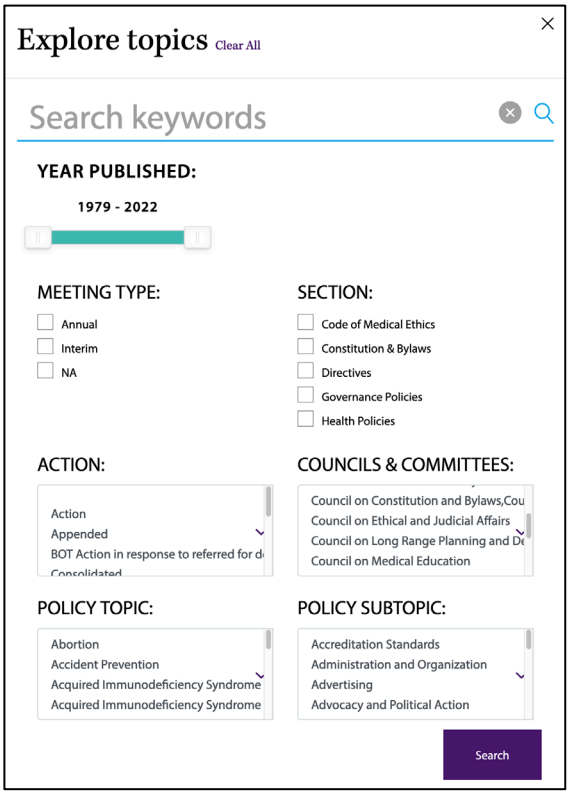
AMA's PolicyFinder resource allows delegates and other interested parties to search prior AMA policies with free text and Boolean keyword search. Information from this search includes Topic, Meeting Type, Action, Council & Committees, Year Last Modified, and Type. In addition to a description of the policy, there is a timeline that shows the trajectory of that policy, including relevant hyperlinks to council reports where possible (see Figure).

AMA's Council Report Finder contains 347 artifacts as of February 2023. Users may search based on keywords and filter by meeting date and by Councils and Committees among others.

AMA Archives contains digests of official actions, historical monographs, HoD proceedings, and Transactions (records of day-to-day activities). As of this writing, the database houses materials from 1847 to 2019.



In addition to keyword searches, users can enable a variety of filters and flags to explore AMA policy. The screenshot below highlights some of these options:



Prior organizational investments in House of Delegates usability

Our AMA maintains a website repository of proceedings, accessible to the public, from prior House of Delegates meetings, covering the prior decade. Visitors to this site can determine the implementation status of reports and resolutions. Materials are available in PDF format and searchable. Meetings dating prior to 2012 are located on AMA's archive database, also available to members, the research community, and public.

In late 2022, AMA's Strategic Insights team was asked to lead a user experience study on our PolicyFinder. Study subjects specifically incorporated members of our HOD, Council, and Reference Committee staff. The goals of the study were to better understand:

- The extent to which the design and functionality of PolicyFinder align with the needs and expectations of target users (with particular attention to the search functionality)
- Usability issues that may impact the user experience and highlight opportunities for further enhancement

This project is concluding at the time of this writing. The conclusions will be used to inform the product development roadmap for PolicyFinder.

Significant financial and logistical challenges exist to maintain a prioritization matrix tool for use by delegates. Any new tool deployment would require rigorous market and user research, product

development roadmaps, and significant data exchange infrastructure among states and specialties that do not exist today. We anticipate there would be a high degree of manual data entry and monitoring for changes that would require dedicated staff members. Additionally, a multi-organization governance mechanism would need to be established that describes the prioritization dimensions. We believe this would be a significant cost burden among AMA and the Federation, without adding great value for the AMA, delegates, and societies.

Federation Activities

The experience of accessing policy and council reports from our Federation ranges widely. State and specialty societies' resources and capabilities devoted to policy databases and reporting systems are unknown but likely vary widely.

We reviewed options for three state medical societies. One society has testimony, letters, and advocacy content available to the public, but the reports of its councils are not publicly available. Another state medical society provided a downloadable Policy Compendium from their House of Delegates but the link was broken. Another state medical association did not have a similar option.

One large specialty society provided a functional public database to browse Guidelines, Expert Consensus Statements, Policy Documents, and artifacts. Another specialty examined did not have any discernable publicly available database or archive of materials from their annual meeting.

RECOMMENDATION

In view of these considerations, your AMA recommends that the following recommendations be adopted in lieu of Resolution 609-A-22 and that the remainder of this report be filed:

1. That our American Medical Association (AMA) maintains the existing resolution management structure within the House of Delegates without imposing a potentially confusing or unsustainable prioritization matrix on delegates and reference committees. (New HOD Policy)

2. That our AMA continues to invest in critical information technology and other appropriate infrastructure that allows for the tracking of past resolutions, existing policy, and supporting materials. (New HOD Policy)

Fiscal note:

REPORT OF THE HOUSE OF DELEGATES COMMITTEE
ON THE COMPENSATION OF THE OFFICERS

Compensation Committee Report, June 2023

Subject: REPORT OF THE HOUSE OF DELEGATES COMMITTEE ON THE COMPENSATION OF THE OFFICERS

Presented by: Ray C. Hsiao, MD, Chair

Referred to: Reference Committee F

This report by the committee at the 2023 Annual meeting presents one recommendation.

BACKGROUND

The Committee has commissioned its external consultant, Ms. Becky Glantz Huddleston, an expert in Board Compensation with Willis Towers Watson, to conduct a comprehensive compensation review of Officer Compensation because it has been five years since the last review. The Committee intends to present the results of this review and related recommendations, if any, to the House at I-2023.

The Committee thanks our Officers for their representation of the AMA and recommends no changes to Officer Compensation pending completion of the comprehensive review.

RECOMMENDATION

1. That there be no changes to the Officers' compensation for the period beginning July 1, 2023 through June 30, 2024. (Directive to Take Action.)

2. That the remainder of the report be filed.

Fiscal Note: $0

APPENDIX

POSITION	GOVERNANCE HONORARIUM
President	$290,160
Immediate Past President	$284,960
President-Elect	$284,960
Chair	$280,280
Chair-Elect	$207,480
Officers	$67,000

Definition of Governance Honorarium Effective July 1, 2017:

The purpose of this payment is to compensate Officers for all Chair-assigned internal AMA work and related travel. This payment is intended to cover all currently scheduled Board meetings, special Board or Board Committee meetings, task forces, subcommittees, Board orientation, development and media training, Board calls, sections, councils, or other internal representation meetings or calls, and any associated review or preparatory work, and all travel days related to all meetings as noted up to eleven (11) Internal Representation days.

Definition of Per Diem for Representation effective July 1, 2017:

The purpose of this payment is to compensate for Board Chair-assigned representation day(s) and related travel. Representation is either external to the AMA, or for participation in a group or organization with which the AMA has a key role in creating/partnering/facilitating, achievement of the respective organization goals such as the AMA Foundation, PCPI, etc. or for Internal Representation days above eleven (11). The Board Chair may also approve a per diem for special circumstances that cannot be anticipated such as weather-related travel delays. Per Diem for Chair-assigned representation and related travel is $1400 per day.

Definition of Telephone Per Diem for External Representation effective July 1, 2017:

Officers, excluding the Board Chair and the President(s) who are assigned as the AMA representative to outside groups as one of their specific Board assignments or assigned Internal Representation days above eleven (11), receive a per diem for teleconference meetings when the total of all teleconference meetings of 30 minutes or longer during a calendar day equal 2 or more hours. Payment for those meetings would require approval of the Chair of the Board. The amount of the Telephonic Per Diem will be ½ of the full Per Diem which is $700.

JOINT REPORT OF THE COUNCIL ON CONSTITUTION AND BYLAWS AND THE COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT

CCB/CLRPD Report 1-A-23

Subject:	Joint Council Sunset Review of 2013 House Policies
Presented by:	Kevin C. Reilly, Sr., MD, Chair, Council on Constitution and Bylaws Edmond Cabbabe, MD, Chair, Council on Long Range Planning and Development
Referred to:	Reference Committee F

Policy G-600.110, "Sunset Mechanism for AMA Policy," calls for the decennial review of American Medical Association (AMA) policies to ensure that our AMA's policy database is current, coherent, and relevant. Policy G-600.010 reads as follows, laying out the parameters for review and specifying the procedures to follow:

1. As the House of Delegates (House) adopts policies, a maximum ten-year time horizon shall exist. A policy will typically sunset after ten years unless action is taken by the House to retain it. Any action of our AMA House that reaffirms or amends an existing policy position shall reset the sunset "clock," making the reaffirmed or amended policy viable for another 10 years.

2. In the implementation and ongoing operation of our AMA policy sunset mechanism, the following procedures shall be followed: (a) Each year, the Speakers shall provide a list of policies that are subject to review under the policy sunset mechanism; (b) Such policies shall be assigned to the appropriate AMA councils for review; (c) Each AMA council that has been asked to review policies shall develop and submit a report to the House identifying policies that are scheduled to sunset; (d) For each policy under review, the reviewing council can recommend one of the following actions: (i) retain the policy; (ii) sunset the policy; (iii) retain part of the policy; or (iv) reconcile the policy with more recent and like policy (per Policy G-600.111(4), The consolidation process permits editorial amendments for the sake of clarity, so long as the proposed changes are transparent to the House and do not change the meaning); (e) For each recommendation that it makes to retain a policy in any fashion, the reviewing council shall provide a succinct, but cogent justification (f) The Speakers shall determine the best way for the House to handle the sunset reports.

3. Nothing in this policy shall prohibit a report to the House or resolution to sunset a policy earlier than its 10-year horizon if it is no longer relevant, has been superseded by a more current policy, or has been accomplished.

4. The AMA councils and the House should conform to the following guidelines for sunset: (a) when a policy is no longer relevant or necessary; (b) when a policy or directive has been accomplished; or (c) when the policy or directive is part of an established AMA practice that is transparent to the House and codified elsewhere such as the AMA Bylaws or the AMA House of Delegates Reference Manual: Procedures, Policies and Practices.

5. The most recent policy shall be deemed to supersede contradictory past AMA policies.

6. Sunset policies will be retained in the AMA historical archives

RECOMMENDATION

The Councils on Constitution and Bylaws and Long Range Planning and Development recommend that the House of Delegates policies that are listed in the appendix to this report be acted upon in the manner indicated and the remainder of this report be filed.

APPENDIX – Recommended Actions

Policy Number	Title	Text	Recommendation
D-405.991	Clarification of the Title "Doctor" in the Hospital Environment	1. Our AMA Commissioners will, for the purpose of patient safety, request that The Joint Commission develop and implement standards for an identification system for all hospital facility staff who have direct contact with patients which would require that an identification badge be worn which indicates the individual's name and credentials as appropriate (i.e., MD, DO, RN, LPN, DC, DPM, DDS, etc), to differentiate between those who have achieved a Doctorate, and those with other types of credentials. 2. Our AMA Commissioners will, for the purpose of patient safety, request that The Joint Commission develop and implement new standards that require anyone in a hospital environment who has direct contact with a patient who presents himself or herself to the patient as a "doctor," and who is not a "physician" according to the AMA definition (H-405.969) that a physician is an individual who has received a "Doctor of Medicine" or a "Doctor of Osteopathic Medicine" degree or an equivalent degree following successful completion of a prescribed course of study from a school of medicine or osteopathic medicine?) must specifically and simultaneously declare themselves a "non-physician" and define the nature of their doctorate degree. 3. Our AMA will request the American Osteopathic Association (AOA) to (1) expand their standards to include proper identification of all medical staff and hospital personnel with their applicable credential (i.e., MD, DO, RN, LPN, DC, DPM, DDS, etc), and (2) Require anyone in a hospital environment who has direct contact with a patient presenting himself or herself to the patient as a "doctor", who is not a "Physician" according to the AMA definition (AMA Policy H-405.969 .. that a physician is an individual who has received a "Doctor of Medicine" or a "Doctor of Osteopathic Medicine" degree or an equivalent degree following successful completion of a prescribed course of study from a school of medicine or osteopathic medicine) must specifically and simultaneously declare themselves a "non-physician" and define the nature of their doctorate degree.	Retain. Still Relevant. [The Councils acknowledge there is some overlap with other AMA policies D-405.974, Clarification of Healthcare Physician Identification: Consumer Truth & Transparency, H-405.989, Physicians and Surgeons, and H-405.951, Definition and Use of the Term Physician, and H-405.969, Definition of a Physician, and plans to issue a consolidation report at I-23.]
D-450.965	Patients' Responsibilities for Health Care Outcomes	Our AMA will: (1) continue to support the development of resources for patients and physicians to promote adherence through its partnerships with the National Council on Patient Information and Education and National Consumer League National Medication Adherence Campaign; (2) publicize existing resources for	Sunset. Superseded by more recent policies that exist, including H-373.993, Medication Adherence, H-

		physicians to help patients adhere to treatment through its website; and (3) examine issues of patient adherence as part of its strategic initiative on Improving Health Outcomes and, if appropriate, will develop with others targeted education and resources to support patient adherence.	450.942, Patient Adherence to Treatment Plans, H-115.967, Addressing Drug Overdose and Patient Compliance with Targeted Pharmaceutical Packaging Efforts, H-275.976, Boundaries of Practice for Health Professionals, H-120.967, Dispensing of Drug Information, and Code of Medical Ethics Opinion 1.1.4, Patient Responsibilities. Improving Health Outcomes is one of AMA's major focus areas. Other resources include The AMA's STEPS Forward™ practice management tools which include modules on patient adherence, BOT Report 3-I-12, Physician Education to Support Patient Adherence to Treatment, and BOT Report 11-A-14, Medication Non-Adherence and Error.
D-75.994	Tubal Ligation and Vasectomy Consents	1. Our AMA will work closely with the American College of Obstetricians and Gynecologists, the American Urological Association, and any other interested organizations, to advocate to Congress for the legislative or regulatory elimination of the required 30 day interval between informed consent and a permanent sterilization procedure. 2. Our AMA will work with the Centers for Medicare & Medicaid Services to eliminate the time restrictions on informed consent for permanent sterilization procedures.	Sunset. Superseded by more current policy H-290.977, Medicaid Sterilization Services Without Time Constraints. Also, BOT 17-A-14, Tubal Ligation and Vasectomy Consents provides a historical context to the issue.
G-600.045	Online Member Forums in the House of Delegates	Online member forums should be incorporated into every House of Delegates policymaking meeting, using the following parameters: a. Each reference committee should participate in the online member	Retain. Still relevant. Policy D-600.956, Increasing the Effectiveness of

		forum process; b. Each online member forum should cover as many items of business as possible, including, at minimum, those items that appear in the initial compilation of the Delegate Handbook; c. Comments submitted to an online member forum should be used to prepare a summary report that reflects the comments received up to that point; d. Full, free and complete testimony should be allowed in the onsite hearings; and e. The Speakers should experiment with alternative procedures to enhance and improve the overall online member forum process.	Online Reference Committee, commits our AMA to a two-year study of preliminary reference committee documents based on the written online testimony, with those documents being used to inform the discussion at the in-person reference committee.
G-615.001	Establishment and Function of Sections	1. Our AMA adopts the following criteria in consideration of requests for establishing new sections or changing the status of member component groups: A. Issue of Concern - Focus will relate to concerns that are distinctive to the subset within the broader, general issues that face medicine. A demonstrated need exists to deal with these matters, as they are not currently being addressed through an existing AMA group. B. Consistency - Objectives and activities of the group are consistent with those of the AMA. Activities make good use of available resources and are not duplicative. C. Appropriateness - The structure of the group will be consistent with its objectives and activities. D. Representation Threshold - Members of the formal group would be based on identifiable segments of the physician population and AMA membership. The formal group would be a clearly identifiable segment of AMA membership and the general physician population. A substantial number of members would be represented by this formal group. At minimum, this group would be able to represent 1,000 AMA members. It is important to note this threshold will not be used to determine representation as each new group will be allocated only one delegate and one alternate delegate. E. Stability - The group has a demonstrated history of continuity. This segment can demonstrate an ongoing and viable group of physicians will be represented by this section and both the segment and the AMA will benefit from an increased voice within the policymaking body. F. Accessibility - Provides opportunity for members of the constituency who are otherwise underrepresented to introduce issues of concern and to be able to participate in the policymaking process within the HOD. 2. Our AMA will consider requests for establishing new sections by letter of application to the CLRPD, which will make recommendations to the	Retain. Still relevant and necessary to specify the criteria used to evaluate new sections or changing the status of a member component group. A five-year review cycle of delineated sections provides an excellent opportunity for the House to receive updates on section activities to ensure that these sections continue to meet HOD goals. CLRPD Report 1-I-10, Establishment and Function of Sections provides a historical context.

		BOT and HOD for further action or by submission of a resolution.	
G-625.020	AMA Strategic Planning	1. Our AMA annual strategic planning cycle shall include the following dimensions: (a) Information: Our AMA strategic planning process shall be based on information about the environment in which medicine and our AMA must function. Drawing from a variety of sources including public and physician survey data, other types of research findings and data, and the work of our AMA councils, sections, and special groups, the Council on Long Range Planning and Development (CLRPD) shall provide strategic support to our AMA Board by identifying, analyzing, and interpreting environmental trends. The Board of Trustees and the CLRPD shall work collaboratively to distribute information on the environment and our AMA's vision, objectives, and strategies to all the participants in the strategic planning process. (b) Participation: Our AMA strategic planning process should provide for broad participation by the House of Delegates, Councils, Sections, Special Groups, staff, and other appropriate internal and external sources. The Board of Trustees shall provide opportunities for these entities to provide input into the development of our AMA's strategic plan. 2. Our AMA strategic planning process should generate: (a) A multi-year plan that identifies the most critical strategic issues for the organization; (b) The critical success factors for each issue; and (c) Annual work plans with measurable performance objectives, tasks and timelines, assignments for implementation, and expected outcomes. 3. The Board must ensure that adequate resources - staff, funding, and material - are available for developing our AMA strategic plan. 4. The goals of our AMA strategic plan should become an overarching part of all Board and Council meetings. All ongoing initiatives and new undertakings must be regularly measured against the plan, and emerging issues that impact the plan should be identified. 5. The AMA strategic plan will be presented to the HOD in a more visible, proactive, and interactive way. 6. Our AMA Board of Trustees will continue to (a) consider input from the House, CLRPD, and broad physician community when developing the Strategic Plan and making resource allocation decisions; (b) exercise its fiduciary responsibilities with respect to allocating resources appropriately and consistent with the AMA's vision, goals and priorities; and (c) monitor the activity and results related to commitments established in the planning process.	Retain as editorially amended in #7 for accuracy. Still Relevant and Necessary.

		7. Our AMA will continue to communicate activities, achievements, and opportunity for physician involvement through the Federation, Physician ~~Action~~ Grassroots Network, AMA publications (paper, email, and web-based), and other channels as appropriate.	
H-255.967	Mock Residency Interview Program	Our AMA will promote the AMA-International Medical Graduates Section's Mock Residency Interview Program to any AMA member who is in the process of applying for a medical residency position and as one of the benefits of AMA membership.	Retain. Still Relevant and Necessary
H-40.993	Support of the Civilian-Military Contingency Hospital System	The AMA supports the CMCHS and urges U.S. civilian hospitals, when requested, to provide all possible support to the Department of Defense CMCHS in this important effort which will enable the U.S. to prepare for the treatment of casualties from any future conventional military conflict.	Retain. Still Relevant.
H-475.992	Definitions of "Cosmetic" and "Reconstructive" Surgery	(1) Our AMA supports the following definitions of "cosmetic" and "reconstructive" surgery: Cosmetic surgery is performed to reshape normal structures of the body in order to improve the patient's appearance and self-esteem. Reconstructive surgery is performed on abnormal structures of the body, caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease. It is generally performed to improve function, but may also be done to approximate a normal appearance. (2) Our AMA encourages third party payers to use these definitions in determining services eligible for coverage under the plans they offer or administer.	Retain. Still Relevant.
H-475.983	Definition of Surgery	Our AMA adopts the following definition of 'surgery' from American College of Surgeons Statement ST-11: Surgery is performed for the purpose of structurally altering the human body by the incision or destruction of tissues and is part of the practice of medicine. Surgery also is the diagnostic or therapeutic treatment of conditions or disease processes by any instruments causing localized alteration or transposition of live human tissue which include lasers, ultrasound, ionizing radiation, scalpels, probes, and needles. The tissue can be cut, burned, vaporized, frozen, sutured, probed, or manipulated by closed reductions for major dislocations or fractures, or otherwise altered by mechanical, thermal, light-based, electromagnetic, or chemical means. Injection of diagnostic or therapeutic substances into body cavities, internal organs, joints, sensory organs, and the central nervous system also is considered to be surgery (this does not include the administration by nursing personnel of some injections, subcutaneous, intramuscular, and intravenous, when ordered by a physician). All of these surgical procedures are invasive, including those that are performed with lasers, and the risks	Retain. Still Relevant.

		of any surgical procedure are not eliminated by using a light knife or laser in place of a metal knife, or scalpel. Patient safety and quality of care are paramount and, therefore, patients should be assured that individuals who perform these types of surgery are licensed physicians (defined as doctors of medicine or osteopathy) who meet appropriate professional standards.	
H-475.988	Laser Surgery	The AMA supports the position that revision, destruction, incision or other structural alteration of human tissue using laser is surgery.	Rescind (duplicative of Policy H-475.983 being recommended for retention).
H-475.984	Office-Based Surgery Regulation	Our AMA supports the following Core Principles on Office-Based Surgery: Core Principle #1: Guidelines or regulations for office-based surgery should be developed by states according to levels of anesthesia defined by the American Society of Anesthesiologists (ASA) excluding local anesthesia or minimal sedation. (American Society of Anesthesiologists. Continuum of depth of sedation. Available at: https://www.asahq.org/standards-and-guidelines/guidelines-for-office-based-anesthesia, https://www.asahq.org/standards-and-guidelines/continuum-of-depth-of-sedation-definition-of-general-anesthesia-and-levels-of-sedationanalgesia ~~http://www.asahq.org/for-members/standards-guidelines-and-statement.aspx. Accessed July 2, 2013)~~. Core Principle #2: Physicians should select patients for office-based surgery using moderate sedation/analgesia, deep sedation/analgesia or general anesthesia by criteria including the ASA Physical Status Classification System and so document. (American Society of Anesthesiologists. ASA physical status classification system. Available at: https://www.asahq.org/standards-and-guidelines/asa-physical-status-classification-system ~~http://www.asahq.org/for-members/clinical-informaion/asa-physical-status-classification-system.aspx. Accessed July 2, 2013~~). Core Principle #3: Physicians who perform office-based surgery with moderate sedation/analgesia, deep sedation/analgesia, or general anesthesia should have their facilities accredited by The Joint Commission, Accreditation Association for Ambulatory Health Care (AAAHC), American Association for Accreditation of Ambulatory Surgical Facilities (AAAASF), American Osteopathic Association (AOA), or by a state recognized entity, such as the Institute for Medical Quality (IMQ), or be state licensed and/or Medicare certified. Core Principle #4: Physicians performing office-based surgery with moderate sedation/analgesia, deep sedation/analgesia, or general anesthesia must have admitting privileges at a nearby hospital, or a transfer agreement with	Retain as editorially amended for accuracy. Still relevant.

		another physician who has admitting privileges at a nearby hospital, or maintain an emergency transfer agreement with a nearby hospital. Core Principle #5: States should follow the guidelines outlined by the Federation of State Medical Boards (FSMB) regarding informed consent. (Report of the Special Committee on Outpatient [Office-Based] Surgery. ~~(Med. Licensure Discipline. 2002; 88: 160-174).~~ Core Principle #6: For office surgery with moderate sedation/analgesia, deep sedation/analgesia, or general anesthesia, states should consider legally privileged adverse incident reporting requirements as recommended by the FSMB and accompanied by periodic peer review and a program of Continuous Quality Improvement. (Report of the Special Committee on Outpatient (Office-Based) Surgery. ~~Journal Medical Licensure and Discipline. 2002; 88:160-174)~~. Core Principle #7: Physicians performing office-based surgery using moderate sedation/analgesia, deep sedation/analgesia or general anesthesia must obtain and maintain board certification by one of the boards recognized by the American Board of Medical Specialties, American Osteopathic Association, or a board with equivalent standards approved by the state medical board within five years of completing an approved residency training program. The procedure must be one that is generally recognized by that certifying board as falling within the scope of training and practice of the physician providing the care. Core Principle #8: Physicians performing office-based surgery with moderate sedation/analgesia, deep sedation/analgesia, or general anesthesia may show competency by maintaining core privileges at an accredited or licensed hospital or ambulatory surgical center, for the procedures they perform in the office setting. Alternatively, the governing body of the office facility is responsible for a peer review process for privileging physicians based on nationally recognized credentialing standards. Core Principle #9: For office-based surgery with moderate sedation/analgesia, deep sedation/analgesia, or general anesthesia, at least one physician who is credentialed or currently recognized as having successfully completed a course in advanced resuscitative techniques (e.g., ATLS, ACLS, or PALS), must be present or immediately available with age- and size-appropriate resuscitative equipment until the patient has met the criteria for discharge from the facility. In addition, other medical personnel with direct patient contact should at a minimum be trained in Basic Life Support (BLS). Core Principle #10: Physicians administering or supervising moderate sedation/analgesia, deep sedation/analgesia, or general anesthesia should have appropriate education and training.	

D-478.977	Exam Room Computing and Patient Physician Interactions	Our AMA will make physicians aware of tips and resources for effectively using computers and electronic health records (EHRs) in patient-physician interactions through AMA publication vehicles, and encourages physicians to incorporate questions regarding use of computers and EHRs in patient-satisfaction surveys to provide feedback on how their own patients experience the use of computers in the examination room.	Sunset. The actions requested have been accomplished. The AMA's STEPS Forward™ practice management tools, found at the AMA Ed Hub™, provide physicians with in-depth CME on acquisition and efficient use of an EHR. Modules include "Electronic Health Record (EHR) Software Selection and Purchase" and "Electronic Health Record Optimization: Strategies for Thriving," which include techniques physicians and office staff can use to "maximize the benefits and minimize the burdens of the EHR." The AMA Ed Hub also includes a substantial selection of EHR case studies. An additional resource is AMA's Taming the EHR Playbook. Policy, H-480.971, commits our AMA to continued work in this area.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 601
(A-23)

Introduced by: Resident and Fellow Section

Subject: Solicitation Using the AMA Brand

Referred to: Reference Committee F

Whereas, Some physicians are turned off by third-party solicitation material mailed with the American Medical Association brand, such as regarding disability insurance or student loan refinancing, potentially harming the AMA's reputation and costing physician membership; and

Whereas, Financial literacy websites such as White Coat Investor detail the flaws in the AMA branded third-party disability insurance plan[1]; and

Whereas, There is a financial and environmental cost to printed solicitation; and

Whereas, Associating the AMA brand to specific third-party products may or may not be in the best interest of the AMA or current and potential AMA members; therefore be it

RESOLVED, That our American Medical Association study the use of AMA branded solicitation material mailed to physicians, the impact it has on the perception of our AMA by current and potential physician members, and the merits of continuing to use these materials in future communications (Directive to Take Action); and be it further

RESOLVED, That our American Medical Association survey our membership on the preferred method to receive third-party solicitation material (mail, phone, email, social media) and provide a method to opt-out of certain methods if not desired. (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000

Received: 3/19/23

REFERENCES

1. AMA's Disability Insurance: You Get What You Pay For - White Coat Investor

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 602
(A-23)

Introduced by: Medical Student Section

Subject: Supporting the Use of Gender-Neutral Language

Referred to: Reference Committee F

Whereas, Existing American Medical Association policy inconsistently uses gendered language- in particular, gender pronouns- when referring to physicians, medical students, patients, and others, most often referencing generic individuals with traditionally male and sometimes female pronouns ("he/him/his", "he or she", "his or hers"); and

Whereas, One of many examples of gendered language is AMA Policy H-140.951, which states "Our AMA believes that the primary mission of the physician is to use his best efforts and skill in the care of his patients…"; and

Whereas, The American medical profession is increasingly gender diverse: 50.5% of all current U.S. medical students are women, and there many medical students and physicians who have other genders that are not male or female, including gender-expansive, gender-fluid, gender-nonconforming, genderqueer, nonbinary, and others[1,2,7]; and

Whereas, The frequent default use of male pronouns to describe generic physicians in AMA policy (for example, using "him" and "his" as pronouns for "the physician") may reinforce patriarchal (pro-male) bias in medicine and disadvantage physicians who do not use such pronouns[3-6]; and

Whereas, Gender identity exists on a spectrum that includes cisgender individuals whose gender identity aligns with their sex assigned at birth and transgender individuals whose gender identity differs from their sex assigned at birth[8]; and

Whereas, Cisnormative, gender-specific language has been shown to contribute to health disparities and alienate gender-diverse people from accessing care [9-12]; and

Whereas, The use of cisnormative, gender-specific language in public health campaigns such as breast cancer screening, testicular cancer awareness, HPV vaccination, and dissemination of PrEP has contributed to health disparities that negatively impact gender-diverse patients[13-15]; and

Whereas, Cisgendered imagery in medical education including anatomical diagrams has been demonstrated to exacerbate gender bias in students and contribute to students' reduced comfort and knowledge in treating gender-diverse patients[16-17]; and

Whereas, Reputable organizations and government departments that guide the public via public health communication continue to use gendered messaging that excludes gender-diverse individuals; for example, alcoholic beverage warning labels that read "*women* should not drink alcoholic beverages during pregnancy because of the risk of birth defects" [18]; and

Whereas, The use of gendered messaging in spaces such as Women's Health Clinics with pink chairs, patient restrooms labeled as a "women's" restrooms, and brochures containing language helpful for cisgender women only, have been shown to be stigmatizing and isolating for gender-diverse individuals and may discourage them from accessing necessary services[19]; and

Whereas, Gender-neutral language has been shown to positively impact the comfort and psychological safety of gender-diverse individuals "in the institutions with which they must interact" [20]; and

Whereas, To address the exclusion of gender-diverse individuals through the use of gendered messaging, peer organizations are already adopting gender-neutral language, including the Section on Women's Health of the American Physical Therapy Association which changed its name to the Academy of Pelvic Health Physical Therapy and the American College of Obstetricians and Gynecologists which released Committee Opinion 823 recognizing that not all pregnant individuals may identify as "mothers" [21-22]; and

Whereas, The AMA should aspire to use gender-neutral language where feasible, recognizing that American physicians and the patients we serve have diverse gender identities and may use similarly diverse personal pronouns; and

Whereas, One solution for correcting the bias established by using traditionally male pronouns as default in AMA policy is to replace them with gender-neutral pronouns such as "they", "them", "their", and "theirs", which are pronouns used by many gender non-binary individuals and may also be used to collectively describe people of all genders[7]; and

Whereas, The pronouns "they", "them", "their", and "theirs" have long been widely accepted as both singular and plural pronouns, allowing them to be incorporated into AMA policy with great flexibility[23-25]; and

Whereas, Adopting consistent gender-neutral pronouns and other non-gendered language into AMA policy would be an efficient and adequate way to collectively reference medical students, physicians, patients, and others of all genders; and

Whereas, Updating the language in our AMA's policies to be maximally inclusive is a simple act that aligns with our organization's work to document and appreciate the diversity in sexual orientation and gender identity (SOGI) of our members as well as to champion gender equity and non-discrimination in medicine and society[26-31]; and

Whereas, AMA policy D-65.990, which calls on the AMA to standardize existing and future language relating to LGBTQ people, establishes precedent for this timely action; therefore be it

RESOLVED, That our American Medical Association (1) Recognize the importance of using gender-neutral language such as gender neutral pronouns, terms, imagery, and symbols in respecting the spectrum of gender identity, (2) revise all relevant policies to utilize gender-neutral language in place of gendered language where such text inappropriately appears, (3) utilize gender-neutral language in future policies, internal communications, and external communications where gendered language does not specifically need to be used, (4) encourage the use of gender-neutral language in public health and medical messaging, (5) encourage other professional societies to utilize gender-neutral language in their work, and (6) support the use of gender-neutral language in clinical spaces that may serve both cisgender and gender-diverse individuals. (New HOD Policy)

Fiscal Note: Up to $23K to review all current AMA policies and compile a report with recommendations for HOD consideration

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RELEVANT AMA POLICY

Professionalism in Medicine H-140.951
Our AMA believes that the primary mission of the physician is to use his best efforts and skill in the care of his patients and to be mindful of those forces in society that would erode fundamental ethical medical practice. The AMA affirms that the medical profession is solely responsible for establishing and maintaining standards of professional medical ethics and that the state neither legislate ethical standards nor excuse physicians from their ethical obligations. The AMA House of Delegates, Board of Trustees, staff, and membership rededicate themselves to professionalism such that it permeates all activities and is the defining characteristic of the AMA's identity.
Citation: Res. 4, A-95; Reaffirmed: CEJA Rep. 2, A-05; Reaffirmation I-09; Consolidated: CEJA Rep. 03, A-19;

Strategies for Enhancing Diversity in the Physician Workforce H-200.951
Our AMA: (1) supports increased diversity across all specialties in the physician workforce in the categories of race, ethnicity, disability status, sexual orientation, gender identity, socioeconomic origin, and rurality; (2) commends the Institute of Medicine (now known as the National Academies of Sciences, Engineering, and Medicine) for its report, "In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce," and supports the concept that a racially and ethnically diverse educational experience results in better educational outcomes; (3) encourages the development of evidence-informed programs to build role models among academic leadership and faculty for the mentorship of students, residents, and fellows underrepresented in medicine and in specific specialties; (4) encourages physicians to engage in their communities to guide, support, and mentor high school and undergraduate students with a calling to medicine; (5) encourages medical schools, health care institutions, managed care and other appropriate groups to adopt and utilize activities that bolster efforts to include and support individuals who are underrepresented in medicine by developing policies that articulate the value and importance of diversity as a goal that benefits all participants, cultivating and funding programs that nurture a culture of diversity on campus, and recruiting faculty and staff who share this goal; and (6) continue to study and provide recommendations to improve the future of health equity and racial justice in medical education, the diversity of the health workforce, and the outcomes of marginalized patient populations.
Citation: CME Rep. 1, I-06; Reaffirmed: CME Rep. 7, A-08; Reaffirmed: CCB/CLRPD Rep. 4, A-13; Modified: CME Rep. 01, A-16; Reaffirmation A-16; Modified: Res. 009, A-21; Modified: CME Rep. 5, A-21;

Principles for Advancing Gender Equity in Medicine H-65.961
Our AMA:
1. declares it is opposed to any exploitation and discrimination in the workplace based on personal characteristics (i.e., gender);
2. affirms the concept of equal rights for all physicians and that the concept of equality of rights under the law shall not be denied or abridged by the U.S. Government or by any state on account of gender;
3. endorses the principle of equal opportunity of employment and practice in the medical field;
4. affirms its commitment to the full involvement of women in leadership roles throughout the federation, and encourages all components of the federation to vigorously continue their efforts to recruit women members into organized medicine;
5. acknowledges that mentorship and sponsorship are integral components of one’s career advancement, and encourages physicians to engage in such activities;
6. declares that compensation should be equitable and based on demonstrated competencies/expertise and not based on personal characteristics;
7. recognizes the importance of part-time work options, job sharing, flexible scheduling, re-entry, and contract negotiations as options for physicians to support work-life balance;
8. affirms that transparency in pay scale and promotion criteria is necessary to promote gender equity, and as such academic medical centers, medical schools, hospitals, group practices and other physician employers should conduct periodic reviews of compensation and promotion rates by gender and evaluate protocols for advancement to determine whether the criteria are discriminatory; and

9. affirms that medical schools, institutions and professional associations should provide training on leadership development, contract and salary negotiations and career advancement strategies that include an analysis of the influence of gender in these skill areas.
Our AMA encourages: (1) state and specialty societies, academic medical centers, medical schools, hospitals, group practices and other physician employers to adopt the AMA Principles for Advancing Gender Equity in Medicine; and (2) academic medical centers, medical schools, hospitals, group practices and other physician employers to: (a) adopt policies that prohibit harassment, discrimination and retaliation; (b) provide anti-harassment training; and (c) prescribe disciplinary and/or corrective action should violation of such policies occur.
Citation: BOT Rep. 27, A-19;

Promotion of LGBTQ-Friendly and Gender-Neutral Intake Forms D-315.974
Our AMA will develop and implement a plan with input from the Advisory Committee on LGBTQ Issues and appropriate medical and community based organizations to distribute and promote the adoption of the recommendations pertaining to medical documentation and related forms in AMA policy H-315.967, Promoting Inclusive Gender, Sex, and Sexual Orientation Options on Medical Documentation,to our membership.
Citation: Res. 014, A-18;

Nondiscriminatory Policy for the Health Care Needs of LGBTQ Populations H-65.976
Our AMA encourages physician practices, medical schools, hospitals, and clinics to broaden any nondiscriminatory statement made to patients, health care workers, or employees to include "sexual orientation, sex, or gender identity" in any nondiscrimination statement.
Citation: Res. 414, A-04; Modified: BOT Rep. 11, A-07; Modified: Res. 08, A-16; Modified: Res. 903, I-17;

Utilization of "LGBTQ" in Relevant Past and Future AMA Policies D-65.990
Our AMA will: (1) utilize the terminology lesbian, gay, bisexual, transgender, and queerand the abbreviation LGBTQ in all future policies and publications when broadly addressing this population; (2) revise all relevant and active policies to utilize the abbreviation LGBTQ in place of the abbreviations LGBT and GLBTwhere such text appears; and (3) revise all relevant and active policies to utilize the terms lesbian, gay, bisexual, transgender, and queer to replace lesbian, gay, bisexual, and transgenderwhere such text appears.
Citation: Res. 016, A-18;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 603
(A-23)

Introduced by: Medical Student Section

Subject: Environmental Sustainability of AMA National Meetings

Referred to: Reference Committee F

Whereas, The World Health Organization (WHO) and our AMA have called climate change "the greatest public health challenge of the 21st century"[1,2]; and

Whereas, Reputable entities including the WHO, Intergovernmental Panel on Climate Change (IPCC), and U.S. Global Change Research Program assert that climate change has had an effect on, and continues to pose a great risk for, human health through climate related extreme weather events, worsening air quality, and increased disease transmission[1,3,4]; and

Whereas, Climate change is primarily driven through human activity and the release of greenhouse gases, including carbon dioxide, into the atmosphere[5]; and

Whereas, The United States healthcare system alone is responsible for 10% of national greenhouse gas emissions and, if it were its own country, it would be the 13th largest producer of greenhouse gas emissions in the world[6,7]; and

Whereas, Extreme weather and climate events have significantly increased healthcare spending in the United States, with $14 billion in additional spending through 760,000 additional patient encounters and 1,689 premature deaths between 2000 and 2009[8,9]; and

Whereas, The Intergovernmental Panel on Climate Change (IPCC) has determined it is possible to avoid warming past 1.5°C above pre-industrial levels by 2100 if extreme measures are taken to curtail anthropogenic emissions[10]; and

Whereas, If global warming exceeds 1.5°C, the estimated global effects include 92,207 additional heat-related deaths per year by 2030, 350 million more humans exposed to severe heat by 2050, and 31 to 69 million humans exposed to flooding from sea level rise by 2100[10]; and

Whereas, Compared to no action, limiting global warming to less than 1.5°C would result in ~50% lower annual health-related costs and prevention of ~50% of infectious disease cases in the United States by 2100[8,9]; and

Whereas, The IPCC has estimated that limiting global warming to 1.5°C would require "global net human-caused emissions of carbon dioxide to fall by about 45 percent from 2010 levels by 2030, and reach net zero by approximately 2050"[10]; and

Whereas, IPCC defines net zero emissions as a state where anthropogenic emissions of greenhouse gasses (GHG) are balanced by anthropogenic removals of GHG over a specific time period[8]; and

Whereas, Setting emissions targets is an essential part of carbon abatement, and many non-profit organizations, large corporations, and countries have committed to carbon neutrality for their business operations by a date certain in order to improve their business efficiencies and to foster the development of carbon neutral practices[11-13;] and

Whereas, Multiple organizations in the healthcare industry have committed to becoming carbon neutral on or before 2030, including Harvard Medical School and its affiliated hospitals, all University of California campus and medical centers, the Cleveland Clinic, and Kaiser-Permanante[14-17]; and

Whereas, Other professional organizations, including the Association of Energy Services Professionals, and International Federation of Medical Students' Associations have committed to making their conferences carbon neutral[18,19]; and

Whereas, Our American Medical Association has set discrete benchmark dates for achieving goals in other settings, including child blood lead levels (H-60.924), accreditation of health care service providers in jails (D-430.997), and disaggregation of demographic data (H-350.954); and

Whereas, Our AMA has substantial policy recognizing the impacts of climate change, committing to sustainable business operations, emphasizing the importance of physician leadership regarding climate change, encouraging the study of environmental causes of disease, and encouraging other stakeholders in healthcare to practice environmental responsibility, but has no explicit emissions goal and no way to account for progress towards environmental sustainability (H-135.938, H-135.923, G-630.100, D-135.997, H-135.973); therefore be it

RESOLVED, That our American Medical Association commit to reaching net zero emissions for its business operations by 2030, and remain net zero or net negative, as defined by a carbon neutral certifying organization, and report annually on the AMA's progress towards implementation (New HOD Policy); and be it further

RESOLVED, That our AMA work with appropriate stakeholders to encourage the United States healthcare system, including but not limited to hospitals, clinics, ambulatory care centers, and healthcare professionals, to decrease emissions to half of 2010 levels by 2030 and become net zero by 2050, and remain net zero or negative, as defined by a carbon neutral certifying organization, including by creating educational materials (Directive to Take Action); and be it further

RESOLVED, That our AMA evaluate the feasibility of purchasing carbon offsets for members traveling to and from Annual and Interim meetings and report back to the House of Delegates (Directive to Take Action); and be it further

RESOLVED, That our AMA evaluate the feasibility of holding future Annual and Interim meetings at Leadership in Energy and Environmental Design-certified or sustainable conference centers and report back to the House of Delegates. (Directive to Take Action)

Fiscal Note: Implementation of this initiative will be a multi-million dollar undertaking due to the need for consultants to develop a plan, project management to implement measures, potential reduction of in-person meetings and travel, and the ongoing purchase of carbon credits to offset areas where AMA may not be able to reduce emissions, including, among others, utilities in rented AMA office space. Measuring and reporting on compliance will contribute to significant annual costs thereafter. It is currently impossible to provide more precise cost information given the myriad factors involved.

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RELEVANT AMA POLICY

Global Climate Change and Human Health H-135.938

Our AMA: 1. Supports scientific consensus that the Earth is undergoing adverse global climate change and that anthropogenic contributions are significant. These climate changes have adversely affected the physical and mental health of people. We recognize that minoritized and marginalized populations, children, pregnant people, the elderly, rural communities, and those who are economically disadvantaged will suffer disproportionate harm from climate change.
2. Supports educating the medical community on the adverse public health effects of global climate change and incorporating the health implications of climate change into the spectrum of medical education, including topics such as population displacement, heat waves and drought, flooding, infectious and vector-borne diseases, and potable water supplies.
3. (a) Recognizes the importance of physician involvement in policymaking at the state, national, and

global level and supports efforts to search for novel, comprehensive, and economically sensitive approaches to mitigating climate change to protect the health of the public; and (b) recognizes that whatever the etiology of global climate change, policymakers should work to reduce human contributions to such changes.
4. Encourages physicians to assist in educating patients and the public on the physical and mental health effects of climate change and on environmentally sustainable practices, and to serve as role models for promoting environmental sustainability.
5. Encourages physicians to work with local and state health departments to strengthen the public health infrastructure to ensure that the global health effects of climate change can be anticipated and responded to more efficiently, and that adaptation interventions are equitable and prioritize the needs of the populations most at risk.
6. Supports epidemiological, translational, clinical and basic science research necessary for evidence-based global climate change policy decisions related to health care and treatment.
7. Encourages physicians to assess for environmental determinants of health in patient history-taking and encourages the incorporation of assessment for environmental determinants of health in patient history-taking into physician training.
Citation: CSAPH Rep. 3, I-08; Reaffirmation A-14; Reaffirmed: CSAPH Rep. 04, A-19; Reaffirmation: I-19; Modified: Res. 424, A-22; Modified: CSAPH Rep. 2, I-22;

AMA Advocacy for Environmental Sustainability and Climate H-135.923
Our AMA (1) supports initiatives to promote environmental sustainability and other efforts to halt global climate change; (2) will incorporate principles of environmental sustainability within its business operations; and (3) supports physicians in adopting programs for environmental sustainability in their practices and help physicians to share these concepts with their patients and with their communities.
Citation: Res. 924, I-16; Reaffirmation: I-19;

Stewardship of the Environment H-135.973
The AMA: (1) encourages physicians to be spokespersons for environmental stewardship, including the discussion of these issues when appropriate with patients; (2) encourages the medical community to cooperate in reducing or recycling waste; (3) encourages physicians and the rest of the medical community to dispose of its medical waste in a safe and properly prescribed manner; (4) supports enhancing the role of physicians and other scientists in environmental education; (5) endorses legislation such as the National Environmental Education Act to increase public understanding of environmental degradation and its prevention; (6) encourages research efforts at ascertaining the physiological and psychological effects of abrupt as well as chronic environmental changes; (7) encourages international exchange of information relating to environmental degradation and the adverse human health effects resulting from environmental degradation; (8) encourages and helps support physicians who participate actively in international planning and development conventions associated with improving the environment; (9) encourages educational programs for worldwide family planning and control of population growth; (10) encourages research and development programs for safer, more effective, and less expensive means of preventing unwanted pregnancy; (11) encourages programs to prevent or reduce the human and environmental health impact from global climate change and environmental degradation.(12) encourages economic development programs for all nations that will be sustainable and yet nondestructive to the environment; (13) encourages physicians and environmental scientists in the United States to continue to incorporate concerns for human health into current environmental research and public policy initiatives; (14) encourages physician educators in medical schools, residency programs, and continuing medical education sessions to devote more attention to environmental health issues;
(15) will strengthen its liaison with appropriate environmental health agencies, including the National Institute of Environmental Health Sciences (NIEHS); (16) encourages expanded funding for environmental research by the federal government; and (17) encourages family planning through national and international support.
Citation: CSA Rep. G, I-89; Amended: CLRPD Rep. D, I-92; Amended: CSA Rep. 8, A-03; Reaffirmed in lieu of Res. 417, A-04; Reaffirmed in lieu of Res. 402, A-10; Reaffirmation I-16;
AMA to Protect Human Health from the Effects of Climate Change by Ending its Investments in Fossil Fuel Companies H-135.921
1. Our AMA will: (a) choose for its commercial relationships, when fiscally responsible, vendors, suppliers, and corporations that have demonstrated environmental sustainability practices that seek to minimize

their fossil fuels consumption; and (b) support efforts of physicians and other health professional associations to proceed with divestment, including to create policy analyses, support continuing medical education, and to inform our patients, the public, legislators, and government policy makers.
2. Our AMA: (a) declares that climate change is an urgent public health emergency, and calls upon all governments, organizations, and individuals to work to avert catastrophe; (b) urges all health and life insurance companies, including those that provide insurance for medical, dental, and long-term care, to work in a timely, incremental, and fiscally responsible manner to end all financial investments or relationships (divestment) with companies that generate the majority of their income from the exploration for, production of, transportation of, or sale of fossil fuels; and (c) will send letters to the nineteen largest health or life insurance companies in the United States to inform them of AMA policies concerned with climate change and with fossil fuel divestments, and urging these companies to divest.
Citation: BOT Rep. 34, A-18; Appended: Res. 607, A-22; Reaffirmed: CSAPH Rep. 2, I-22;

Support of Clean Air and Reduction in Power Plant Emissions H-135.949
1. Our AMA supports (a) federal legislation and regulations that meaningfully reduce the following four major power plant emissions: mercury, carbon dioxide, sulfur dioxide and nitrogen oxide; and (b) efforts to limit carbon dioxide emissions through the reduction of the burning of coal in the nation's power generating plants, efforts to improve the efficiency of power plants and continued development, promotion, and widespread implementation of alternative renewable energy sources in lieu of carbon-based fossil fuels.
2. Our AMA will: (a) support the Environmental Protection Agency’s proposal, under the Clean Air Act, to regulate air quality for heavy metals and other air toxins emitted from smokestacks. The risk of dispersion through air and soil should be considered, particularly for people living downwind of smokestacks; and (b) urge the EPA to finalize updated mercury, cadmium, and air toxic regulations for monitoring air quality emitted from power plants and other industrial sources, ensuring that recommendations to protect the public’s health are enforceable.
Citation: Res. 429, A-03; Reaffirmation I-07; Reaffirmed in lieu of Res. 526, A-12; Reaffirmed: Res. 421, A-14; Modified: Res. 506, A-15; Modified: Res. 908, I-17; Appended: Res. 401, A-22;

EPA and Green House Gas Regulation H-135.934
1. Our AMA supports the Environmental Protection Agency's authority to promulgate rules to regulate and control green house gas emissions in the United States.
2.Our AMA: (a) strongly supports evidence-based environmental statutes and regulations intended to regulate air and water pollution and to reduce greenhouse gas emissions; and (b) will advocate that environmental health regulations should only be modified or rescinded with scientific justification.
Citation: Res. 925, I-10; Reaffirmed in lieu of Res. 526, A-12; Reaffirmed: Res. 421, A-14; Appended: Res. 523, A-17;

Conservation, Recycling and Other "Green" Initiatives G-630.100
AMA policy on conservation and recycling include the following: (1) Our AMA directs its offices to implement conservation-minded practices whenever feasible and to continue to participate in "green" initiatives. (2) It is the policy of our AMA to use recycled paper whenever reasonable for its in-house printed matter and publications, including JAMA, and materials used by the House of Delegates, and that AMA printed material using recycled paper should be labeled as such. (3) During meetings of the American Medical Association House of Delegates, our AMA Sections, and all other AMA meetings, recycling bins, where and when feasible, for white (and where possible colored) paper will be made prominently available to participants.
Citation: CCB/CLRPD Rep. 3, A-12; Modified: Speakers Rep., A-15; Reaffirmed: CCB/CLRPD Rep. 1, A-22;

Disaggregation of Demographic Data Within Ethnic Groups H-350.954
1. Our AMA supports the disaggregation of demographic data regarding: (a) Asian-Americans and Pacific Islanders in order to reveal the within-group disparities that exist in health outcomes and representation in medicine; and (b) ethnic groups in order to reveal the within-group disparities that exist in health outcomes and representation in medicine.
2. Our AMA: (a) will advocate for restoration of webpages on the Asian American and Pacific Islander (AAPI) initiative (similar to those from prior administrations) that specifically address disaggregation of health outcomes related to AAPI data; (b) supports the disaggregation of data regarding AAPIs in order to reveal the AAPI ethnic subgroup disparities that exist in health outcomes; (c) supports the disaggregation of data regarding AAPIs in order to reveal the AAPI ethnic subgroup disparities that exist in representation in medicine, including but not limited to leadership positions in academic medicine; and (d) will report back at the 2020 Annual Meeting on the issue of disaggregation of data regarding AAPIs (and other ethnic subgroups) with regards to the ethnic subgroup disparities that exist in health outcomes and representation in medicine, including leadership positions in academic medicine.
Citation: Res. 001, I-17; Appended: Res. 403, A-19;

Reducing Lead Poisoning H-60.924
1. Our AMA: (a) supports regulations and policies designed to protect young children from exposure to lead; (b) urges the Centers for Disease Control and Prevention to give priority to examining the current weight of scientific evidence regarding the range of adverse health effects associated with blood lead concentrations below the current "level of concern" in order to provide appropriate guidance for physicians and public health policy, and encourage the identification of exposure pathways for children who have low blood lead concentrations, as well as effective and innovative strategies to reduce overall childhood lead exposure; (c) encourages physicians and public health departments to screen children based on current recommendations and guidelines and to report all children with elevated blood levels to the appropriate health department in their state or community in order to fully assess the burden of lead exposure in children. In some cases this will be done by the physician, and in other communities by the laboratories; (d) promotes community awareness of the hazard of lead-based paints; and (e) urges paint removal product manufacturers to print precautions about the removal of lead paint to be included with their products where and when sold.
2. Our AMA will call on the United States government to establish national goals to: (a) ensure that no child has a blood lead level >5 g/dL (>50 ppb)by 2021, and (b) eliminate lead exposures to pregnant women and children, so that by 2030, no child would have a blood lead level >1 g/dL (10 ppb).
3. Our AMA will call on the United States government in all its agencies to pursue the following strategies to achieve these goals: (a) adopt health-based standards and action levels for lead that rely on the most up-to-date scientific knowledge to prevent and reduce human exposure to lead, and assure prompt implementation of the strongest available measures to protect pregnant women and children from lead toxicity and neurodevelopmental impairment; (b) identify and remediate current and potential new sources of lead exposure (in dust, air, soil, water and consumer products) to protect children before they are exposed; (c) continue targeted screening of children to identify those who already have elevated blood lead levels for case management, as well as educational and other services; (d) eliminate new sources of lead introduced or released into the environment, which may entail banning or phasing out all remaining uses of lead in products (aviation gas, cosmetics, wheel weights, industrial paints, batteries, lubricants, and other sources), and the export of products containing lead, and setting more protective limits on emissions from battery recyclers and other sources of lead emissions; (e) provide a dedicated funding stream to enhance the resources available to identify and eliminate sources of lead exposure, and provide educational, social and clinical services to mitigate the harms of lead toxicity, particularly to protect and improve the lives of children in communities that are disproportionately exposed to lead; and (f) establish an independent expert advisory committee to develop a long-term national strategy, including recommendations for funding and implementation, to achieve the national goal of eliminating lead toxicity in pregnant women and children, defined as blood lead levels above 1 g/dL (10 ppb).
4.Our AMA supports requiring an environmental assessment of dwellings, residential buildings, or child care facilities following the notification that a child occupant or frequent inhabitant has a confirmed elevated blood lead level, to determine the potential source of lead poisoning, including testing the water supply.
Citation: CCB/CLRPD Rep. 3, A-14; Appended: Res. 926, I-16; Appended: Res. 412, A-17;

Pollution Control and Environmental Health H-135.996
Our AMA supports (1) efforts to alert the American people to health hazards of environmental pollution and the need for research and control measures in this area; and (2) its present activities in pollution control and improvement of environmental health.
Citation: Sub. Res. 40, A-70; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Modified: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 01, A-20;

Research into the Environmental Contributors to Disease D-135.997
Our AMA will (1) advocate for greater public and private funding for research into the environmental causes of disease, and urge the National Academy of Sciences to undertake an authoritative analysis of environmental causes of disease; (2) ask the steering committee of the Medicine and Public Health Initiative Coalition to consider environmental contributors to disease as a priority public health issue; and (3) lobby Congress to support ongoing initiatives that include reproductive health outcomes and development particularly in minority populations in Environmental Protection Agency Environmental Justice policies.
Citation: Res. 402, A-03; Appended: Res. 927, I-11; Reaffirmed in lieu of: Res. 505, A-19;

Environmental Health Programs H-135.969
Our AMA (1) urges the physicians of the United States to respond to the challenge for a clean environment individually and through professional groups by becoming the spokespersons for environmental stewardship; and (2) encourages state and county medical societies to establish active environmental health committees.
Citation: Res. 124, A-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 01, A-20;

Federal Programs H-135.999
The AMA believes that the problem of air pollution is best minimized through the cooperative and coordinated efforts of government, industry and the public. Current progress in the control of air pollution can be attributed primarily to such cooperative undertakings. The Association further believes that the federal government should play a significant role in these continuing efforts. This may be done by federal grants for (1) the development of research activity and (2) the encouragement of local programs for the prevention and control of air pollutants.
Citation: BOT Rep. M, A-63; Reaffirmed: CLRPD Rep. C, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmation I-06; Reaffirmation I-07; Reaffirmed: CSAPH Rep. 01, A-17;

Racism as a Public Health Threat H-65.952
1. Our AMA acknowledges that, although the primary drivers of racial health inequity are systemic and structural racism, racism and unconscious bias within medical research and health care delivery have caused and continue to cause harm to marginalized communities and society as a whole.
2. Our AMA recognizes racism, in its systemic, cultural, interpersonal, and other forms, as a serious threat to public health, to the advancement of health equity, and a barrier to appropriate medical care.
3. Our AMA encourages the development, implementation, and evaluation of undergraduate, graduate, and continuing medical education programs and curricula that engender greater understanding of: (a) the causes, influences, and effects of systemic, cultural, institutional, and interpersonal racism; and (b) how to prevent and ameliorate the health effects of racism.
4. Our AMA: (a) supports the development of policy to combat racism and its effects; and (b) encourages governmental agencies and nongovernmental organizations to increase funding for research into the epidemiology of risks and damages related to racism and how to prevent or repair them.
5. Our AMA will work to prevent and combat the influences of racism and bias in innovative health technologies.
Citation: Res. 5, I-20; Reaffirmed: Res. 013, A-22; Modified: Speakers Rep., A-22;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 604
(A-23)

Introduced by: American Academy of Physical Medicine and Rehabilitation

Subject: Speakers Task Force to Review and Modernize the Resolution Process

Referred to: Reference Committee F

Whereas, Our American Medical Association House of Delegates recently reviewed and revised the election process for officers and councils through a Speakers Task Force; and

Whereas, The process of submitting, reviewing, evaluating, reporting, and voting on resolutions in our HOD has not changed in many years; and

Whereas, For the past two years, all delegations and sections have met virtually and have been able to work asynchronously to discuss and vote on potential resolutions to submit to the AMA HOD; and

Whereas, The Saturday/Sunday tote contains a significant amount of new resolutions each year; and

Whereas, The resolutions in the Saturday/Sunday tote cannot be adequately reviewed and vetted by all delegations and delegation staff and reference committee members prior to the start of the reference committee hearings; and

Whereas, According to Bylaws 2.11.3.1.3, “Late resolutions may be presented by a delegate prior to the recess of the opening session of the House of Delegates, and will be accepted as business of the House of Delegates only upon two-thirds vote of delegates present and voting”; and

Whereas, According to Bylaws 2.11.3.1.4 Emergency Resolutions, “resolutions of an emergency nature may be presented by a delegate any time after the opening session of the House of Delegates is recessed. Emergency resolutions will be accepted as business only upon a three-fourths vote of delegates present and voting, and if accepted shall be presented to the House of Delegates without consideration by a reference committee. A simple majority vote of the delegates present, and voting shall be required for adoption”; and

Whereas, The ability to meet virtually and work asynchronously was enhanced during the pandemic to the point where it is potentially more efficient and convenient for Delegations and Sections; therefore be it

RESOLVED, That our American Medical Association form a Speakers Task Force on the Resolution Process to review the entire process of handling resolutions for our AMA House of Delegates, including but not limited to definitions of on time resolutions, emergency resolutions, and late resolutions, deadlines for submission of resolutions by all sections, processing and review of reference committee reports, and use of virtual meetings so that all on time resolutions can be submitted by the same deadline (Directive to Take Action); and be it further

RESOLVED, That our AMA Speakers Task Force on the Resolution Process report back to our AMA House of Delegates by the 2024 Annual Meeting with recommendations regarding the resolution process. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000

Received: 5/2/23

RELEVANT AMA POLICY

Procedure B-2.11
2.11.3.1.3 Late Resolutions. Late resolutions may be presented by a delegate prior to the recess of the opening session of the House of Delegates, and will be accepted as business of the House of Delegates only upon two-thirds vote of delegates present and voting.
2.11.3.1.4 Emergency Resolutions. Resolutions of an emergency nature may be presented by a delegate any time after the opening session of the House of Delegates is recessed. Emergency resolutions will be accepted as business only upon a three-fourths vote of delegates present and voting, and if accepted shall be presented to the House of Delegates without consideration by a reference committee. A simple majority vote of the delegates present and voting shall be required for adoption.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 605
(A-23)

Introduced by: International Medical Graduates Section

Subject: Equity and Justice Initiatives for International Medical Graduates

Referred to: Reference Committee F

Whereas, International medical graduates represent 25% of the physician workforce in the United States and constitutes the backbone of the medical healthcare system in rural and underserved areas; and

Whereas, International medical graduates continue to be treated with explicit and implicit biases during their training, academic and community careers, careers in organized medicine, and consideration for leadership positions as reported by recent studies; and

Whereas, The American Medical Association created the Center for Health Equity in 2019 which released the health equity strategic plan in 2021, which lacks a specific strategy to address the unique challenges faced by international medical graduates in achieving equity and justice in their medical practice in the U.S.; therefore be it

RESOLVED, That our American Medical Association, via the Center for Health Equity, create a yearly session (during the Interim or Annual Meeting) as a part of the equity forum that will be dedicated to international medical graduates (Directive to Take Action); and be it further

RESOLVED, That our AMA, via the Center of Health Equity, create an amendment to the health equity plan that will address the issues of equity and justice for international medical graduates. (Directive to Take Action)

Fiscal Note: Approximately $44K for a one-time update of the health equity strategic plan, plus ~$24k annually to produce the requested forum.

Received: 4/27/23

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1. StackPath. (n.d.). https://www.hcinnovationgroup.com/population-health-management/health-equity/news/21244786/ama-releases-guide-to-advancing-health-equity
2. Professional experiences of international medical graduates practicing primary care in the United States. Peggy Guey-Chi Chen et al. Sep 2010. PMID: 20502974
3. Professional challenges of non-US-born international graduates and recommendations for support during residency training. Nov 2011. Peggy Guey-Chi Chen et al. PMID: 21952056

RELEVANT AMA POLICY

Plan for Continued Progress Toward Health Equity D-180.981

1. Our AMA will develop an organizational unit, e.g., a Center or its equivalent, to facilitate, coordinate, initiate, and track AMA health equity activities.
2. The Board will provide an annual report to the House of Delegates regarding AMAs health equity activities and achievements.
Citation: BOT Rep. 33, A-18;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 606
(A-23)

Introduced by: Georgia, Mississippi, Oklahoma, New Jersey, Alabama, Virginia, Delaware

Subject: AMA Reimbursement of Necessary HOD Business Meeting Expenses for Delegates and Alternate Delegates

Referred to: Reference Committee F

Whereas, Our American Medical Association is the largest and only national organization that convenes delegations from 190+ state and national medical specialty societies and other critical stakeholders twice a year, with the mission of promoting the art and science of medicine and the betterment of public health; and

Whereas, At these meetings, our AMA's policies are determined by our AMA House of Delegates (HOD), which is an incredibly diverse deliberating body whose delegates bring a wealth of knowledge, experience, and perspective to the debates; and

Whereas, Many of our AMA's constituent and component medical societies are facing significant financial challenges—in some cases even existential; and

Whereas, In too many instances, these financial challenges are negatively affecting the sponsoring societies' ability to fully fund the essential activities (travel, lodging, meals, staffing, caucus expenses, etc.) of their AMA delegation members, including medical students, residents, and fellows; and

Whereas, When the financial costs of participating in AMA delegation activities become the personal expense obligations of the individual delegation members, this may result in an unfortunate and potentially devastating reversal of the diversity of the delegation representation—possibly weighting them towards older, more financially successful membership and conceivably resulting in reduced medical student, resident, and fellow representation; and

Whereas, The 2021 AMA Annual Report reported over 278,000 AMA members, $34.8 Million in dues receipts, consolidated revenue and income of $459.7 Million before tax, net operating income of $77.9 Million, and reserves of almost $1 Billion; and

Whereas, Instituting a reimbursement policy to help state and national specialty societies fund their AMA delegation HOD business meeting expenses will not significantly affect the AMA's financial position while providing a critical lifeline for many of the former; therefore be it

RESOLVED, That our American Medical Association develop a reimbursement policy consistent with established AMA travel policies for reasonable travel expenses that any state or national specialty society is eligible to receive reimbursement for its delegate's and alternate delegate's actual expenses directly related to the necessary business functions required of its AMA delegates and alternate delegates in service to the AMA at HOD meetings, including travel, lodging, and meals (Directive to Take Action); and be it further

RESOLVED, That each state or national specialty society requesting such reimbursement for its delegate's and alternate delegate's reasonable travel expenses will submit its own aggregated documentation to the AMA in whatever form is requested by the AMA. (Directive to Take Action)

Fiscal Note: This policy would result in AMA being responsible for approximately $8.1 million annually based on current AMA travel policy, estimated average costs for airfare and travel, and current number of delegates and alternate delegates.

Received: 5/9/23

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 607
(A-23)

Introduced by: Matthew D. Gold, M.D., Delegate

Subject: Enabling Sections of the American Medical Association

Referred to: Reference Committee F

Whereas, The American Medical Association is the premiere single organization that represents the entire spectrum of the medical profession; and

Whereas, Sections of the AMA serve as centers of association of individuals around a theme regardless of residence or practice location, in contrast to State delegations which are geographically limited; and

Whereas, Sections of the AMA traditionally have developed novel initiatives and serve as a source of synthesis of ideas from diverse perspectives, in a setting more conducive to person to person interaction than the much larger House of Delegates; and

Whereas, The financial expenditure, as well as opportunity cost (e.g., time away from practice) involved in attending a Section meeting is virtually the same whether that meeting is held over one or two days; and

Whereas, Restricting Section meetings to a single calendar day significantly limits the opportunity for sharing of ideas, development of policy and educational sessions, and enrichment of interpersonal connections; and

Whereas, Restricting Section meetings to a single calendar day reduces the opportunity for Sections to interact, collaborate, and share educational sessions; and

Whereas, Compressing the Session meetings leaves those who are involved in other AMA business unable fully to participate in their Sections business and activities; and

Whereas, The effect of limiting Section meetings to a single day is a disincentive to attend, at least in person; therefore be it

RESOLVED, That our American Medical Association Section meetings be held officially over no less than two calendar days in anticipation of general House of Delegates meetings, unless otherwise determined by a given individual Section. (Directive to Take Action)

Fiscal Note: Space permitting within currently contracted venues, the incremental daily cost of expanding an AMA Section meeting beyond one day is ~$10-$12K per meeting, per section.

Received: 5/9/23

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 608
(A-23)

Introduced by: Illinois

Subject: Supporting Carbon Offset Programs for Travel for AMA Conferences

Referred to: Reference Committee F

Whereas, Climate change is a grave threat facing human and planetary health and is an issue that is already recognized and addressed by our American Medical Association. According to the World Health Organization, it is "…the single biggest health threat facing humanity, and health professionals worldwide are already responding to the health harms caused by this unfolding crisis;"[1] and

Whereas, The healthcare industry, which is one of the most carbon-intensive service sectors in the industrialized world, is responsible for 4.4–4.6 percent of worldwide greenhouse gas (GHG) emissions, largely stemming from fossil fuel combustion[2], and

Whereas, In 2022, our AMA adopted policy to declare climate change a public health crisis and advocates for policies that reduce emissions aimed at carbon neutrality and supports rapid implementation in incentivization of clean energy solutions and significant investments in climate resilience through a climate justice lens (D-135.966, *Declaring Climate Change a Public Health Crisis*); and

Whereas, Our AMA supports calling on the health sector to lead by example to commit to carbon neutrality by 2050 by supporting initiatives to promote environmental sustainability within its business operations (D-135.966, H-135.921, *AMA to Protect Human Health from the Effects of Climate Change by Ending its Investments in Fossil Fuel Companies*, and H-135.923, *AMA Advocacy for Environmental Sustainability and Climate*); and

Whereas, Carbon offsetting is "the act of reducing carbon dioxide or greenhouse gases in order to compensate for emissions that were produced elsewhere;"[3] and

Whereas, Our AMA has resumed in-person meetings, allowing for enhanced didactic sessions, colleague interaction and efficient discussion and advancement of relevant and timely policy impacting the healthcare profession and public health. These conferences require air and ground travel for hundreds of participants, amounting to thousands of tons of greenhouse gas emissions; and

Whereas, Carbon pollution from transportation is due to burning fossil fuels such as gasoline and diesel, releasing GHG into the atmosphere, and such emissions from transportation are the largest contributor of U.S. GHG emissions, accounting for about 27%[4]; and

Whereas, Carbon-neutral procurement and other purchasing options or equivalent carbon offsets are a mechanism to mitigate such emissions; therefore be it

RESOLVED, That our American Medical Association facilitate the mitigation or offset of carbon emissions related to AMA events, including planning and management, travel, and conference

operations, by procurement of sustainable or otherwise carbon-neutral energy, travel services, supplies, etc. under the direct control of the AMA and provision for conference attendees and other external stakeholders to access the equivalent mitigation or offsets for their own attendance and related activities. Mitigation and offset measures may include purchase of renewable energy credits, sustainable purchasing requirements integrating emissions criteria, investment in forestry and conservation, energy efficiency projects, or other instruments traded by accredited entities. (Directive to Take Action)

Fiscal Note: Implementation of this initiative will be a multi-million dollar undertaking due to the need for consultants to develop a plan, project management to implement measures, potential reduction of in-person meetings and travel, and the ongoing purchase of carbon credits to offset AMA emissions, including, among others, making mitigation efforts accessible to attendees. Measuring and reporting on compliance will contribute to significant annual costs thereafter. It is currently impossible to provide more precise cost information given the myriad factors involved.

Received: 5/5/23

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2. Eckelman M, Kaixin H, et al. Health care pollution and public health damage in the Unites Sate: An update. Health Affairs. 2020; 39:12. https://www.healthaffairs.org/doi/10.1377/hlthaff.2020.01247.Accessed January 7, 2023
3. https://sustainabletravel.org/our-work/carbon-offsets/faq/#:~:text=Carbon%20offsetting%20is%20the%20act,emissions%20that%20were%20produced%20elsewhere.
4. United States Environmental Protection Agency. Carbon Pollution from Transportation. https://www.epa.gov/transportation-air-pollution-and-climate-change/carbon-pollution-transportation#:~:text=Transportation%20and%20Climate%20Change,-Burning%20fossil%20fuels&text=%E2%80%8BGreenhouse%20gas%20(GHG)%20emissions,contributor%20of%20U.S.%20GHG%20emissions. Accessed January 11, 2023

RELEVANT AMA POLICY

Declaring Climate Change a Public Health Crisis D-135.966
1. Our AMA declares climate change a public health crisis that threatens the health and well-being of all individuals.
2. Our AMA will protect patients by advocating for policies that: (a) limit global warming to no more than 1.5 degrees Celsius, (b) reduce US greenhouse gas emissions aimed at carbon neutrality by 2050, and (c) support rapid implementation and incentivization of clean energy solutions and significant investments in climate resilience through a climate justice lens.
3. Our AMA will develop a strategic plan for how we will enact our climate change policies including advocacy priorities and strategies to decarbonize physician practices and the health sector with report back to the House of Delegates at the 2023 Annual Meeting.
Citation: Res. 420, A-22;

AMA to Protect Human Health from the Effects of Climate Change by Ending its Investments in Fossil Fuel Companies H-135.921
1. Our AMA will: (a) choose for its commercial relationships, when fiscally responsible, vendors, suppliers, and corporations that have demonstrated environmental sustainability practices that seek to minimize their fossil fuels consumption; and (b) support efforts of physicians and other health professional associations to proceed with divestment, including to create policy analyses, support continuing medical education, and to inform our patients, the public, legislators, and government policy makers.
2. Our AMA: (a) declares that climate change is an urgent public health emergency, and calls upon all governments, organizations, and individuals to work to avert catastrophe; (b) urges all health and life insurance companies, including those that provide insurance for medical, dental, and long-term care, to work in a timely, incremental, and fiscally responsible manner to end all financial investments or relationships (divestment) with companies that generate the majority of their income from the exploration for, production of, transportation of, or sale of fossil fuels; and (c) will send letters to the nineteen largest

health or life insurance companies in the United States to inform them of AMA policies concerned with climate change and with fossil fuel divestments, and urging these companies to divest.
Citation: BOT Rep. 34, A-18; Appended: Res. 607, A-22; Reaffirmed: CSAPH Rep. 2, I-22;

AMA Advocacy for Environmental Sustainability and Climate H-135.923
Our AMA (1) supports initiatives to promote environmental sustainability and other efforts to halt global climate change; (2) will incorporate principles of environmental sustainability within its business operations; and (3) supports physicians in adopting programs for environmental sustainability in their practices and help physicians to share these concepts with their patients and with their communities.
Citation: Res. 924, I-16; Reaffirmation: I-19;

Environmental Health Programs H-135.969
Our AMA (1) urges the physicians of the United States to respond to the challenge for a clean environment individually and through professional groups by becoming the spokespersons for environmental stewardship; and (2) encourages state and county medical societies to establish active environmental health committees.
Citation: Res. 124, A-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 01, A-20;

Referral Change:
Was Resolution 506

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 609
(A-23)

Introduced by:	Medical Student Section
Subject:	Encouraging Collaboration Between Physicians and Industry in AI (Augmented Intelligence) Development
Referred to:	Reference Committee F

Whereas, Our American Medical Association supports augmented intelligence (AI) systems that advance the quadruple aim, specifically AMA H-480.939, "Augmented Intelligence in Health Care:"

(1) To enhance the patient experience of care and outcomes,
(2) To improve population health,
(3) To reduce overall costs for the healthcare system while increasing value,
(4) To support the professional satisfaction of physicians and the healthcare team; and

Whereas, Our AMA seeks to identify opportunities to integrate practicing physicians' perspectives into the development, design, validation, and implementation of health care AI AMA policy H-480.940, "Augmented Intelligence in Health Care"; and

Whereas, Research from the medical device industry has provided evidence that physicians substantially contribute to medical device innovation, specifically that:

(1) Physicians contributed to a fifth of medical device patents and generated a great number of citations, demonstrating a substantial physician involvement in medical device innovation[1],
(2) Physician patents were cited more times by subsequent patents than those without physician involvement, where the number of citation by follow-on inventions indicate the significance of the original innovation[1],
(3) Physician patents generated more follow-on innovations from a more diverse set of disciplines, emphasizing the broader impact of physician involvement in research[1]; and

Whereas, Research on the implementation of electronic health records (EHRs) has indicated that technology developed with physician involvement is associated with physicians' perceived ease of use and acceptance[2]; and

Whereas, Current research on AI has indicated that:

(1) Physicians assisted by AI models can outperform physicians or AI alone, specifically in diagnosing metastatic breast cancer and diabetic retinopathy[3, 4],
(2) Physicians can use interactive AI-based technologies in medical image segmentation and identification, providing evidence that physicians and AI technologies can work together to better fulfill the quadruple aim[5]; and

Whereas, Our AMA has launched pathways for healthcare innovation, but these pathways are greatly targeted to physicians currently involved in AI, such as Health 2047, a business that connects our AMA to leading experts in AI and machine learning to produce healthcare solutions[6]; and

Whereas, Our AMA has supported physician innovation, especially in the field of AI, through the Physician Innovation Network (PIN), an online forum board for entrepreneurs to seek medical specialists to "connect the health care innovation ecosystems to improve the development of emerging healthcare technology solutions"[7]; and

Whereas, Early analysis of the PIN has identified that early engagement of physicians and respecting a physician's time and expertise contribute to more meaningful connections between physicians and entrepreneurs[8]; and

Whereas, The PIN currently experiences limited physician utilization, as evidenced by:

(1) Interviews with current physicians on the PIN suggest that the PIN only appeals to a small subset of physicians who have already realized early in their careers that they wish to pursue a nontraditional path in medicine and innovation[9],

(2) As of 2018, only 2,600 physicians were reported to be on the network, or about 1% of our AMA's physician membership base[10]; and

Whereas, Our AMA advocates that our organization, national, and medical specialty societies and state medical associations (AMA, H-480.939):

(1) Leverage medical expertise to ensure clinical validation and assessment of clinical applications of AI systems by practicing physicians,

(2) Outline a new professional role to aid and guide health care AI systems; therefore be it

RESOLVED, That our American Medical Association augment the existing Physician Innovation Network (PIN) through the creation of advisors to specifically link physician members of AMA and its associated specialty societies with companies or individuals working on augmented intelligence (AI) research and development, focusing on:

(1) Expanding recruitment among AMA physician members,

(2) Advising AMA physician members who are interested in healthcare innovation/AI without knowledge of proper channels to pursue their ideas,

(3) Increasing outreach from AMA to industry leaders and companies to both further promote the PIN and to understand the needs of specific companies,

(4) Facilitating communication between companies and physicians with similar interests,

(5) Matching physicians to projects early in their design and testing stages,

(6) Decreasing the time and workload spent by individual physicians on finding projects themselves,

(7) Above all, boosting physician-centered innovation in the field of AI research and development (Directive to Take Action); and be it further

RESOLVED, That our AMA support selection of PIN advisors through an application process where candidates are screened by PIN leadership for interpersonal skills, problem solving, networking abilities, objective decision making, and familiarity with industry. (New HOD Policy)

Fiscal Note: Approximately $47,000 for identifying, recruiting, promoting, and facilitating industry-physician relationships through the Physician Innovation Network regarding AI.

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RELEVANT AMA POLICY

Augmented Intelligence in Health Care H-480.940

As a leader in American medicine, our AMA has a unique opportunity to ensure that the evolution of augmented intelligence (AI) in medicine benefits patients, physicians, and the health care community.
To that end our AMA will seek to:
1. Leverage its ongoing engagement in digital health and other priority areas for improving patient outcomes and physiciansprofessional satisfaction to help set priorities for health care AI.
2. Identify opportunities to integrate the perspective of practicing physicians into the development, design, validation, and implementation of health care AI.
3. Promote development of thoughtfully designed, high-quality, clinically validated health care AI that:
a. is designed and evaluated in keeping with best practices in user-centered design, particularly for physicians and other members of the health care team;
b. is transparent;
c. conforms to leading standards for reproducibility;
d. identifies and takes steps to address bias and avoids introducing or exacerbating health care disparities including when testing or deploying new AI tools on vulnerable populations; and
e. safeguards patientsand other individualsprivacy interests and preserves the security and integrity of personal information.
4. Encourage education for patients, physicians, medical students, other health care professionals, and health administrators to promote greater understanding of the promise and limitations of health care AI.
5. Explore the legal implications of health care AI, such as issues of liability or intellectual property, and advocate for appropriate professional and governmental oversight for safe, effective, and equitable use of and access to health care AI.
Citation: BOT Rep. 41, A-18;

Augmented Intelligence in Health Care H-480.939
Our AMA supports the use and payment of augmented intelligence (AI) systems that advance the quadruple aim. AI systems should enhance the patient experience of care and outcomes, improve population health, reduce overall costs for the health care system while increasing value, and support the professional satisfaction of physicians and the health care team. To that end our AMA will advocate that:
1. Oversight and regulation of health care AI systems must be based on risk of harm and benefit accounting for a host of factors, including but not limited to: intended and reasonably expected use(s); evidence of safety, efficacy, and equity including addressing bias; AI system methods; level of automation; transparency; and, conditions of deployment.
2. Payment and coverage for all health care AI systems must be conditioned on complying with all appropriate federal and state laws and regulations, including, but not limited to those governing patient safety, efficacy, equity, truthful claims, privacy, and security as well as state medical practice and licensure laws.
3. Payment and coverage for health care AI systems intended for clinical care must be conditioned on (a) clinical validation; (b) alignment with clinical decision-making that is familiar to physicians; and (c) high-quality clinical evidence.
4. Payment and coverage for health care AI systems must (a) be informed by real world workflow and human-centered design principles; (b) enable physicians to prepare for and transition to new care delivery models; (c) support effective communication and engagement between patients, physicians, and the health care team; (d) seamlessly integrate clinical, administrative, and population health management functions into workflow; and (e) seek end-user feedback to support iterative product improvement.
5. Payment and coverage policies must advance affordability and access to AI systems that are designed for small physician practices and patients and not limited to large practices and institutions. Government-conferred exclusivities and intellectual property laws are meant to foster innovation, but constitute interventions into the free market, and therefore, should be appropriately balanced with the need for competition, access, and affordability.
6. Physicians should not be penalized if they do not use AI systems while regulatory oversight, standards, clinical validation, clinical usefulness, and standards of care are in flux. Furthermore, our AMA opposes:
a. Policies by payers, hospitals, health systems, or governmental entities that mandate use of health care AI systems as a condition of licensure, participation, payment, or coverage.
b. The imposition of costs associated with acquisition, implementation, and maintenance of healthcare AI systems on physicians without sufficient payment.
7. Liability and incentives should be aligned so that the individual(s) or entity(ies) best positioned to know the AI system risks and best positioned to avert or mitigate harm do so through design, development, validation, and implementation. Our AMA will further advocate:
a. Where a mandated use of AI systems prevents mitigation of risk and harm, the individual or entity issuing the mandate must be assigned all applicable liability.
b. Developers of autonomous AI systems with clinical applications (screening, diagnosis, treatment) are in the best position to manage issues of liability arising directly from system failure or misdiagnosis and must accept this liability with measures such as maintaining appropriate medical liability insurance and in their agreements with users.
c. Health care AI systems that are subject to non-disclosure agreements concerning flaws, malfunctions, or patient harm (referred to as gag clauses) must not be covered or paid and the party initiating or enforcing the gag clause assumes liability for any harm.
8. Our AMA, national medical specialty societies, and state medical associations—
a. Identify areas of medical practice where AI systems would advance the quadruple aim;
b. Leverage existing expertise to ensure clinical validation and clinical assessment of clinical applications of AI systems by medical experts;
c. Outline new professional roles and capacities required to aid and guide health care AI systems; and
d. Develop practice guidelines for clinical applications of AI systems.
9. There should be federal and state interagency collaboration with participation of the physician community and other stakeholders in order to advance the broader infrastructural capabilities and requirements necessary for AI solutions in health care to be sufficiently inclusive to benefit all patients, physicians, and other health care stakeholders. (New HOD Policy)
10. AI is designed to enhance human intelligence and the patient-physician relationship rather than replace it.
Citation: BOT Rep. 21, A-19; Reaffirmation: A-22;