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REPORT OF THE BOARD OF TRUSTEES

B of T Report 09-A-25

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| Subject: | Council on Legislation Sunset Review of 2015 House Policies |
| Presented by: | Michael Suk, MD, JD, MPH, MBA, Chair |
| Referred to: | Reference Committee B |

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 (HOD) adopts policies, a maximum ten-year time horizon shall exist. A policy will typically sunset after 10 years unless action is taken by the HOD to retain it. Any action of our AMA HOD 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 HOD 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; (e) For each recommendation that it makes to retain a policy in any fashion, the reviewing council shall provide a succinct, but cogent justification; or (f) The Speakers shall determine the best way for the HOD to handle the sunset reports.

3. Nothing in this policy shall prohibit a report to the HOD or resolution to sunset a policy earlier than its 10-year horizon if it is no longer relevant, has been superseded by a more current policy, or has been accomplished.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 HOD 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 HOD 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 Board of Trustees recommends 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 |
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| D-105.995 | Protecting Social Media Users by Updating FDA Guidelines | Our AMA will lobby the Food and Drug Administration to: (1) update regulations to ensure closer regulation of paid endorsements of drugs or medical devices by individuals on social media; and (2) develop guidelines to ensure that compensated parties on social media websites provide information that includes the risks and benefits of specific drugs or medical devices and off-use prescribing in every related social media communication in a manner consistent with advertisement guidelines on traditional media forms. | Retain – this policy remains relevant. |
| D-130.976 | Implications of the November 2003 Emergency Medical Treatment and Labor Act (EMTALA) Final Rule | Our AMA will: (1) ask the EMTALA Technical Advisory Group (TAG) and the Centers for Medicare and Medicaid Services (CMS) for assistance in ameliorating the differential economic and staffing burdens on certain categories of facilities, including but not limited to academic health centers, trauma centers, critical access hospitals, and safety net hospitals, which are likely to receive high volumes of patients as a result of the EMTALA regulations; (2) work with the EMTALA TAG and CMS to ensure that physicians staffing emergency departments and on-call emergency services be appropriately compensated for providing EMTALA mandated services; (3) with input from all interested Federation members, coordinate an effort to educate the membership about emergency department coverage issues and the efforts to resolve them; (4) seek to require all insurers, both public and private, to pay promptly and fairly all claims for services mandated by | Retain – this policy remains relevant. |

| Policy Number | Title | Text | Recommendation |
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| | | EMTALA for all plans they offer, or face fines and penalties comparable to those imposed on providers; and (5) seek to have CMS require all states participating in Medicaid, as a condition of continued participation, establish and adequately fund state Emergency Medical Services funds which physicians providing EMTALA-mandated services may bill, and from which those physicians shall receive prompt and fair compensation. | |
| D-165.961 | Physician Taxes | Our AMA will (1) proactively and vigorously oppose taxes on physician services, physician-owned facility taxes or "pass-through" taxes on medical services; and (2) work closely with national specialty societies and state medical societies to assist with advocacy efforts to combat existing and proposed taxes on physician services and physician-owned facilities. | Retain – this policy remains relevant. |
| D-165.989 | Managed Care Organization Reimbursement Formulas | Our AMA will continue to assist states medical associations in their efforts to enact meaningful legislation that protects patients and patient access through network adequacy provisions. | Retain – this policy remains relevant. |
| D-180.998 | Insurance Parity for Mental Health and Psychiatry | Our AMA in conjunction with the American Psychiatric Association and other interested organizations will develop model state legislation for the use of state medical associations and specialty societies to promote legislative changes assuring parity for the coverage of mental illness, alcoholism, and substance abuse. | Sunset this policy.<br><br>The AMA worked with the American Psychiatric Association and other organizations to develop and promote model state legislation that has been successfully enacted in multiple states and provisions have been introduced in at least four states in the 2025 state legislative sessions. |
| D-185.999 | Information Included On Health Insurance Identification Cards | Our AMA will continue to work with payers, the federal and state governments, and standards organizations to adopt and implement appropriate policies, technologies (e.g., smart cards, telephone hot lines, electronic data interchange, and website access), and national technology standards to provide physicians with | Retain – this policy remains relevant. |

| Policy Number | Title | Text | Recommendation |
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| | | accurate and real time verification of patient eligibility, co-payment due, deductible payable information, and claims processing. | |
| D-260.993 | Opposition to Laboratory Reporting Provisions of H.R. 4302 | Our American Medical Association will work with federation members and other major stakeholders, including the clinical laboratory and hospital associations, to identify and pursue viable congressional and regulatory strategies to eliminate or substantially reduce the reporting burden associated with Medicare rate setting for laboratory fee schedule services and procedures while supporting access to clinical laboratory services among the spectrum of providers of these services. | Retain – this policy remains relevant. |
| D-265.990 | Strategic Lawsuits Against Public Participation (SLAPP) | Our AMA will make available, but not as a matter of advocacy priority, model anti-SLAPP legislation protecting physicians? First Amendment rights in the context of proceedings relating to quality of health care. | Retain – this policy remains relevant. |
| D-270.995 | Physician Ownership and Referral for Imaging Services | Our AMA will work collaboratively with state medical societies and specialty societies to actively oppose any and all federal and state legislative and regulatory efforts to repeal the in-office ancillary exception to physician self-referral laws, including as they apply to imaging services. | Retain – this policy remains relevant. |
| D-275.955 | MOC Provisions of Interstate Medical Licensure Compact | Our American Medical Association will, in collaboration with the Federation of State Medical Boards and interested state medical boards, request a clarifying statement from the Interstate Medical Licensure Compact Commission that the intent of the language in the model legislation requiring that a physician "holds" specialty certification refers only to initial specialty certification recognized by the American Board of Medical Specialties or the American Osteopathic Association's (AOA's) Bureau of Osteopathic Specialists and that there is no requirement for participation in ABMS's Maintenance of Certification or AOA's Osteopathic Continuous Certification (OCC) program in order to receive initial or continued | Sunset this policy.<br><br>This directive has been accomplished. In 2015, the AMA requested a clarifying statement from the Interstate Medical Licensure Compact Commission (IMLCC) as specified in this directive. In a response letter, the IMLCC clarified that a physician must hold specialty certification at the time of their application to the Compact but is not required to participate in MOC or OCC. The letter stated that |

| Policy Number | Title | Text | Recommendation |
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| | | licensure under the Interstate Medical Licensure Compact. | the Compact does not have any language requiring that physicians participate in MOC or OCC and has no requirement for continued certification beyond the initial authorization of licensure. |
| D-285.963 | Out of Network Coverage Denials for Physician Prescriptions and Ordered Services | Our American Medical Association will pursue regulation or legislation to prohibit any insurer from writing individual or group policies which deny or unreasonably delay coverage of medically necessary prescription drugs or services based on network distinctions of the licensed health care provider ordering the drug or service. | Retain – this policy remains relevant. |
| D-305.955 | Funding for Teaching Health Center Graduate Medical Education Program | Our American Medical Association will encourage Congress to reauthorize the Teaching Health Center Graduate Medical Educational Program to its full and ongoing funding needs to continue the training of primary providers in community based health centers in underserved areas to assure a continuing supply of primary providers and dentists for the underserved populations. | Retain – this policy remains relevant. |
| D-315.977 | Indemnity for Breaches in Electronic Health Record Cybersecurity | Our AMA will advocate for indemnity or other liability protections for physicians whose electronic health record data and other electronic medical systems become the victim of security compromises. | Retain – this policy remains relevant. |
| D-315.978 | Protecting Consumers' Personal Data | Our AMA supports legislation that prohibits the inappropriate sharing of health and other personal information obtained from health insurance marketplaces. | Retain – this policy remains relevant. |
| D-330.907 | Protect Medicare Beneficiary Access to Complex Rehabilitation Wheelchairs | Our AMA strongly encourages the Centers for Medicare and Medicaid Services (CMS) to refrain from implementing policies on January 1, 2016 that would curtail access to complex rehabilitation technology (CRT) wheelchairs and accessories by applying competitively bid prices to these specialized devices. In the event that CMS does not refrain from implementing policies limiting access to | Sunset this policy.<br><br>This policy has been accomplished. The 2022 Inpatient Rehabilitation Facility final rule permanently exempted (across all settings) complex rehabilitation technology wheelchairs and accessories from |

| Policy Number | Title | Text | Recommendation |
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| | | CRT wheelchairs, our AMA will encourage Congress to support legislation (e.g. H.R. 3229) that would provide a technical correction to federal law to clarify that CMS cannot apply Medicare competitive bidding pricing to CRT wheelchairs. | Medicare's competitive bidding program. |
| D-330.908 | Improving the Local Coverage Determination Process | 1. Our AMA will advocate through legislative and/or regulatory efforts as follows: A. When Medicare Administrative Contractors (MACs) propose new or revised Local Coverage Determinations (LCDs) said Contractors must: (1) Ensure that Carrier Advisory Committee meeting minutes are recorded and posted to the Contractor's website; and (2) Disclose the rationale for the LCD, including the evidence upon which it is based when releasing an approved LCD; B. That the Centers for Medicare and Medicaid Services adopt a new LCD reconsideration process that allows for an independent review of a MAC's payment policies by a third-party, with appropriate medical and specialty expertise, empowered to make recommendations to the Secretary of Health and Human Services that said policies should be withdrawn or revised; and C. That MACs shall be prohibited from adopting another MAC's LCD without first undertaking a full and independent review of the underlying science and necessity of such LCD in their jurisdiction.<br><br>2. Our AMA will work with interested state medical and national specialty societies to develop model legislation or regulations requiring commercial insurance companies, state Medicaid agencies, or third party payers to: A. Publish all edits that are to be used in their claims processing in a manner that is freely accessible and downloadable to physicians; and B. Participate in a transparent process that allows for review, challenge, and deletion of unfair edits. | Retain – this policy remains relevant. |

| Policy Number | Title | Text | Recommendation |
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| D-330.944 | Admission Criteria for Inpatient Rehabilitation Services | Our AMA will seek a legislative change to the admission criteria for Inpatient Rehabilitation Facilities to diagnosis-specific, functional-level and limitations of the individual patient as opposed to diagnosis-specific criteria alone. | Sunset this policy.<br><br>The intent of this policy has been realized through regulatory updates to the 2017 Inpatient Rehabilitation Facilities (IRF) Reference Booklet, which outlines both diagnosis-specific and functional-level assessments in determining IRF admissions. |
| D-330.948 | Medicare Demonstration Projects | Our AMA will: (1) encourage CMS to continue to seek input at the earliest possible occurrence from medical associations in the development of Medicare demonstration projects that are intended to contain costs and/or improve the appropriateness or quality of patient care; (2) encourage CMS to continue to vary the types of physician practices (e.g., by size, geographic location) that it utilizes in its Medicare demonstration projects; (3) encourage CMS to limit requirements that may make participation in Medicare demonstration projects financially and/or administratively impracticable for a wide range of physician practices; and (4) join state and specialty societies early on to assist with developing Medicare demonstration projects to protect the interests of patients and physicians. | Retain – this policy remains relevant. |
| D-35.982 | AMA Support for States in Their Development of Legislation to Support Physician-Led, Team Based Care | 1. Our AMA will continue to assist states in opposing legislation that would allow for the independent practice of certified registered nurse practitioners.<br><br>2. Our AMA will assist state medical societies and specialty organizations that seek to enact legislation that would define the valued role of mid-level and other health care professionals within a physician-led team based model structured to efficiently deliver optimal quality patient care and to assure patient safety. | Retain – this policy remains relevant. |

| Policy Number | Title | Text | Recommendation |
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| | | 3. Our AMA will actively oppose health care teams that are not physician-led. | |
| D-383.980 | Health Care Entity Consolidation | Our AMA will (1) study the potential effects of monopolistic activity by health care entities that may have a majority of market share in a region on the patient-doctor relationship; and (2) develop an action plan for legislative and regulatory advocacy to achieve more vigorous application of antitrust laws to protect physician practices which are confronted with potentially monopolistic activity by health care entities. | Retain – this policy remains relevant. |
| D-385.974 | Freedom of Practice in Medical Imaging | Our AMA will:<br><br>(1) encourage and support collaborative specialty development and review of any appropriateness criteria, practice guidelines, technical standards, and accreditation programs, particularly as Congress, federal agencies and third party payers consider their use as a condition of payment, and to use the AMA Code of Ethics as the guiding code of ethics in the development of such policy;<br><br>(2) actively oppose efforts by private payers, hospitals, Congress, state legislatures, and the Administration to impose policies designed to control utilization and costs of medical services unless those policies can be proven to achieve cost savings and improve quality while not curtailing appropriate growth and without compromising patient access or quality of care;<br><br>(3) actively oppose efforts to require patients to receive imaging services at imaging centers that are mandated to require specific medical specialty supervision and support patients receiving imaging services at facilities where appropriately trained medical specialists can perform and interpret imaging services regardless of medical specialty; and | Retain – this policy remains relevant. |

| Policy Number | Title | Text | Recommendation |
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| | | (4) actively oppose any attempts by federal and state legislators, regulatory bodies, hospitals, private and government payers, and others to restrict reimbursement for imaging procedures based on physician specialty, and continue to support the reimbursement of imaging procedures being performed and interpreted by physicians based on the proper indications for the procedure and the qualifications and training of the imaging specialists in that specific imaging technique regardless of their medical specialty. | |
| D-390.952 | 96-Hour Rule for Critical Access Hospitals | 1. Our American Medical Association will support and lobby for passage of legislation that would provide relief to Critical Access Hospitals from the "96-hour rule."<br>2. Our AMA will join with other affected stakeholders to enhance efforts for passage of legislation that would provide relief to Critical Access Hospitals from the "96-hour rule." | Retain – this policy remains relevant. |
| D-390.979 | Economic Impact of Shifts in Site of Service | Our AMA will strongly advocate that, should the Sustainable Growth Rate formula continue to be used, the Centers for Medicare and Medicaid Services increase the SGR target to take into account procedures that are newly priced in the office setting, and continue to analyze the shift in site of service of these procedures to determine if the SGR target adjustments are accurate. | Sunset this policy.<br><br>This policy is outdated. The SGR formula was permanently repealed in 2015 with the passage of the Medicare Access and CHIP Reauthorization Act. |
| D-40.990 | Support for the Veterans to Paramedics Transition Act of 2015 | Our AMA supports legislation to enable veterans who desire to serve as paramedics to obtain training to satisfy emergency medical services personnel certification requirements, taking into account previous medical coursework and training received when such veterans were members of the armed forces. | Sunset this policy.<br><br>The Veterans to Paramedics Transition Act of 2015 has not been reintroduced since 2015. |
| D-410.995 | Fairness in Medical Imaging Interpretation | 1. Our AMA will continue to work with specialty societies and CMS to ensure that fair Medicare accreditation standards for advanced imaging services are adopted by the selected accrediting organizations. | Retain this policy in part.<br><br>Delete clauses 2 and 3. The MIPPA accreditation program has been fully implemented and the two- |

| Policy Number | Title | Text | Recommendation |
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| | | ~~2. Our AMA will encourage Congress and the Administration to allow the MIPPA-mandated Medicare accreditation program to be fully implemented and evaluated before further changes to Medicare's imaging standards and payments are made.~~<br><br>~~3. Our AMA will monitor the two-year Medicare appropriateness program, scheduled to begin in 2010, and work with specialty societies and the CMS to develop appropriateness (and exceptions) criteria if it decides to move forward with a permanent program.~~<br><br>~~4~~2. Our AMA will continue to work with specialty societies to correct payer and RBM policies that unfairly exclude qualified physicians from providing imaging services. | year Medicare appropriateness program ended over a decade ago. |
| D-435.969 | Liability Related to Referrals from Free Clinics | That our American Medical Association will work with interested medical associations to enact state legislation that provides medical liability immunity, similar to the protections granted under the Federal Tort Claims Act (FTCA), to physicians who provide charity care in hospitals, offices, clinics or other health care settings to patients referred from free clinics. | Retain – this policy remains relevant. |
| D-435.980 | Inclusion of Residents in Medical Liability Reform | Our AMA: (1) officially supports the inclusion of all physicians, including unlicensed residents, in state and federal medical liability caps; (2) will advocate for the inclusion of unlicensed residents in all pending and future federal medical liability reform legislation; and (3) will work with state medical societies to advocate for the inclusion of unlicensed residents in all current, pending, and future state medical liability reform legislation. | Retain – this policy remains relevant. |
| D-450.964 | Medicare Quality and Resource Use Reports | Our AMA will continue to work with the Centers for Medicare & Medicaid Services to improve the design, content, and performance indicators included in the Quality and Resource Use Reports | Sunset this policy.<br><br>The QRURs and VBM program were discontinued after |

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| | | (QRURs) for physicians, so that the reports reflect the quality and cost data associated with these physicians in calculating Value-Based Payment Modifiers (VBM). | December 31, 2018, after the transition to the Merit-based Incentive Payment System. |
| D-450.967 | The PQRI Reporting Standard Should be Amended | Our AMA will petition the Centers for Medicaid and Medicare Services to streamline and make less arduous the reporting standard of the Physicians' Quality Reporting Initiative and ask Congress to delay implementation of the mandatory nature of the program until the system has been refined to be more efficient and physician friendly. | Sunset this policy.<br><br>The Physicians' Quality Reporting Initiative was discontinued and replaced by the Merit-based Incentive Payment System. |
| D-95.975 | Physician Self-Monitoring of Controlled Substance Prescriptions | Our American Medical Association will work with the National Alliance for Model State Drug Laws (NAMSDL), as well as other appropriate national organizations and stakeholders, to update the NAMSDL's Model Prescription Monitoring Program Act to provide health care professionals the opportunity to review their schedule 2-5 controlled substance prescribing patterns as a means to help monitor appropriate prescribing and detect and identify fraudulent prescriptions dispensed under their respective Drug Enforcement Administration numbers. | Sunset this policy.<br><br>Every state now has a functional Prescription Drug Monitoring Program, and there are procedures to permit an authorized user the opportunity to review their prescribing history. |
| H-120.939 | Physicians Should be Able to Cancel or Rescind Renewals of Prescriptions After the Prescription has Been Delivered to the Pharmacy | Our AMA will support legislation or regulations that: (i) authorize physicians to cancel or rescind renewals of prescriptions previously written; (ii) mandate pharmacies, including pharmacy benefit plans, to implement easy-to- use procedures to permit physicians to issue orders to cancel or rescind renewals of prescriptions previously written; (iii) prevent such renewals from being filled or mailed to the patient; and (iv) enable the pharmacy or pharmacy benefit plan to readily implement such renewal orders, when directed by the physician, regardless of the state of residence of the patient, the state of practice or licensure of the physicians, and the state of business operation of the pharmacy or the pharmacy benefit plan. | Retain – this policy remains relevant. |

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| H-120.955 | Non-Physician Prescribing | 1. Our AMA advocates that prescriptive authority include the responsibility to monitor the effects of the medication and to attend to problems associated with-the use of the medication. This responsibility includes the liability for such actions.<br><br>2. Our AMA supports the development of methodologically valid research on the relative impact of non-physician prescribing on the quality of health care. | Retain – this policy remains relevant. |
| H-130.941 | Legal Issues Surrounding the Deployment and Utilization of Licensed Physicians in Response to Declared Disasters | Our AMA: (1) encourages physicians who are interested in volunteering during a disaster to register with their state's Emergency System for Advance Registration of Volunteer Health Professionals program, local Medical Reserve Corps unit, or similar registration systems capable of verifying that practitioners are licensed and in good standing at the time of deployment; and (2) (a) supports the National Conference of Commissioners on Uniform State Laws (NCCUSL) Uniform Emergency Volunteer Health Practitioners Act (UEVHPA) with the liability language of Alternative A; and (b) continues to advocate for civil liability protections for qualified physicians that provide care in a disaster who are not covered under the UEVHPA, but are covered in AMA model legislation titled "To Protect Physicians from Civil Liability Arising from Health Care Provided During a Disaster." | Retain – this policy remains relevant. |
| H-140.861 | Physicians' Self-Referral | Business arrangements among physicians in the health care marketplace have the potential to benefit patients by enhancing quality of care and access to health care services. However, these arrangements can also be ethically challenging when they create opportunities for self-referral in which patients' medical interests can be in tension with physicians' financial interests. Such arrangements can undermine a robust commitment to professionalism in medicine as well as | Retain – this policy remains relevant. |

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| | | trust in the profession.<br><br>In general, physicians should not refer patients to a health care facility that is outside their office practice and at which they do not directly provide care or services when they have a financial interest in that facility. Physicians who enter into legally permissible contractual relationships--including acquisition of ownership or investment interests in health facilities, products, or equipment; or contracts for service in group practices--are expected to uphold their responsibilities to patients first. When physicians enter into arrangements that provide opportunities for self-referral they must:(1) Ensure that referrals are based on objective, medically relevant criteria.<br><br>(2) Ensure that the arrangement:<br><br>(a) is structured to enhance access to appropriate, high quality health care services or products;<br><br>(b) within the constraints of applicable law:<br><br>(i) does not require physician-owners/investors to make referrals to the entity or otherwise generate revenues as a condition of participation;<br><br>(ii) does not prohibit physician-owners/investors from participating in or referring patients to competing facilities or services; and<br><br>(iii) adheres to fair business practices vis-a-vis the medical professional community--for example, by ensuring that the arrangement does not prohibit investment by nonreferring physicians.<br><br>(3) Take steps to mitigate conflicts of interest, including: | |

| Policy Number | Title | Text | Recommendation |
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| | | (a) ensuring that financial benefit is not dependent on the physician-owner/investor's volume of referrals for services or sales of products;<br><br>(b) establishing mechanisms for utilization review to monitor referral practices; and<br><br>(c) identifying or if possible making alternate arrangements for care of the patient when conflicts cannot be appropriately managed/mitigated.<br><br>(4) Disclose their financial interest in the facility, product, or equipment to patients; inform them of available alternatives for referral; and assure them that their ongoing care is not conditioned on accepting the recommended referral. | |
| H-140.874 | Opposition to Legislation that Presumes to Prescribe Patients' Preferences for Artificial Hydration and Nutrition | Our AMA opposes legislation that would presume to prescribe the patient's preferences for artificial hydration and nutrition in situations where the patient lacks decision-making capacity and an advance directive or living will. | Retain – this policy remains relevant. |
| H-180.947 | Maintaining Freedom of Choice with Insurance Products | Our AMA opposes consolidation in the health insurance industry that may result in anticompetitive markets. | Retain – this policy remains relevant. |
| H-185.932 | Support for Inclusion of Vasectomy in the ACA Preventive Services and Contraceptive Mandate | Our American Medical Association will work in concert with national specialty and state medical societies to advocate for patient access to the full continuum of evidence-based contraceptive methods and sterilization procedures, including vasectomy and male contraceptive counseling, to promote gender equity in contraceptive services under the ACA. | Retain – this policy remains relevant. |
| H-190.955 | Virtual Credit Card Payments | 1. Our American Medical Association will educate its members about the use of virtual credit cards by third party payers, including the costs of accepting virtual credit card payments from third party payers, the beneficiaries of the administrative fees paid by the physician practice inherent in accepting such payments and the lower cost alternative | Retain – this policy remains relevant. |

| Policy Number | Title | Text | Recommendation |
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| | | of electronic funds transfer via the Automated Clearing House.<br><br>2. Our AMA will advocate for advance disclosure by third-party payers of transaction fees associated with virtual credit cards and any rebates or other incentives awarded to payers for utilizing virtual credit cards.<br><br>3. Our AMA supports transparency, fairness, and provider choice in payers' use of virtual credit card payments, including: advanced physician consent to acceptance of this form of payment; disclosure of transaction fees; clear information about how the provider can opt out of this payment method at any time; and prohibition of payer contracts requiring acceptance of virtual credit card payments for network inclusion. | |
| H-230.969 | Strengthening Medical Staff Bylaws | The AMA: (1) will study the feasibility of assisting states in developing legislation to mandate that hospital medical staff bylaws be viewed as contracts; and (2) will study the feasibility of introducing federal legislation to mandate that medical staff bylaws be viewed as a contract. | Retain – this policy remains relevant. |
| H-275.955 | Physician Licensure Legislation | Our AMA reaffirms earlier policy urging licensing jurisdictions to adopt laws and rules facilitating the movement of physicians between states, to move toward uniformity in requirements for the endorsement of licenses to practice medicine, and to base endorsement of medical licenses on an assessment of competence rather than on passing a written examination of cognitive knowledge. | Sunset this policy.<br><br>This policy has been superseded by Policy H-275.978, as modified. |
| H-275.965 | Health Care Quality Improvement Act of 1986 Amendments | The AMA supports modification of the federal Health Care Quality Improvement Act in order to provide immunity from federal antitrust liability to those medical staffs credentialing and conducting good faith peer review for allied health professionals to the same extent that immunity applies to credentialing of physicians and dentists. | Retain – this policy remains relevant. |

| Policy Number | Title | Text | Recommendation |
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| H-280.950 | Medicare's Three-Day Hospital Stay Requirement | Our AMA will ask the leadership of the American Association of Retired Persons, the Federation, the American Hospital Association, the Federation of American Hospitals, and the American Osteopathic Association to join with the AMA as signatories on a letter requesting that the Centers for Medicare & Medicaid rescind Medicare's three-day hospital stay requirement for access to skilled nursing care. | Sunset this policy.<br>The HOD adopted more recent policy on this topic (i.e., H-280.947 "Three-Day Stay Rule"), and continues to advocate (e.g., sign-on letter) to the Centers for Medicare & Medicaid Services with other organizations. |
| H-280.977 | Direct Admission of Medicare Patients to Skilled Nursing Facilities | Our AMA supports regulatory change and any necessary legislation which would delete the 3-day prior hospitalization requirement for provision of skilled nursing facility benefits under Medicare, so as to allow coverage for direct admission of Medicare patients to a skilled nursing facility whether or not they have been discharged from an acute care hospital within the last 30 days. | Retain – this policy remains relevant. |
| H-320.946 | Radiology Benefits Manager | Our American Medical Association: (1) strongly encourages radiology benefits managers (RBMs) to adhere to uniform physician-developed best practice guidelines; (2) supports the use of appropriate use criteria developed by physicians with relevant expertise working in a collaborative process involving all national medical specialty societies that provide and/or order the imaging service in question; (3) supports an independent study assessing the magnitude of the cost and administrative burden of imaging utilization strategies on ordering physician offices, imaging providers, and patients and the impact these strategies have on patient safety and outcomes; (4) strongly encourages each radiology benefit manager (RBM) to publish and distribute the specific diagnostic codes used by their firm to approve or disapprove specific imaging procedures. This information should be distributed by the RBM via electronic or paper means to each physician who is credentialed to participate on health plans that utilize that particular RBM; and (5) opposes the practice of forced | Retain this policy in part.<br><br>Clauses 1-5 of this policy remains relevant. The Physician Consortium for Performance Improvement referenced in clause 6 no longer exists, so this clause can be deleted. |

| Policy Number | Title | Text | Recommendation |
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| | | test substitution and arbitrary denial of requested imaging services by RBMs contracted by third-party payers that meet appropriate use criteria, and that RBMs be held accountable for harm caused by substitution or delay of requested studies~~; and (6) encourages the Physician Consortium for Performance Improvement? to continue to develop patient-centered measures, including those that address the appropriate use of imaging~~. | |
| H-330.897 | Quality Cancer Care Preservation Act | Our AMA continues to support existing policy principles in evaluating legislative language on matters relating to Medicare reimbursement for physician acquisition and administration of prescription drugs. | Retain – this policy remains relevant. |
| H-330.928 | Managed Medicare Reimbursement | The AMA advocates that Medicare managed care plans (e.g., Medicare Advantage, etc.) that use the RBRVS do so in a manner that maintains the relativity of the RBRVS utilized in the traditional Medicare program. | Retain – this policy remains relevant. |
| H-330.939 | Reimbursement by Medicare for Psychotherapy Provided by Residents | The AMA will work with CMS to accomplish regulations for Medicare Part B payment for attending physicians' services that would not require the "physical presence" of the attending physician in the room at the same time that a resident provided psychotherapy. | Retain – this policy remains relevant. |
| H-340.903 | Quality Improvement Organization Status | The AMA urges CMS to carefully review the potential for conflict of interest when the same organization that contracts as a Medicare Quality Improvement Organization fulfills similar quality improvement contracts in the private sector. | Retain – this policy remains relevant. |
| H-340.990 | QIO Involvement in Quality Review and Physician Sanctions | The AMA urges modification of CMS's QIO contracts and regulations to provide that: (1) any perceived quality review assessment involving a member of a hospital's organized medical staff be concurrently presented for comment and review by the appropriate committee(s) of the organized medical staff; (2) the organized medical staff have the opportunity to make appropriate | Retain – this policy remains relevant. |

| Policy Number | Title | Text | Recommendation |
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| | | recommendations for corrections, when it deems that it is applicable, before the QIO shall act on a quality review matter; (3) the organized medical staff should act and inform the QIO organization in a reasonable period of time concerning what action, if any, was taken in relation to a perceived quality review problem; and (4) the QIO should be prohibited from taking any further action, such as sanctions of a member of the medical staff, before such medical staff involvement, review and reporting has been completed. | |
| H-370.958 | Removing Disincentives and Studying the Use of Incentives to Increase the National Organ Donor Pool | 1. Our AMA supports the efforts of the National Living Donor Assistance Center, Health Resources Services Administration, American Society of Transplantation, American Society of Transplant Surgeons, and other relevant organizations in their efforts to eliminate disincentives serving as barriers to living and deceased organ donation.<br>2. Our AMA supports well-designed studies investigating the use of incentives, including valuable considerations, to increase living and deceased organ donation rates. 3. Our AMA will seek legislation necessary to remove legal barriers to research investigating the use of incentives, including valuable considerations, to increase rates of living and deceased organ donation. | Retain – this policy remains relevant. |
| H-375.973 | Protecting Physicians at the Peer Review Process in the Current Managed Care Environment | Our AMA: (1) will work with the Federation of State Medical Boards to adopt a policy to support state legislative efforts to protect the integrity and effectiveness of the peer review process by prohibiting managed care companies from automatically terminating providers who have been sanctioned by state medical boards or by information being provided by the National Practitioners Data Bank without providing due process to the provider; and (2) espouses as policy the guarantee of due process and civil rights safeguards to physicians in peer review and in credentialing. | Retain – this policy remains relevant. |

| Policy Number | Title | Text | Recommendation |
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| H-375.990 | Peer Review of the Performance of Hospital Medical Staff Physicians | Our American Medical Association encourages peer review of the performance of hospital medical staff physicians, which is objective and supervised by physicians. Membership on peer review committees and hearing panels should be open to all physicians on the medical staff and should not be restricted to those physicians who have an exclusive contract with the hospital, salaried physicians, or those on the faculty. | Retain – this policy remains relevant. |
| H-385.914 | Stark Law and Physician Compensation | Our AMA opposes and continues to advocate against the misuse of the Stark Law and regulations to cap or control physician compensation. | Retain – this policy remains relevant. |
| H-385.941 | Opposition to CMS User Fees | Our AMA strongly: (1) opposes any attempt on the part of the federal or state governments or other entities to impose user fees, provider taxes, access fees, or bed taxes on physicians and other health care providers to subsidize or fund any health care program; (2) opposes any directive from the CMS to slow down the rate of payment of Medicare claims or reduce administrative services to patients, physicians, and other health care providers; and (3) urges Congress to appropriate sufficient funds to enable the CMS and its carriers to carry out their statutorily required functions. | Retain – this policy remains relevant. |
| H-40.992 | Prohibition of Pay Allowances to Military Physicians Serving in Managerial and Administrative Positions | The AMA opposes legislative or regulatory prohibition of the application of various special pay allowances to military physicians serving in executive and managerial positions. | Retain – this policy remains relevant. |
| H-405.989 | Physicians and Surgeons | 1. It is AMA policy to refer only to Doctors of Medicine (MDs) and Doctors of Osteopathy (DOs) as “physicians and surgeons.”<br><br>2. The AMA supports working to ensure that federal and state regulations and hospital medical staff bylaws comply with this designation. | Retain – this policy remains relevant. |

| Policy Number | Title | Text | Recommendation |
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| H-435.953 | Minor Statute of Repose/Limitations | Our AMA supports federal legislation that would establish a Minor Statute of Repose/Limitations that includes the following language: An action by a minor upon a medical claim shall be commenced within 3 years from the date of the alleged manifestation of injury, except that actions by a minor under the full age of 6 years shall be commenced within 3 years of manifestation of injury or prior to the minor's 8th birthday, whichever provides the longer period. Such time limitation shall be tolled for minors for any period during which a parent or guardian and a health care provider or health care organization have committed fraud or collusion in the failure to bring an action on behalf of the injured minor. | Retain – this policy remains relevant. |
| H-435.956 | Professional Liability Alternative Financing | Our AMA supports legislation that would amend the Internal Revenue Code to allow medical professionals and entities to establish tax-exempt professional liability trusts to pay medical liability claims. | Retain – this policy remains relevant. |
| H-435.969 | Report of the Special Task Force on Professional Liability and the Advisory Panel on Professional Liability | Our AMA: (1) reaffirms its support for investigating promising Alternative Dispute Resolution (ADR) mechanisms, in the context of demonstration projects designed to evaluate whether they resolve medical liability claims fairly and in a more timely and cost-effective manner. (2) The AMA strongly recommends that if cost containment goals are to be achieved, ADR proposals designed to provide greater access to legal process must incorporate effective mechanisms to: (a) identify non-meritorious claims and dispose of them; (b) decrease the proportion of cases being litigated; (c) increase the portion of any settlement payment received by the patient; and (d) identify appropriate guidelines for the payment of damages; and (3) continues to monitor and disseminate information to state and component medical societies about state and federal initiatives that address the issue of protections from liability risks | Retain this policy in part.<br><br>The reference to MICRA should be deleted. MICRA has been amended since this policy was first adopted and some states have stronger liability protections for physicians. |

| Policy Number | Title | Text | Recommendation |
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| | | for physicians who provide volunteer activities and care of the indigent, as well as the effectiveness of those initiatives. Effective medical liability reform~~, based on the California Medical Injury Compensation Reform Act (MICRA) model,~~ is integral to health system reform. | |
| H-435.975 | ~~Bush Administration Professional Liability Proposal~~ Federal Medical Liability Reform Policy | (1) Our AMA ~~commends the Bush Administration for its legislative efforts designated to achieve medical liability reform and~~ supports the elements of medical liability reform legislative proposals ~~introduced in the 102nd Congress~~ which are consistent with Association policy, including (1) limitations of $250,000 or lower on recovery of non-economic damages; (2) the mandatory offset of collateral sources of plaintiff compensation; (3) a decreasing, sliding scale regulation of attorney contingency fees; (4) periodic payment of future awards of damages; and (5) a limitation on the period for suspending the application of state statutes of limitations for minors to no more than six years after birth. Effective medical liability reform~~, based on the California Medical Injury Compensation Reform Act (MICRA) model,~~ is integral to health system reform. | Retain this policy in part.<br><br>The substance of this policy remains relevant; however, a new title and edits will more accurately describe this policy without tying it to a prior Congress or Administration.<br><br>Also, the reference to MICRA should be deleted. MICRA has been amended since this policy was first adopted and some states have stronger liability protections for physicians. |
| H-435.983 | Impact of Product Liability on the Development of New Medical Technologies | The AMA (1) urges the continuation of efforts at the state and federal level to reform product liability laws, (2) supports creative solutions to prevent product liability suits from slowing the development and utilization of medical technologies in this country. Effective medical liability reform~~, based on the California Medical Injury Compensation Reform Act (MICRA) model,~~ is integral to health system reform; and (3) continues to support efforts to alleviate the growing health crisis caused by decreasing availability or provision of biomaterials to manufacturers of medical devices and implants and to support legislative efforts to provide legal | Retain this policy in part.<br><br>The reference to MICRA should be deleted. MICRA has been amended since this policy was first adopted and some states have stronger liability protections for physicians. |

| Policy Number | Title | Text | Recommendation |
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| | | protection to biomaterial suppliers to ensure that all Americans have access to medical devices. | |
| H-5.998 | Public Funding of Abortion Services | Our American Medical Association reaffirms its opposition to legislative proposals that utilize federal or state health care funding mechanisms to deny established and accepted medical care to any segment of the population. | Retain – this policy remains relevant. |
| H-95.937 | Abuse-Deterrent Prescription Drugs | Our AMA supports the Food and Drug Administration's ongoing efforts to evaluate the efficacy, safety, and labeling of abuse-deterrent technology, and opposes barriers to appropriate access to and coverage of prescription drugs with abuse-deterrent properties. | Retain – this policy remains relevant. |

REPORT OF THE BOARD OF TRUSTEES

B of T Report 13-A-25

Subject: The Uniform Health-Care Decisions Act (Resolution 250-A-24)

Presented by: Michael Suk, MD, JD, MPH, MBA, Chair

Referred to: Reference Committee B

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## INTRODUCTION

This American Medical Association (AMA) Board of Trustees report arises from Resolution 250-A-24, "Endorsement of the Uniform Health-Care Decisions Act." As introduced by the Michigan Delegation. Resolution 250-A-24 called upon the AMA to amend policy D-140.968, "Standardized Advance Directives," as follows:

> Our AMA will endorse the "Uniform Health-Care Decisions Act," which was drafted and adopted by the National Conference of Commissioners on Uniform State Laws (NCCUSL) in ~~1993~~ 2023, and work with our state medical societies to advocate for its adoption in the states.

Testimony in support of Resolution 250-A-24 emphasized that AMA had endorsed the 1993 version of the Uniform Health-Care Decisions Act (UHCDA), that a new and updated version of the UHCDA had been approved in 2023, and that endorsement of the 2023 version was a needed update to AMA policy. Supportive testimony also praised the UHCDA's new provisions related to end-of-life care. On the other hand, other testimony voiced concern about the UHCDA provisions related to mental health and expressed that the UHCDA inadequately addressed complex issues that would negatively impact medical practice.

Resolution 250-A-24 was referred. This report examines the binary question of whether the AMA should endorse the 2023 UHCDA as adopted by the Uniform Laws Commission (ULC). This report does not seek or recommend changes to the UHCDA.

## BACKGROUND

The ULC is a nonpartisan, non-profit association comprised of state commissions on uniform laws from each state. Members of the ULC are licensed attorneys. The ULC's purpose is "to study and review the law of the states to determine which areas of law should be uniform [and] promote the principle of uniformity by drafting and proposing specific statutes in areas of the law where uniformity between the states is desirable."[1] Importantly, the ULC drafts model legislation, but the legislation must be enacted by a state legislature to be effective.

In 1993, the ULC, then known as the National Conference of Commissioners on Uniform State Laws, promulgated the UHCDA, a third-generation model bill that addressed advance health care directives and health care decision-making on behalf of patients lacking capacity. Subsequently, the AMA adopted policy to endorse the 1993 UHCDA. Six states (Alaska, Hawaii, Maine,

Mississippi, New Mexico, and Wyoming) enacted the 1993 UHCDA. In 2020, the ULC appointed a drafting committee to modernize and expand the UHCDA, and in 2023 the ULC approved and recommended the 2023 UHCDA for enactment in all states.

The 2023 UHCDA governs powers of attorney for health care, advance directives, and other forms of health care instructions intended to inform health care professionals and agents about a patient's wishes, priorities, and values regarding health care decisions made for them when they are unable to make such decisions themselves. The UHCDA also governs determination of capacity, judicial review, and appointment of surrogate decisionmakers when there is no advance directive. In addition, the UHCDA establishes certain duties and powers of agents and health care professionals and shields them from liability when they act reasonably and in good faith.

Among the changes in the 2023 UHCDA is the authorization of advance directives specifically for mental health care. These directives enable individuals to provide specific instructions reflecting their preferences for mental health care and/or to authorize an agent to make mental health care decisions on their behalf. The provisions also allow an individual to limit their own ability to revoke an advance mental health care directive when experiencing an acute mental health event.

To date, one state (Delaware) has enacted the 2023 UHCDA.

AMA POLICY

As noted earlier in this report, AMA Policy D-140.968, "Standardized Advance Directives," endorses the 1993 UHCDA and urges state medical societies to advocate for its adoption.

Policy H-85.957, "Encouraging Standardized Advance Directives Forms Within States," encourages each state medical society to develop a standardized form of advance directives for use by physicians and other health care providers as a template to discuss end-of-life care with their patients.

Policy H-140.845, "Encouraging the Use of Advance Directives and Health Care Powers of Attorney," states that AMA will: (1) encourage health care providers to discuss with and educate young adults about the establishment of advance directives and the appointment of health care proxies; (2) encourage nursing homes to discuss with resident patients or their health care surrogates/decision maker as appropriate, a care plan including advance directives, and to have on file such care plans including advance directives; and that when a nursing home resident patient's advance directive is on file with the nursing home, that advance directive shall accompany the resident patient upon transfer to another facility; (3) encourage all physicians and their families to complete a Durable Power of Attorney for Health Care (DPAHC) and an Advance Directive (AD); (4) encourage all medical schools to educate medical students and residents about the importance of having a DPAHC/AD before becoming severely ill and encourage them to fill out their own DPAHC/AD; (5) along with other state and specialty societies, work with any state that has technical problems with their DPAHC/AD to correct those problems; (6) encourage every state medical association and their member physicians to make information about Living Wills and health care powers of attorney continuously available in patient reception areas; (7) (a) communicate with key health insurance organizations, both private and public, and their institutional members to include information regarding advance directives and related forms and (b) recommend to state Departments of Motor Vehicles the distribution of information about advance directives to individuals obtaining or renewing a driver's license; (8) work with Congress and the Department of Health and Human Services to (a) make it a national public health priority to educate the public as to the importance of having a DPAHC/AD and to encourage patients to work

with their physicians to complete a DPAHC/AD and (b) to develop incentives to individuals who prepare advance directives consistent with our current AMA policies and legislative priorities on advance directives; (9) work with the Centers for Medicare and Medicaid Services to use the Medicare enrollment process as an opportunity for patients to receive information about advance health care directives; (10) continue to seek other strategies to help physicians encourage all their patients to complete their DPAHC/AD; and (11) advocate for the implementation of secure electronic advance health care directives.

Policy H-85.956, "Educating Physicians About Advance Care Planning," supports efforts to increase the prevalence and quality of meaningful advance care planning, including the use of advance directives, to improve recognition of and adherence to a patient's advance care decisions, the development of materials to educate physicians, patients and others about advance care planning and the requirements and implications of the Patient Self-Determination Act, and patient education resources. The Policy also encourages medical schools and residency programs to increase awareness of advance care planning and educate trainees about the use of such tools.

Policy H-140.970, "Decisions to Forgo Life-Sustaining Treatment for Incompetent Patients," states that: (1) Advance directives (living wills and durable powers of attorney for health care) are the best insurance for individuals that their interests will be promoted if they become incompetent. Generally, it is most effective if the individual designates a proxy decisionmaker and discusses with the proxy his or their values regarding decisions about life support. (2) Without an advance directive that designates a proxy, the patient's family should become the surrogate decisionmaker. Family includes people with whom the patient is closely associated. In the case when there is no person closely associated with the patient, but there are people who both care about the patient and have some relevant knowledge of the patient, such relations should be involved in the decision-making process and may be appropriate surrogates. (3) It is the responsibility of physicians to provide all relevant medical information and to explain to surrogate decisionmakers that decisions should be based on substituted judgment (what the patient would have decided) when there is evidence of patients' preferences and values. If there is not adequate evidence of preferences and values, the decision should be based on the best interests of the patient (what outcome would most likely promote the patient's well-being). (4) Institutional ethics committees should be established for the purpose of facilitating sound decision-making. These ethics committees should be structured so that a diversity of perspectives, including those from outside medicine, are represented. (5) The surrogate's decision should almost always be accepted by the physician. However, there are four situations that may require either institutional or judicial review and/or intervention in the decision-making process. These situations are when: (a) there is no available family willing to be the patient's surrogate decisionmaker; (b) there is a dispute among family members and there is no decisionmaker designated in an advance directive; (c) a health care provider believes that the family's decision is clearly not what the patient would have decided if competent; and (d) a health care provider believes that the decision is not a decision that could reasonably be judged to be in the patient's best interests. Decisions based on a conflict of interest generally would not be in the patient's best interest. In these four cases, the guidelines outlined in the report should be followed. When there are disputes among family members or between family and health care providers, the use of ethics committees specifically designed to facilitate sound decision-making is recommended before resorting to the courts. (6) Judicial reviews for decisions about life-sustaining treatment should be a last resort. It is strongly encouraged that when judicial review is necessary, in nonemergency situations, the courts should determine who is to make treatment decisions, including appointing a guardian, rather than making treatment decisions. (7) When a permanently unconscious patient was never competent or had not left any evidence of previous preferences or values, since there is no objective way to ascertain what would be in the

best interests of the patient, the surrogate's decision should not be challenged as long as the decision is based on the decisionmaker's true concern for what would be best for the patient. (8) In the case of seriously ill or handicapped newborns, present and future interests of the infant must be considered. Due to the complexities involved in deciding about life support for seriously ill newborns, physicians should specifically discuss with parents the risks and uncertainties involved. When possible, parents should be given time to adjust to the shock of the situation and absorb the medical information presented to them before making decisions about life-sustaining treatment. In addition, counseling services and an opportunity to talk with couples who have had to make similar decisions should be available to the parents. (9) Due to the complexity of decisions for permanently unconscious patients and newborns, an ethics committee should be available, whenever possible, to facilitate the surrogate's decision-making. (10) Hospitals and other health care facilities should establish protocols regarding assessment of decision-making capacity, informing patients about advance directives, identifying surrogate decisionmakers, the use of advance directives, substituted judgment and best interests in decision-making, and the procedures for challenging the decision of a surrogate. These protocols should be in accordance with the CEJA preceding guidelines.

Policy H-85.952, "Advance Directives During Pregnancy," affirms the patient-physician relationship as the appropriate locus of decision making and the independence and integrity of that relationship, promotes awareness and understanding of the ethical responsibilities of physicians with respect to advance care planning, the use of advance directives, and surrogate decision making, regardless of gender or pregnancy status, set out in the Code of Medical Ethics, and recognizes that there may be extenuating circumstances which may benefit from institutional ethics committee review, or review by another body where appropriate.

Finally, AMA Policy H-140.826, "Use of Psychiatric Advance Directives," recognizes the potential for advance care planning to promote the autonomy of patients with mental illness and urges the mental health community to continue to study the role of advance care planning in therapeutic relationships and the use of psychiatric advance directives to promote the interests and well-being of patients, and support efforts to increase awareness and appropriate utilization of psychiatric advance directives.

DISCUSSION

Advance care planning is an important aspect of ensuring patient treatment preferences are respected in the event the patient is unable to communicate their wishes. Central to respecting patient autonomy at the end of life or during incapacity is the use of advance directives, a health care power of attorney, and other advance care planning instruments. However, laws governing these instruments may vary across states and this inconsistency can create confusion, complexity, and barriers to effective health care decision-making, ultimately undermining the very goals of advance care planning. A uniform approach among state laws could help minimize confusion and inconsistency and promote high-quality patient care and effective communication and decision-making between patients, families, and health care professionals, particularly in cases when medical decision-making may occur across state lines, amidst conflict between family members or when a patients' preferences have not been made clear. The UHCDA provides a framework for the creation, execution, and recognition of advance care planning tools, the delegation of health care decision-making, and the relevant duties of agents and health care providers. Indeed, existing AMA policy aligns with the goals of the UHCDA. However, inconsistencies between the UHCDA, AMA policy, and clinical practice raise concerns about whether broad endorsement of the UHCDA is appropriate for the AMA.

One critical criticism of the 2023 UHCDA centers around determinations of patient capacity to make health care decisions, and the lack of clear guidelines for complex medical scenarios. Specifically, under the UHCDA, the determination of capacity requires consideration of two criteria: (1) whether an individual is willing and able to communicate a decision and (2) whether the individual understands the nature and consequences of making or revoking a decision or instruction. In contrast, the widely accepted assessment of decisional capacity in clinical practice, which has been incorporated into state laws, assesses four skills: whether the individual is able to understand relevant information; appreciate the clinical circumstances; exhibit a rational process of decision making; and communicate a consistent choice.[2] While the approaches are not necessarily in conflict in all cases, the UHCDA approach could, particularly with regard to psychiatric care, conflict with the accepted medical standard for assessing capacity. This could lead to confusion among health care professionals and in application in the courts.

Additionally, some UHCDA provisions directly conflict with existing AMA policy. For example, AMA Policy H-140.970, "Decisions to Forgo Life-Sustaining Treatment for Incompetent Patients," states that, in the absence of an advance directive, the patient's family should become the surrogate decisionmaker regarding decisions to forgo life-sustaining treatment, whereas the UHCDA first prioritizes "an adult the individual has identified, other than in a power of attorney for health care, to make a health-care decision for the individual if the individual cannot make the decision" before family. AMA policy also identifies when decisions to forgo life-sustaining treatment warrant institutional or judicial review, including when there is a dispute among family members and no designated decisionmaker, and when there is no available family willing to be the patient's surrogate decisionmaker. In contrast, the UHCDA instructs health care providers to comply with the decision of a majority of the family members when there is a dispute and authorizes non-family members to function as surrogate decisionmakers according to a priority list. AMA policy also advocates for use of institutional ethics committees, whereas the UHCDA makes no mention of ethics committees. The UHCDA also authorizes and promotes use of mental health advance directives, whereas AMA policy merely recognizes the potential benefit of mental health advance directives and urges further study.

The UHCDA also conflicts with AMA policies that vigorously support and advocate for appropriate physician supervision of non-physician clinical staff in all areas of medicine. Specifically, the UHCDA authorizes a "responsible health-care professional" to determine whether a patient lacks capacity when a physician, psychologist, physician assistant, advanced practice registered nurse, or social worker is unavailable, and a prompt decision is necessary to avoid loss of life or serious harm. The UHCDA does not require the "responsible health-care professional" to have any specific training, expertise, or license. AMA Policy H-160.949, "Practicing Medicine by Non-Physicians," expressly opposes state legislation allowing non-physician groups to engage in the practice of medicine without physician training or appropriate physician supervision.

It is critical to note that AMA does not endorse the actions of other organizations with which it does not completely and wholly agree. Though individuals may disagree about the appropriate weight to be given to the concerns and conflicts discussed in this report, the Board of Trustees (the Board) finds the lack of perfect alignment determinative. Therefore, the Board recommends against endorsement of the UHCDA. Additionally, adoption of the 2023 UHCDA by the ULC renders AMA Policy D-140.968, "Standardized Advance Directives," outdated and the policy should be rescinded.

RECOMMENDATION

The Board of Trustees recommends that the following be adopted in lieu of Resolution 250-A-24 and the remainder of the report be filed.

1. That Policy D-140.968, "Standardized Advance Directives," be rescinded. (Rescind HOD Policy)

Fiscal Note: Less than $500

REFERENCES

[1] "About Us", Uniform Laws Commission, available at https://www.uniformlaws.org/aboutulc/overview
[2] Paul S. Appelbaum & Thomas Grisso, Assessing patients' capacities to consent to treatment, 319 NEJM 25, 1635-8 (Dec. 1988); Jacob M. Appel, The Statutory Codification of Decisional Capacity Standards, 51 J Am Academy Psych & Law 4, 506-519 (Dec. 2023).

**REVISED**

REPORT 14 OF THE BOARD OF TRUSTEES (A-25)
A Public Health-Centered Criminal Justice System
(Reference Committee B)


EXECUTIVE SUMMARY

INTRODUCTION. Resolution 215-I-23, "A Public Health-Centered Criminal Justice System," was referred. This resolution asked that our American Medical Association support legislation that reduces the negative health impacts of incarceration by: a. advocating for decreasing the magnitude of penalties, including the length of prison sentences, to create a criminal justice model focused on citizen safety and improved public health outcomes and rehabilitative practices rather than retribution; b. advocating for legislation and regulations that reduce the number of people placed in prison conditions, such as preventing people who were formerly incarcerated from being sent back to prison without justifiable cause; and c. supporting the continual review of sentences for people at various time points of their sentence to enable early release of people who are incarcerated but unlikely to pose a risk to society. It also asked that our AMA recognize the inefficacy of mandatory minimums and three-strike rules and the negative consequences of resultant longer prison sentences to the health of incarcerated individuals, and support legislation that reduces or eliminates mandatory minimums and three-strike rules.

DISCUSSION. The United States (U.S.) incarcerates nearly two million people, far more than any other country in the world. The problem of mass incarceration in the U.S. is not just a function of the number of people in prison—or the larger number of people who cycle in and out of correctional facilities every year but also a function of the length of time the system incarcerates people. Retribution, deterrence, incapacitation, and rehabilitation are all concepts that have been central to sentencing theory, policy, and practice over the last two centuries. These principles have been backed by limited evidence of success—and evidence of harm. This report discusses the history of sentencing in the U.S., the use of mandatory minimums and three-strike penalties, the impact of longer sentencing on public safety, racial disparities observed in longer sentencing practices, and reforms that have reduced longer sentences without compromising public safety. This report also discusses sentencing reforms to address mass incarceration and summarizes AMA policy as it relates to the criminal justice system.

CONCLUSION. Experts argue that future reforms are still needed to address mass incarceration. This includes more expansive drug law reform such as addressing mandatory minimum sentences for drug offenses, repealing the 18:1 disparity between crack and powder cocaine, expanding alternative sentences, including the existing statutory safety valve, and reducing the number of people currently held in correctional facilities by making changes retroactive. The recommendations in this report support efforts to reduce the reliance on incarceration, particularly for non-violent offenders, acknowledges that rehabilitation and successful reentry into the community requires adequate support systems and services, and supports providing judges with the discretion to help ensure that sentences are fair and fit the crime. Further, the recommendations of this report build upon existing AMA policy centered around drug policy reform and lend way to adopting policies needed for public health centered-criminal justice system.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 14-A-25

Subject: A Public Health-Centered Criminal Justice System

Presented by: Michael Suk, MD, JD, MPH, MBA, Chair

Referred to: Reference Committee B

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INTRODUCTION

Resolution 215-I-23, "A Public Health-Centered Criminal Justice System," introduced by the Medical Student Section was referred. This resolution asked that that our American Medical Association:

> support legislation that reduces the negative health impacts of incarceration by: a. advocating for decreasing the magnitude of penalties, including the length of prison sentences, to create a criminal justice model focused on citizen safety and improved public health outcomes and rehabilitative practices rather than retribution, b. advocating for legislation and regulations that reduce the number of people placed in prison conditions, such as preventing people who were formerly incarcerated from being sent back to prison without justifiable cause, and c. supporting the continual review of sentences for people at various time points of their sentence to enable early release of people who are incarcerated but unlikely to pose a risk to society; and
>
> (1) recognize the inefficacy of mandatory minimums and three-strike rules and the negative consequences of resultant longer prison sentences to the health of incarcerated individuals, and (2) support legislation that reduces or eliminates mandatory minimums and three-strike rules.

BACKGROUND

The U.S. incarcerates nearly two million people, far more than any other country in the world.[1] The problem of mass incarceration in the U.S. is not just a function of the number of people in prison—or the larger number of people who cycle in and out of correctional facilities every year but also a function of the length of time the system incarcerates people. Retribution, deterrence, incapacitation, and rehabilitation are all concepts that have been central to sentencing theory, policy, and practice over the last two centuries.[1]

As of 2019, 57 percent of the U.S. prison population was serving sentences of 10 or more years.[1,2] As of 2020, one in seven people in U.S. correctional facilities was serving a life sentence.[1,3] In 2022, the Council on Criminal Justice, examining National Corrections Reporting system data, found that from 2005 to 2019 the percentage of people serving sentences of 10 or more years in state correctional facilities grew substantially, reaching 57 percent of the total population in 2019.[1,4] On any given day, there are nearly 1.7 million people serving sentences in prison and jail, almost 500,000 more detained in jail pretrial, another 4.4 million under some form of probation or parole control, and between 70 and 100 million marked with a record of arrest or conviction.[1,5,6,7] This level of incarceration reaches into more than 100 million U.S. households: half of all adults in

the U.S. have had a family member detained at least overnight.[1,8] Black and Latinx people make up 58
percent of the U.S. prison population but just 31 percent of the nation's overall population.[1,9,10] Among those serving life and "virtual life" sentences—sentences of 50 years or more—nearly half are Black, and another 16 percent are Latinx.[1,11] One in five Black men in prison is serving a life sentence.[12] Black men receive harsher sentences and serve more time in prison compared to white men—in the federal system, for example, their sentences are 19.1 percent longer—even after controlling for factors like conviction history, education, and income.[1,12] In the same system, Black people are also 21.2 percent less likely to receive a sentence shorter than advised by the sentencing guidelines than white people.[1,12] In the last 20 years, however, racial disparities have dropped as the number of White people in prison continues to increase while the number of Black people drops.[1,13]

*Incarceration and Health*

It is well documented that justice-involved people have a higher prevalence of acute and chronic health conditions than the general U.S. population.[14] This includes higher rates of infectious diseases, mental health diagnoses, substance use disorders, traumatic brain injuries, hypertension, heart-related problems, diabetes, asthma, and stroke, along with overall lower life expectancy.[15,16,17] The higher prevalence of these acute and chronic conditions among incarcerated people has been partially attributed to pre-incarceration exposure to adverse structural determinants such as poverty and unstable housing.[15] However, the experience of incarceration itself is also associated with adverse health outcomes.[16-17] Violence—whether self-directed, interpersonal, or perpetrated by agents of the state—is also a significant documented harm of incarceration.[18] While men are more likely to experience interpersonal violence from another justice-involved person, women are more likely to be assaulted by staff.[18,19] Strikingly, transgender people are targeted at nearly 10 times the rate of other justice-involved people.[18,20] In addition to widespread violence and sexual assault inside carceral settings, other extreme human rights violations such as mass forced sterilizations, regular use of solitary confinement, and abandonment during natural disasters are known harms linked to incarceration.[18,21]

In addition to direct health consequences experienced by justice-involved people, the harms of the carceral system extend to families and communities of justice-involved people through mechanisms such as family separation and disruption of community cohesion.[22] For example, parental/caregiver incarceration is associated with food insecurity during childhood and a greater risk of living with mental health issues in childhood and adolescence.[23] If incarcerated pregnant people have children or give birth while incarcerated, the harm from incarceration is carried through generations even after release.[23] These detrimental consequences also extend to adult partners and relatives, inducing relationship strain and onset of depression and anxiety.[24] Some of the carceral system's harms are indirectly mediated through pathways such as added economic pressures (e.g., household income loss and paying for fees and fines) and housing precarity, which have been linked to adverse health outcomes.[25]

*A Public Health Approach to Criminal Justice*

A public health-centered approach to the criminal justice system is focused on prevention and early intervention and prioritizes addressing structural determinants such as poverty, education, employment, and environment that shape the prevalence of incarceration and increase the risk of adverse health outcomes.[26] These prevention strategies include providing equitable access to resources that communities need to thrive, including stable and supportive housing, affordable high-quality education starting in early childhood, well-paying employment, culturally responsive youth programs, and affordable and accessible health care (including access to mental health first

responders and within-community mental health services).[26,27] A public health approach emphasizes treatment for those facing mental health crises or substance use disorders rather than incarceration to help address underlying conditions. For those who are incarcerated, providing comprehensive health care services during incarceration, and linking people to services post release can help improve health and well-being. Rehabilitation and reentry programs are also vital to help individuals reintegrate into society post-release. It is also important to evaluate the effectiveness of these interventions to understand the impact not only on justice-involved individuals, but also on public safety and the overall health of communities. There is also a significant lack of support for women once they are released. There are fewer options for job training, fewer housing options, and often incarcerated women have less support systems when released compared to men.[28] Creating reentry programs tailored to women's needs is essential and these programs should focus on trauma-informed care, parenting support, and vocational training to address the unique challenges women face.[28]

*Restorative Justice Approaches*

Restorative justice is a nonpunitive, nonretributive process to address interpersonal harm that centers survivors of harm and brings together everyone affected to decide collectively how to heal and to repair harm.[29] Transformative justice builds upon this process by focusing not only on the individuals involved but also on the larger systems and structures that created the conditions for that harm to occur.[30] Although restorative and transformative justice processes vary widely in implementation, making evaluation of their effectiveness challenging, research on restorative justice shows it to be a promising solution to the problem of incarceration.[30] For example, one of the most comprehensive meta-analyses on restorative justice revealed higher levels of satisfaction among individuals involved in the process (including those who were harmed and those who did harm), a greater likelihood of adhering to restorative agreements, and decreased rates of recidivism relative to those who did not participate in a restorative justice process.[31] Another meta-analysis of restorative justice programs with young people less than 18 years of age showed a general trend of decreased reengagement with the legal system, a greater sense of fairness among both the young people who did harm and the people who were harmed, and greater satisfaction in comparison with those who did not participate in a program.[32] These outcomes suggest better mental well-being for all individuals involved when a restorative justice process is used as an alternative to the carceral system.[30,31] Preliminary evidence suggests that restorative justice approaches provide a more effective and less harmful means of accountability than continuing to invest in punitive paradigms.[18,30,31]

## SENTENCING IN THE U.S.

Sentencing in criminal law refers to the process of determining the appropriate punishment or penalty for a person who has been convicted.[33] It typically involves taking into consideration factors, such as the nature and severity of the crime, the defendant's criminal history, and any mitigating or aggravating circumstances.[32] Retribution, deterrence, incapacitation, and rehabilitation are all concepts that have been central to sentencing theory, policy, and practice over the last two centuries.[32] The federal courts and some states have sentencing guidelines to guide judges in determining appropriate sentences and to encourage uniformity.[32]

Near the end of the 20th century, states and the federal government passed sentencing laws and policies that resulted in increasing incarceration rates in the U.S.[33] These laws fell into four main categories—mandatory minimums, "truth in sentencing," new and longer enhancements based on prior criminal convictions (such as "three-strikes" laws and other "habitual offender" laws), and laws that restricted parole release, such as life without parole sentences.[1,34] This report is focused

on mandatory minimum sentences, including three strike laws, as they fall within the purview of the original resolution.

MANDATORY MINIMUM PENALTIES & SENTENCING ENHANCEMENTS

All 50 states, the District of Columbia, and the federal government require a judge to order a set minimum period of incarceration if a person is convicted of certain crimes.[1,35] Mandatory minimums, limit judges' discretion to consider a person's individual circumstances.[1,34] On the federal level, the term "mandatory minimum penalty" requires, upon conviction of a federal criminal offense and the satisfaction of criteria set forth in that statute, the imposition of a specified minimum term of imprisonment.[36] Mandatory minimum penalties vary in length depending on the offense type and specified criteria, from two years for aggravated identity theft, to life in prison for certain drug trafficking offenses. The statutory criteria that trigger mandatory minimum penalties can be classified into at least one of three categories: (a) penalties triggered by offense characteristics or elements of the offense of conviction; (b) penalties triggered by reference to another underlying offense; or (c) penalties triggered by the offender's criminal history.[35]

Not all offenders convicted of an offense carrying a mandatory minimum penalty are sentenced to the minimum term of imprisonment specified in the statute of conviction.[35,37] Under the current system, a sentencing court can impose a sentence below an otherwise applicable statutory mandatory minimum penalty if: (1) the prosecution files a motion based on the defendant's "substantial assistance" to authorities in the investigation or prosecution of another person who has committed an offense; or (2) in certain drug trafficking cases, the defendant qualifies for the statutory "safety valve" contained in 18 U.S.C. § 3553(f).[35,36,38]

Unlike a substantial assistance departure—which applies to all types of federal offenses carrying a mandatory minimum penalty—the safety valve statute only applies in cases in which a defendant faces a mandatory minimum penalty after being convicted of a drug trafficking offense listed in the statute.[35,39] In addition, the safety valve only applies if the following five criteria are met:

- the defendant does not have more than one criminal history point, as determined under the sentencing guidelines;
- the defendant did not use violence or credible threats of violence or possess a firearm or other dangerous weapon (or induce another participant to do so) in connection with the offense;
- the offense did not result in death or serious bodily injury to any person;
- the defendant was not an organizer, leader, manager, or supervisor of others in the offense, as determined by the sentencing guidelines and was not engaged in a continuing criminal enterprise; and
- no later than the time of the sentencing hearing, the defendant has truthfully provided to the Government all information and evidence the defendant has concerning the offense or offenses that were part of the same course of conduct or of a common scheme or plan, but the fact that the defendant has no relevant or useful or other information to provide or that the government is already aware of the information shall not preclude a determination by the court that the defendant has not complied with this requirement.[35-38]

Where these criteria are met, judges shall impose a sentence without regard to the statutory mandatory minimum penalty for the covered offenses.[35,38] The drug trafficking guideline also provides for a 2-level decrease if the defendant meets the safety valve subdivision criteria.[40] This decrease applies regardless of whether the defendant was convicted of an offense carrying a mandatory minimum penalty.[41] It should also be noted that states have mandatory minimum

sentencing laws as well, but these vary state by state.[42] Successful state reforms to mandatory minimum sentencing are summarized in Appendix I. Ultimately, federal mandatory minimums result in longer incarceration because few ways around them exist, except via safety valve provisions or substantial assistance motions as mentioned above.

*Three Strike Laws*

Three strike laws are a criminal sentencing structure in which significantly harsher punishments are imposed on repeated offenders.[43] These laws generally mandate a life sentence for the third violation of violent felonies. These types of laws originated from the Violent Crime Control and Law Enforcement Act of 1994.[44] The federal three strikes statute punishes a defendant with "mandatory life imprisonment if he or she is convicted in federal court of a 'serious violent felony' and has two or more prior convictions in federal or state courts, at least one of which is a 'serious violent felony.'[43] The other prior offense may be a 'serious drug offense.'"[43] The "serious violent felony" includes murder, manslaughter, sex offenses, kidnapping, robbery, and any offense punishable by 10 years or more which includes an element of the use of force or involves significant risk of force.[43]

At the federal level, the First Step Act has eased the mandatory minimum sentencing imposed under the three strikes law.[44] Previously, a person with two or more prior convictions involving a "serious violent felony" or "serious drug felony" was punishable with life imprisonment without parole.[44] Now, this sentence is reduced to 25 years in prison and the sentence for the first offense is reduced from 20 years to 15 years in prison.[44] This reform has given more discretion to judges.[44] The Bureau of Prisons reports that the federal prison population is declining, thanks to the First Step Act.[45] However, a significant portion of the prison population resides in state correctional facilities.[44] Currently, 28 states have enacted the three strikes law.[46] Moreover, some states have a "two-strikes provision," where a subsequent strike-able offense is punishable with twice the term of its ordinary term.[45] In a few states, someone can be released on parole after serving a certain number of years in prison.[45]

ARGUMENTS IN SUPPORT OF MANDATORY MINIMUMS

*Promotion of Uniformity in Sentencing and Avoidance of Unwarranted Disparity*

Some view mandatory minimum penalties as promoting uniformity and reducing unwarranted disparities because such penalties require courts to impose similar sentences for similar offenses.[47,48] Congress enacted many mandatory minimum penalties, together with the then-mandatory guidelines system, as part of its effort in the 1980s to narrow judicial sentencing discretion and curb what it viewed as unduly disparate and lenient sentences.[49] According to some scholars, the importance of mandatory minimum penalties in ensuring uniformity has increased. The Department of Justice has observed that sentencing disparities have increased under the advisory guidelines system because for "offenses for which there are no mandatory minimums, sentencing decisions have become largely unconstrained as a matter of law."[50] This has led to greater variation in sentencing, which in turn "undermines the goals of sentencing to treat like offenders alike, eliminate unwarranted disparities in sentencing, and promote deterrence through predictability in sentence."[51] Furthermore, some prosecutors have charged offenses carrying mandatory minimum penalties to narrow the sentencing court's discretion.[52]

*Protection of the Public through Certainty in Punishment, Deterrence, and Incapacitation*

Law enforcement officials have historically urged the enactment of mandatory minimum penalties.[52] It is believed by some that mandatory minimum penalties deter crime by imposing certain, predictable, and generally severe punishment.[53] Because mandatory minimum penalties require a certain term of incarceration, they are viewed as "an effective means of alerting would-be offenders to the consequences of certain illegal conduct."[54] According to the Department of Justice, sentencing reforms in the 1980s, including the enactment and enhancement of many mandatory minimum penalties, helped reduce crime rates.[48] Some prosecutors and police officers report that the certainty of punishment provided by mandatory minimum penalties is "critical" to law enforcement efforts.[55] Furthermore, some believe that the severity of mandatory minimum penalties increases their deterrent effect by raising the "cost" of committing crime to would-be offenders.[56] In addition to their deterrent effect, some policymakers assert that mandatory minimum penalties reduce crime by incapacitating criminals and protecting the public from their potential future offenses.[57] For example, law enforcement officers have reported that incapacitation through mandatory minimum penalties has reduced methamphetamine- and firearm-related crime.[58]

*Effective Law Enforcement Tool that Induces Pleas and Cooperation*

The threat of a mandatory minimum penalty gives law enforcement leverage over defendants, who may be encouraged to cooperate in exchange for lesser charges or safety valve and substantial-assistance benefits.[59] Some have stated that the potential application of more severe penalties in federal court "has convinced a number of suspects to give up information."[60] Similarly, the Department of Justice views mandatory minimum penalties as an essential and critical tool in obtaining cooperation from members of "violent street gangs and drug distribution networks."[59]

*Assistance to State and Local Law Enforcement*

Another justification for federal mandatory minimum penalties relates to the relationship between state and federal law enforcement.[61] Due to the substantial concurrent state and federal jurisdiction in many drug and firearm cases, if a state sentence for a crime is inappropriately low, the existence of a substantially higher, federal mandatory minimum can help ensure a sentence that protects the public.[60] The prospect of being convicted under a federal statute carrying a mandatory minimum penalty can induce defendants to plead to state charges.[60]

ARGUMENTS IN OPPOSITION OF MANDATORY MINIMUMS

*Contribution to Excessive Uniformity and Unwarranted Disparity*

One of the weaknesses of mandatory minimums is that they apply one-size-fits-all sentences to defendants who are not equally liable.[62] According to the American Bar Association (ABA), "[t]reating unlike offenders identically is as much a blow to rational sentencing policy as is treating similar offenders differently."[63] Mandatory minimum penalties may result in arbitrary and disparate sentences because they rely on certain specified triggering facts.[64] For example, so-called "sentencing cliffs" occur when an offender's "conduct just barely brings them within the terms of the mandatory minimum.[65] In such a case, the offender is subject to a significantly higher sentence than an offender whose conduct fell just outside the scope of the mandatory minimum penalty, even though their conduct was only marginally different.[66] For example, a defendant convicted of trafficking 100 grams of heroin would be subject to the five-year mandatory minimum penalty while one who sold only 99 grams of the drug would not, meaning that these defendants are subject to substantially different sentences despite nearly identical conduct.[67] A majority of judges believe that mandatory minimum penalties contribute to sentencing disparity. In a survey of United States

District Judges on a range of sentencing issues, 52 percent of judges ranked mandatory minimum penalties among the top three factors contributing to sentencing disparity.[68] In contrast, 78 percent believed that the sentencing guidelines have reduced unwarranted sentencing disparities among similarly situated defendants.[67]

*Excessive Severity and Disproportionality*

Many scholars view current federal mandatory minimum penalties as producing sentences that are excessively harsh relative to the gravity of the offense committed, in part because "all sentences for a mandatory minimum offense must be at the floor or above regardless of the circumstances of the crime."[69] The Department of Justice has stated that there are real and significant excesses in terms of the imprisonment meted out for some offenders under existing mandatory sentencing laws, especially for some non-violent offenders.[70] The Department of Justice explained that "[m]andatory minimum sentencing statutes in the federal system now apply to a significant array of serious crimes; and they also, by and large, mandate very severe imprisonment terms."[69] This, in turn, has produced exponential growth in the federal prison population since the 1980s, and the federal Bureau of Prison's overcapacity "has real and detrimental consequences for the safety of prisoners and guards, effective prisoner reentry, and ultimately, public safety."[69] For this reason, the Department of Justice suggests some reforms of existing mandatory minimum sentencing statutes to eliminate excess severity in current statutory sentencing laws and to help address the unsustainable growth in the federal prison population.[69]

*Lack of Individualized Sentencing*

Critics often argue that mandatory minimum penalties conflict with the goal of individualized sentencing.[71] For instance, the Judicial Conference has long urged Congress "to reconsider the wisdom" of mandatory minimum penalties because they "block judges from considering the individual circumstances of particular cases."[72,73] Because mandatory minimum penalties may prevent a judge from considering all (or even most) of the pertinent facts and circumstances of the case (such as offender characteristics), the resulting sentence may be unfair or irrational.[70-72] Likewise, the American Bar Association has also called for the repeal of federal mandatory minimum penalties after concluding that they are "inconsistent with the notion of individualized sentencing within a guided discretion regime."[71,72] Moreover, there is significant agreement with the Judicial Conference and the ABA among judges and lawmakers, practitioners, scholars, and advocacy groups.[74]

*Ineffectiveness as a Deterrent or as a Law Enforcement Tool to Induce Pleas and Cooperation*

Some scholars counter the claims made by proponents of mandatory minimum penalties that these penalties serve as an effective deterrent to crime.[75] Research conducted by social scientists and public policy analysts has found little evidence to support the argument that mandatory minimums prevent crime.[76] In fact, many assert it is an increase in the certainty of punishment through the prosecution of more offenders that is the more cost-effective deterrent compared to the severity of punishment that mandatory minimum penalties or longer sentences provide.[77] Some also dispute the claims that mandatory minimum penalties are a useful law enforcement tool for the investigation and prosecution of criminals by inducing pleas and cooperation. Others have also argued that mandatory minimum penalties are inefficient investigative tools.[78] Some further believe that mandatory minimum penalties cause a "cooperation backlash" that occurs "when sentencing practices are viewed as overly severe" and "many citizens become reluctant to assist the law enforcement effort."[77] Therefore, while mandatory minimum penalties can increase cooperation by offenders who face those punishments, they can hinder the

willingness of citizens to cooperate with law enforcement at the early stages of investigation and arrest.[77]

*Disproportionate Impact Across Demographic Groups*

Some scholars express concerns that mandatory minimum penalties unfairly impact racial minorities and the economically disadvantaged.[79] This may be attributed in part to the fact that the most frequently applied mandatory minimum penalties are for drug offenses, which according to some, disproportionately impacts certain racial or ethnic groups.[80] While acknowledging that this disproportionate impact may be more a function of law enforcement priorities rather than sentencing policy, some assert that mandatory minimum penalties are being applied most frequently to a population that is not necessarily representative of all people violating such laws.[81] They argue that this perceived uneven application creates perceptions of unfairness that undermine the public's acceptance of the criminal justice system.[80] Some also view legally relevant factors, such as criminal history and prosecutorial discretion in charging decisions or plea agreements, as contributors to the demographically disparate impact of mandatory minimum penalties.[80] Studies show that racial minorities are more likely than whites to have a prior record, which may result from disproportionate processing by the criminal justice system.[82] Research likewise indicates that offenders in certain racial groups may be less likely to get the benefit of prosecutorial discretion in charging decisions or plea agreements.[81]

*Limited impact on reducing crime rates*

Evidence across the U.S. shows there is no discernable relationship between incarceration rates and crime rates: cities with high incarceration rates do not have lower crime rates than cities with low incarceration rates.[1,83] Mandatory minimums have been justified as an incapacitation strategy for people who have committed violent crimes based on the assumption that they are likely to continue to do so.[1,81,82] Research also shows that people "age out" of crime.[1,84] Violent crime, measured by arrest rates, is much more prevalent among younger people from their late teens to early twenties.[1,83] The rate of arrest for such crimes begins to sharply decline after this point and is more than halved by the mid-thirties.[1,85] This means that people who commit crimes, even if they once presented a danger to others, may be safely released much before the end of the 20-, 30-, and 40-year or life sentences they are now serving.[1,84] Additionally, a substantial body of research demonstrates that incarceration of any length is developmentally harmful for young people and contradicts safety, increasing the risk of future involvement with the criminal legal system rather than reducing crime.[1,86] Increases in the number and length of prison and jail sentences have not produced more public safety, because most justice-involved people are not a danger to the community.[1,84,85] A tiny fraction of people commit the majority of violent crimes in the U.S.—according to the data, 1 to 5 percent of people engaged in unlawful behavior commit 50 to 75 percent of all violent crimes.[1,87]

*Counterproductive for public safety*

Long-term sentences produce diminishing returns for public safety as individuals "age out" of the high-crime years; such sentences are particularly ineffective for drug crimes as drug sellers are easily replaced in the community; increasingly punitive sentences add little to the deterrent effect of the criminal justice system; and mass incarceration diverts resources from program and policy initiatives that hold the potential for greater impact on public safety.[1,82-86] Further, removing large numbers of people, mostly men, from their communities and placing them in correctional facilities for years at a time creates more harm than good.[1,88] Not only does the loss of these primary relationships cause trauma, but employers also lose employees, churches lose members, and

neighborhood groups lose contributors. [1,87] A meta-analysis of 116 studies found that custodial sentences not only do not prevent reoffending, but they can also actually increase it.[1,89] Data suggests that incarceration itself can be "criminogenic"—that the prison environment, separation from community, or even the process of returning to the community is so destabilizing that it increases the likelihood of continued encounters with the criminal legal system.[1,90]

*Increases cost of incarceration*

Scholars argue that if mandatory sentences for nonviolent and drug offenders were necessary for public safety, their cost would be justified.[91] However, as corrections spending has climbed, most experts have come to believe incarcerating huge numbers of low-level, nonviolent and drug offenders post-conviction is an inefficient and ineffective method of controlling crime.[90] While public safety benefits of incapacitating dangerous individuals justifies the costs, according to the Pew Center on the States, "most criminologists now consider the increased use of prison for nonviolent offenders a questionable public expenditure, producing little additional crime control benefit for each dollar spent."[92] A study looked at the cost effectiveness of mandatory minimum drug laws and asserted: "[I]f reducing consumption or violence is the goal, more can be achieved by spending additional money arresting, prosecuting, and sentencing dealers to standard prison terms than by spending it on sentencing (fewer) dealers to longer, mandatory terms."[93] As a result, many states have adopted evidence-based, cost-effective sentencing reforms. For instance, prosecutors in Michigan suggested to legislators that the state was "warehousing too many low-level nonviolent offenders with a minimal role in the drug trade for too long in costly prison beds."[94] As a result, Michigan repealed most of its drug-related mandatory minimums. Prison admittances fell and Michigan saved billions in tax dollars.[93] More importantly, the crime rate fell 27 percent in the decade after the repeal. Other states have moved in a similar direction.[93]

PROPOSED REFORMS TO ADDRESS LONG SENTENCING

*Removing extensions of sentences based on prior convictions*

Most states have prior conviction enhancements, which increase the probability and length of prison sentences for each felony conviction a person has on their record.[1,95] However, experts argue that sentence enhancements based on prior conviction history are problematic on at least three grounds: they do not promote safety, they are one of the major drivers of racial disparities in sentencing, and they punish people disproportionately for their behavior.[1,94] Policymakers often support prior record enhancements by using a deterrence argument: they claim that people will be deterred by knowing that if they commit a crime again, they will be punished more severely.[1,96] But increasing the severity of punishment based on a person's previous convictions does not effectively deter future criminal behavior as mentioned above.[1,97] Scholars argue that people who engage in repeated acts of serious harm—the 1 to 5 percent subset of the people who have committed violence— are perhaps the intended focus for proposed incapacitation, but suggest there are targeted ways to address these people, such as requiring specific findings of patterned harm at sentencing to extend sentences, as opposed to indiscriminately doing so for everyone based on prior records.[1,96]

*Abolishing mandatory minimums for low-level nonviolent offenses and drug offenses*

There is growing discourse about abolishing mandatory minimums and requiring prosecutors and judges to wrestle with the appropriateness of incarceration in each case, as well as the length of any carceral sentence.[1,98] Experts argue that states can remove all mandatory minimums by reviewing existing statutes and deleting each reference to a set minimum period of incarceration per crime or

class of crime and replace it with a more general statement that a judge may sentence someone to incarceration up to the maximum period of incarceration.[1,97]

*Creating a "second-look" sentencing review*

Second-look laws allow courts to reexamine a sentence after a person has served a period of time—10 to 15 years in most instances —to determine if the sentence still serves its original purpose.[1,99] These laws have increasingly become a viable way to reexamine needlessly long sentences and send people home from prison who can safely return to the community.[1,100] In the 2021 legislative session, second-look bills were introduced in 14 states; three, in Illinois, Maryland, and Oregon, passed.[1,101] The less restrictive versions of these bills allow justice-involved people to petition for relief; more restrictive versions reserve the petition power to district attorneys or the courts.[1,102] Although second-look laws may reduce the number of people currently incarcerated, they can suffer from the same pitfalls as parole boards.[1,101] For example, the California prosecutor-led second-look law that passed in 2019 has thus far resulted in about 100 releases in a state with a daily prison population of nearly 100,000 people.[1,103] The District of Columbia law, along with its later expansion to encompass people who were convicted of offenses that occurred up to age 26, has a better track record, with 67 people released in five years in a jurisdiction that has a daily justice-involved population of around 1,400.[1,104]

*Expanding the existing statutory safety valve*

Scholars argue that if Congress maintains mandatory minimum sentences, it should limit their use to exceptional cases and expand the statutory "safety valve" provision to allow courts more discretion.[1,105] Currently the safety valve provision permits a sentencing court to disregard a statutory minimum sentence for the benefit of certain low-level, nonviolent, cooperative defendants who have a minimal prior criminal record and were convicted of certain mandatory minimum controlled-substance offenses.[1,106] While the First Step Act of 2018 expanded relief for defendants with slightly more extensive prior criminal records, some have encouraged Congress to permit courts to invoke the safety valve in a broader set of circumstances.[1,107]

CURRENT AMA POLICY

The AMA has extensive policy addressing criminal justice system reform due to the intersections with health. Most relevant to this report is AMA Policy D-430.992 "Reducing the Burden of Incarceration on Public Health" which calls on the AMA to support efforts to reduce the negative health impacts of incarceration, through implementation and incentivization of adequate funding and resources towards indigent defense systems; implementation of practices that promote access to stable employment and laws that ensure employment non-discrimination for workers with previous non-felony criminal records; and housing support for formerly incarcerated people, including programs that facilitate access to immediate housing after release from carceral settings. This policy also calls on the AMA to partner with public health organizations and other interested parties to urge Congress, the Department of Justice, the Department of Health and Human Services, and state officials and agencies to minimize the negative health effects of incarceration by supporting programs that facilitate employment at a living wage, and safe, affordable housing opportunities for formerly individuals who are incarcerated, as well as research into alternatives to incarceration. AMA Policy H-80.993 "Ending Money Bail to Decrease Burden on Lower Income Communities" supports legislation that promotes the use of non-financial release options for individuals charged with nonviolent crimes.

AMA Policy H-95.907 "Address Disproportionate Sentencing for Drug Offenses" supports efforts to eliminate this sentencing disparity (from 18:1 to 1:1) and apply them retroactively to those already convicted or sentenced. AMA Policy H-100.955 "Support for Drug Courts" supports the establishment of drug courts as an effective method of intervention for individuals with addictive disease who are convicted of nonviolent crimes; encourages legislators to establish drug courts at the state and local level in the U.S.; and encourages drug courts to rely upon evidence-based models of care for those who the judge or court determine would benefit from intervention rather than incarceration. AMA Policy H-95.899 "Restorative Justice for the Treatment of Substance Use Disorders" acknowledges that inequitable sentencing structures, such as towards crack cocaine versus opioids, have contributed to unjust imprisonments. AMA Policy H-95.901 "Drug Policy Reform" states that the AMA supports elimination of criminal penalties for drug possession for personal use as part of a larger set of related public health and legal reforms designed to improve carefully selected outcomes. Further, AMA Policy H-430.980 "Compassionate Release for Incarcerated Patients" supports policies that facilitate compassionate release for incarcerated patients based on serious medical conditions and advanced age.

CONCLUSIONS

Incarceration in the U.S. rose at an unprecedented rate for nearly four decades beginning in 1973.[108] The initiatives, under the narrative of "tough on crime," involved enacting a range of sentencing policies designed to increase admissions to prison and to lengthen the amount of time served on a felony sentence.[107] Such policies were adopted by the federal government and every state to varying degrees. As a result of these changes, the combined prison and jail population of about 330,000 in 1972 has grown to over 1.9 million today.[109] The goal of mass incarceration was to improve public safety outcomes.[110] Evidence has shown that incarceration has an impact on crime, but the scale of that effect is much more modest than many policymakers or members of the public believe.[108,109] At best, the rise of incarceration may have produced about a quarter of the decline in crime that has occurred since the early 1990s.[111] Other studies have found this effect to be as low as five percent.[1,109,110] The second primary research finding on the effects of incarceration is that there are diminishing returns to public safety.[110] A key factor underlying this conclusion is that lengthy prison terms keep individuals behind bars long after they present a significant risk to public safety.[1,110] Further, incarceration has negative health impacts on those who are incarcerated with studies noting higher rates of infectious diseases, mental health diagnoses, substance use disorders, and overall lower life expectancy.[1,23,110] Birthing people in correctional facilities face even more unique issues such as issues related to breastfeeding, the possibility of being shackled while giving birth, lack of access to prenatal care, as well as the trauma of being separated from their newborns.[1,23,110]

There have also been efforts to address the length of prison terms in both the federal and state systems. At the federal level, the most impactful shift has been the decisions by the U.S. Sentencing Commission to revise drug offense guidelines downward, initially for crack cocaine offenses and subsequently for all drug offenses, and then to apply those revisions retroactively.[1,110] In state corrections systems, approaches to reduce sentence lengths have been relatively modest. While twenty-nine states have adopted reforms to mandatory sentencing procedures since 2000, many of these have been narrow in scope, and as a result the impact of reform may be limited.[112] Half of the states still maintain life sentencing policies of "three strikes and you're out" habitual offender laws, and more than half limit parole consideration (generally until eighty-five percent of a sentence has been served) due to the adoption of "truth in sentencing" laws that apply to many convictions.[113] Experts argue that future reforms are still needed to address mass incarceration, these include, but are not limited to removing prior conviction enhancements, providing for judicial discretion in sentencing, and adequate support systems and services for successful reentry into the

community.[1,112] Ongoing research is essential to assess the effects of sentencing reform on individuals who have been incarcerated and public safety.

RECOMMENDATIONS

The Board of Trustees recommends that the following be adopted in lieu of Resolution 215-I-23, and the remainder of this report be filed.

1. Our AMA: (1) recognizes the negative impacts associated with prolonged incarceration, including on the physical and mental health of justice-involved individuals and their families, (2) supports efforts to reduce the reliance on incarceration, particularly for non-violent offenders, with recognition that rehabilitation and successful reentry into the community requires adequate support systems and services, (3) supports a system of continuous review of sentences for individuals who are incarcerated providing the opportunity for those who demonstrate rehabilitation and pose a minimal risk to society to be considered for early release, and (4) supports providing judges with the discretion to help ensure that sentences are fair and fit the crime, while protecting against unjust and inconsistent results. (New HOD Policy)
2. Our AMA supports additional research to assess the effects of sentencing reforms on the health impacts of individuals who have been incarcerated and public safety. (New HOD Policy)
3. That our AMA reaffirm the following policies: D-430.992 "Reducing the Burden of Incarceration on Public Health," H-95.899, "Restorative Justice for the Treatment of Substance Use Disorders;" H-95.901, "Drug Policy Reform," H-80.993, "Ending Money Bail to Decrease Burden on Lower Income Communities" (Reaffirm HOD Policy)

Fiscal Note: Minimal - less than $1,000

APPENDIX I - Successful State Reforms to Mandatory Minimum Sentencing

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| California's Proposition 47 | Proposition 47 which passed in 2014, reclassified several property and drug offenses as misdemeanors and led to retroactively reduced sentences.[114] Within three months, almost 9,000 people had been released from California correctional facilities; within one year, that became 13,000 people. Evaluations of Proposition 47 have shown that it led to an immediate 15 percent decline in total drug arrests and a 20 percent decline in property crime arrests, as well as a reduction in racial disparities in arrest rates.[111] Analyses of Proposition 47 impact on crime rates in California have found that the proposition's passage was not associated with a change in violent crime rates, although larceny theft increased modestly following passage.[111] Proposition 47 also reduced recidivism: two-year rearrest and reconviction rates were significantly lower for people released after serving sentences for Proposition 47 offenses compared to their pre-reform counterparts.[115] |
| New York's Rockefeller Drug Law Reform | In 2009, the New York State Legislature passed full repeal of New York's Rockefeller Drug law and replaced it with a different statutory structure.[116] This sentencing reform permitted drug treatment and alternative-to-prison programs instead of prison sentences and set shorter sentence lengths for those still permitted to be imprisoned for felony drug convictions.[113] An impact study of these reforms found that in the nine months prior to Rockefeller Drug Law repeal, Black and Latinx people were three times more likely than white people to receive a prison sentence following a felony drug arrest.[117] After the drug law reforms, they were twice as likely as white people to go to prison—a 33 percent reduction in a disparity that researchers concluded could not be explained by factors other than race.[114] A follow-up on both sample groups showed that those sentenced to diversion after the reforms had 43 percent fewer rearrests than those sentenced to incarceration.[114] |
| Illinois | From 1980 to 1983, Illinois corrections officials released 21,000 incarcerated individuals—or 10 percent of the prison population—to alleviate the state's severe prison overcrowding, brought about in part by a huge increase in prosecutorial staffing and the state's move from indeterminate to determinate sentencing.[118] The largest portion of people released were convicted of burglary (26 percent) and armed robbery (15 percent).[115] The average sentence reduction per person was about 105 days, or 12 percent.[115] For the people released early who did go on to commit crimes, these accounted for less than 1 percent (4,500 arrests) of all recorded arrests for the three-year period covering their releases.[115] |

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REPORT OF THE BOARD OF TRUSTEES

B of T Report 16-A-25

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|---|---|
| Subject: | Research Correcting Political Misinformation and Disinformation on Scope of Practice |
| Presented by: | Michael Suk, MD, JD, MPH, MBA, Chair |
| Referred to: | Reference Committee B |

## INTRODUCTION

At the 2024 Annual Meeting, the American Medical Association (AMA) House of Delegates (HOD) adopted Policy D-405.968, "Research Correcting Political Misinformation and Disinformation on Scope of Practice," which calls for the following:

> That our AMA Board of Trustees perform a comprehensive literature review on current research on correcting political misinformation and disinformation and conduct field research on ways to correct political misinformation and disinformation amongst policymakers as it pertains to scope of practice. (Directive to Take Action)
>
> That our AMA Board of Trustees report its findings and recommendations to the HOD on correcting political misinformation and disinformation and that our AMA incorporate these findings to the extent possible into our AMA's advocacy efforts on scope of practice. (Directive to Take Action)

This report will provide an overview of the current research on correcting political misinformation and disinformation, as well as highlight field research currently underway by our AMA based on learnings from this literature review.

## BACKGROUND

The topic of how to correct misinformation and disinformation has garnered much attention over the last decade, particularly as the internet and social media platforms have increased the ability for misinformation and disinformation to spread.[1] Misinformation and disinformation can occur across various disciplines such as health, the environment, politics, and crime[2] and can include "inaccurate news, conspiracy theories, disinformation campaigns, propaganda, and slanted reporting."[3] Misinformation can be created and spread by individuals, organizations, government entities, politicians, corporations, and/or the media.[4] In contrast to disinformation, there does not need to be mal-intent or even intent to mislead for something to qualify as misinformation. Indeed, misinformation can even arise unintentionally, such as through reporting on evolving events like natural disasters where information changes as the event unfolds and new information becomes available.[5] The scientific process also lends itself to refinement over time, "this piecemeal approach to knowledge construction is the very essence of the scientific process, through which isolated initial findings are sometimes refuted or found not to be replicable."[6]

For the purposes of this report, the Board of Trustees has been asked to focus its research on how best to correct political misinformation and disinformation. It is important to understand that the leading scholars on this issue caution that the issue is complex and there is no one-size fits all solution.[7] The ability to correct misinformation may depend on a variety of factors, such as the credibility of the source of information, whether the information aligns with one's personal beliefs, and whether the information aligns with one's social and political identities.[8] That said, studies do reveal some techniques that have shown promise in effectively correcting misinformation. In November 2023, the American Psychological Association published a Consensus Statement entitled*, Using Psychological Science to Understand and Fight Health Misinformation* (*APA Consensus Statement*). The *APA Consensus Statement* describes the body of research on the psychology of misinformation, noting that experts remain divided on many key issues, including "how to define misinformation clearly, how to quantify how many people are regularly exposed to it, what factors make people susceptible to believing and hearing it online and offline, and how best to counter the problem at scale."[9]

*Defining Misinformation and Disinformation*

There is not a commonly agreed upon definition for misinformation or disinformation. The *APA Consensus Statement* defines misinformation as "any information that is demonstrably false or otherwise misleading, regardless of its source or intention"[10] and goes on to distinguish between misinformation and disinformation, specifying that disinformation involves an explicit intent to deceive or manipulate others. The *APA Consensus Statement* elected to focus on the broader term of misinformation, noting the difficulty in proving motive, and thus the challenge in distinguishing between misinformation and disinformation.[11]

Other scholars in this area have offered the following definitions:

- Misinformation occurs when false information is shared, but no harm is meant;
- Disinformation occurs when false information is knowingly shared to cause harm; and
- Malinformation occurs when "genuine information is shared to cause harm, often by moving information designed to stay private into the public sphere."[12] Malinformation has also been defined as information that stems from the truth but is exaggerated in a way that misleads and causes potential harm.[13]

*Theories for Correcting Misinformation*

Much of the literature on corrective techniques focuses on misinformation not disinformation or malinformation. Misinformation corrective techniques may focus on correcting specific messages or teaching individuals how to spot manipulation techniques and stop the spread of misinformation.

The *APA Consensus Statement* describes the following four corrective techniques found in literature on this topic:

1. Debunking or fact-checking;
2. Inoculation theory or prebunking;
3. Literacy interventions; and
4. Nudging.

A separate meta-analysis comparing the effectiveness of techniques used to correct misinformation across science, health, politics, marketing, and crime focuses on the following common corrective techniques.

These techniques overlap with those in the *APA Consensus Statement* as noted below:

1. Appeals to consensus (similar to nudging);
2. Coherence (part of the corrective technique in debunking);
3. Source credibility (similar to literacy interventions);
4. Fact-checking (similar to debunking); and
5. Providing general warnings (similar to inoculation).

Debunking or Fact-Checking

Debunking or fact-checking is a common corrective technique used to state the inaccuracy of information, why it is incorrect, and often followed-up with the correct information. Unlike the inoculation or prebunking technique, which will be discussed below, this technique is used after misinformation has already been shared. Fact-checking is commonly used during political debates either in real-time or post-debate.

In general, studies have found that debunking alone is ineffective. One reason cited is because individuals tend to follow conversational norms and assume that speakers are truthful. Individuals may also continue to believe misinformation despite attempts to fact-check due to the "continued influence effect," in which misinformation retains its perceived truth despite attempts to correct.[14] In other words, fact-checking does not fully remove the false information from one's memory and familiarity with a message – even if it is incorrect – can increase its perceived truth. For example, one study found that debunking misinformation rarely eliminated one's reliance on misinformation, reducing references by only about 50 percent.[15] Studies also point to the importance of the tone of the correction, noting that authoritative retractions can be especially ineffective and may lead individuals to further entrench in the misinformation. The use of negative emotions in the correction has also been studied. For example, one study examining the use of emotions in corrective techniques related to tobacco found that the use of negative emotions was more effective than a simple correction; however, authors of the study caution that their findings are limited to the controlled setting in which they were examined and cannot be generalized.[16]

Research has found that the effectiveness of debunking increases when paired with other corrective methods, such as following up with correct information. According to several researchers, refuting the misinformation and replacing it with correct information has proven effective because it maintains the coherence of the story.[17] Indeed, leaving gaps in a narrative can limit the effectiveness of a corrective technique. Similarly, simple explanations are preferred over complex explanations.[18]

Inoculation Theory or Prebunking

Inoculation theory was originally developed by McGuire in the 1960s as a strategy to prevent misinformation from influencing individuals by building an individual's resistance to persuasion. Unlike fact-checking, inoculation or prebunking occurs before an individual receives the misinformation. The idea is to inoculate an individual by providing them with a weakened form of the misinformation, share why it is inaccurate, and provide clues on how one might be able to spot it in the future.[19] The theory has evolved to include both inoculating against specific messages and providing general mechanisms or forewarnings on how to spot common manipulation tactics.[20] Using inoculation techniques for specific issues typically involves two parts (1) identifying the threat, and (2) refutational preemption (prebunking). The threat component includes a warning that an individual will hear a specific piece of misinformation plus a less convincing version of the falsehood. This warning is then followed up with a refutational preemption or prebunking, i.e., the

correct information.[21] Noting the challenges with prebunking every piece of misinformation, researchers have turned to using inoculation to inform individuals on how to spot common manipulations techniques used to spread misinformation. These are often gamified and include platforms like "Bad News," (https://www.getbadnews.com/en) a role-playing game that teaches users manipulation techniques and awards them points for crafting a misinformation campaign that attracts followers, with the intent to make them better informed and able to spot misinformation in their daily lives.[22] Truth Labs for Education (https://inoculation.science/inoculation-videos/), is another example. Truth Labs for Education is a collaboration between Cambridge University, the University of Bristol, and Google Jigsaw that also has a series of videos aimed at inoculating individuals against common manipulation techniques used to spread misinformation. Similarly, Google has a series of videos (https://prebunking.withgoogle.com/) aimed at helping individuals spot manipulation techniques and providing guidance on how to successfully prebunk misinformation. Notably, there is overlap with these inoculation techniques and the literacy interventions and nudging techniques described below.

Inoculation has proven an effective technique in preempting the effect of misinformation. For example, one study found that inoculation of specific messages on climate change proved effective.[23] Researchers have also found that corrective actions including both a forewarning and preemptive refutation (prebunking) of the misinformation was most effective.[24] Since it would be nearly impossible to perform inoculation against each and every falsehood, studies have also measured the scalability of inoculation techniques across issues. The findings are promising. For example, studies have found that an individual who has been inoculated against one falsehood is less likely to be susceptible to misinformation in other contexts.[25] Similarly, a systemic review and meta-analysis confirmed this phenomenon finding that inoculation is "effective in creating more resistant attitudes against misinformation while improving truth discernment."[26] Studies have also found that inoculation can have long term effects – up to a week – and up to three months with brief reminders ("booster shots") of the inoculation.

Researchers, however, note that there are limitations with inoculation, including that most studies on the effectiveness of inoculation are done in controlled environments with only a few studies examining its effectiveness in correcting real-world misinformation.[27] In addition, most studies in this body of research focus on the effectiveness of inoculation techniques in improving the identification of misinformation. More research is needed on the effectiveness of inoculation in replacing misinformation with accurate information.

Literacy Interventions

Literacy intervention techniques are focused on improving an individual's ability to discern the accuracy of information and spot misinformation. As mentioned above, this technique often incorporates inoculation theories. The *APA Consensus Statement* describes this technique in terms of health literacy, media literacy, and digital literacy. Health literacy includes informing individuals how to evaluate health content for quality or accuracy. Media literacy includes the ability to evaluate the quality of print and online media and digital literacy includes the ability to properly execute tasks online.[28] These interventions often occur in formal settings, including schools, universities, and community centers.

In terms of the effectiveness of these approaches, the *APA Consensus Statement* describes mixed results, noting that there may be some short-term benefits, but that interventions may require a significant investment of time and resources (e.g., interventions lasting more than five hours were more likely to be effective than those lasting one hour).[29] In addition, the report notes that few

studies have focused on or shown a lasting effect of literacy interventions, challenging their long term impact.[30]

Nudging

Unlike the techniques described above, which are often focused on correcting misinformation, nudging is a technique used to encourage behavioral changes in individuals, such as encouraging them to correctly identify misinformation. Anti-misinformation nudges may include accuracy nudges, social-norm nudges, and motivational nudges.[31] Accuracy nudges encourage people to reflect on the importance of only sharing accurate information with others. Per the *APA Consensus Statement*, "social-norm nudges are geared toward news-sharing behavior and emphasize either injunctive norms (i.e., behaviors most people find acceptable or not) or descriptive norms about it (i.e., how other people respond in certain situations)."[32] Finally, motivational nudges "seek to motivate people to be as accurate as possible (e.g., paying them to correctly identify true and false news)."[33]

In general nudging is a systems-based technique aimed at correcting one's behavior rather than a technique used to correct misinformation related to specific topics or specific messages. For example, X and TikTok have, at times, integrated nudging techniques into their platform to encourage users to examine the veracity of the information and re-consider whether it should be shared with others.[34] Some have suggested that when inoculation is combined with nudging, the effectiveness of both techniques increases.[35]

In terms of the effectiveness of nudging, a meta-analysis described in the *APA Consensus Statement* "found that accuracy nudges were effective overall at improving sharing discernment, although this effect was both small and heterogeneous."[36] Similarly, a field study on X, when it was known as Twitter, found that social norm nudges were effective in improving the identification of misinformation.[37] Finally, motivational nudges, including paying people to correctly identify misinformation, were also found effective in both improving people's ability to accurately identify misinformation and reducing any partisan bias when reviewing information.

However, researchers also note mixed findings on studies of the effectiveness of nudging, as well as some general limitations. Notably, there is concern that effectiveness may be short-lived and wear off after several repetitions.[38] Nudging may also be less effective toward individuals who do not want to be nudged.[39]

DISCUSSION

The body of literature on techniques to correct political misinformation and disinformation provides guidance which may be applicable to correct myths often used by those supporting inappropriate scope of practice expansions. As noted in the literature, however, correction of political misinformation poses unique challenges, as research consistently shows people are more resistant to changing political beliefs compared to other domains. This resistance appears particularly strong among educated political partisans, suggesting that corrective techniques relying solely on increased education or providing additional information on a topic may be insufficient. This may be particularly true among legislators. Indeed, researchers have noted that an individual's worldview or ideology can play a key role in one's susceptibility to misinformation and the effectiveness of corrective techniques. Correcting political misinformation may also be faced with suspicion due to perceived motivations behind the misinformation and those correcting the misinformation.

Scholars have also shared limitations in this body of research. For example, much of the research has been done in a controlled setting, therefore, these techniques may not have the same level of effectiveness when replicated in a real-world environment. Finally, these theories are often tested on specific age groups or the general population, not policymakers or lawmakers, making it difficult to know whether these techniques will prove effective for this audience.

This literature review has been instrumental in providing the basis for our next step: assessing the effectiveness of these techniques to counter arguments related to scope of practice expansions. This step is currently underway and includes our AMA engaging in field research to test these techniques on specific messages often used by those supporting scope of practice expansions. Our AMA will incorporate findings from this field research into our scope of practice advocacy campaign. The cost necessary to implement Policy D-405.968, "Research Correcting Political Misinformation and Disinformation on Scope of Practice" including conducting the field research has already been approved and allocated by our AMA. With the directives having been accomplished, the Board of Trustees recommends rescinding this policy.

RECOMMENDATION

The Board of Trustees recommends the following recommendation be adopted and the remainder of the report be filed:

That our American Medical Association rescind Policy D-405.968, "Research Correcting Political Misinformation and Disinformation on Scope of Practice." (Rescind HOD Policy)

Fiscal Note: Less than $500.

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REPORT 17 OF THE BOARD OF TRUSTEES (A-25)
Antidiscrimination Protections for LGBTQ+ Youth in Foster Care Report
(Reference Committee B)

## EXECUTIVE SUMMARY

Background: During the 2024 Annual Meeting, the House of Delegates (HOD) referred for report the second Resolve of Resolution 224 titled, Antidiscrimination Protections for LGBTQ+ Youth in Foster Care. The resolve recommended, "that our AMA support efforts by the Department of Health and Human Services and other appropriate stakeholders to establish a reporting mechanism for the collection of anonymized and aggregated sexual orientation and gender identity data in the Adoption and Foster Care Analysis and Reporting System (AFCARS) only when strong privacy protections exist."

Discussion: LGBTQ+ youth, particularly transgender individuals, are disproportionately represented in the foster care system, facing significant challenges such as discrimination, mental health issues, and unstable placements. However, the lack of comprehensive data collection on sexual orientation and gender identity (SOGI) has hindered efforts to develop focused policies and interventions. Despite an unstable policy landscape, collecting SOGI data remains crucial.[i] Data collection enables child welfare agencies to better assess disparities, tailor services, and improve placement stability for LGBTQ+ youth.

This report explores considerations for integrating SOGI data into AFCARS, emphasizing the need for strong privacy protections. Creating a successful data strategy requires navigating political headwinds, concerns about privacy and data security, and varying state policies. To succeed, federal agencies can implement rigorous privacy measures, provide technical assistance to states, and ensure that SOGI data collection is voluntary and confidential. Moreover, ongoing collaboration between HHS, child welfare agencies, advocacy groups, and healthcare professionals is essential to establishing a sustainable reporting mechanism. Physicians and health care professionals play a key role by advocating for accurate data collection, safeguarding privacy, and ensuring that LGBTQ+ youth receive appropriate mental health and medical care.

Conclusion: Integrating SOGI data into AFCARS represents a critical step toward a more inclusive and equitable foster care system. With careful implementation, strong privacy protections, and support from healthcare professionals, this initiative can improve outcomes for LGBTQ+ youth and ensure that child welfare policies reflect the diverse needs of the children they serve.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 17-A-25

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|---|---|
| Subject: | Antidiscrimination Protections for LGBTQ+ Youth in Foster Care |
| Presented by: | Michael Suk, MD, JD, MPH, MBA, Chair |
| Referred to: | Reference Committee B |

**BACKGROUND**

During the 2024 Annual Meeting, the House of Delegates (HOD) Resolve 2 of Resolution 224-A-2-24 titled, Antidiscrimination Protections for LGBTQ+ Youth in Foster Care was referred for report.[ii] The resolve recommended:

> RESOLVED, that our AMA support efforts by the Department of Health and Human Services and other appropriate stakeholders to establish a reporting mechanism for the collection of anonymized and aggregated sexual orientation and gender identity data in the Foster Care Analysis and Reporting System only when strong privacy protections exist.

Resolution 224-A-24 received mixed reviews when it was up for discussion in Reference Committee B. Testimony reflected that most LGBTQ+ groups believe that this data should be collected by the federal government "to enhance recruitment of foster homes, promote visibility for marginalized groups, help to analyze youth outcomes, and address disparities."[iii] However, there were serious concerns related to data privacy and overall child safety.[iv] Additional testimony highlighted the divide between which governmental body should collect SOGI data for LGBTQ+ youth, federal or state and local governments.[v]

**DISCUSSION**

The foster care system in the United States serves as a critical safety net for children and youth who are unable to remain in their homes due to abuse, neglect, or other family challenges. Administered at the state level with federal oversight and funding, the system provides temporary care and placement, aiming to ensure the safety, well-being, and permanency of children. (Permanency "is a permanent, stable living situation, ideally one in which family connections are preserved.")[vi] While the foster care system supports over 390,000 children annually, it faces significant challenges, including a shortage of foster families, disparities in outcomes for children of color and LGBTQ+ youth, and barriers to achieving permanency through reunification or adoption.[vii]

LGBTQ+ youth, particularly transgender individuals, are significantly overrepresented in the foster care system, with approximately 30 percent identifying as LGBTQ+ and five percent as transgender—far exceeding their representation in the general population.[viii] These youth face heightened risks of discrimination, mental health challenges, and disrupted placements due to systemic biases and lack of affirming care. Collecting sexual orientation and gender identity

(SOGI) data in the foster care system would be a critical step toward improving such outcomes for LGBTQ+ youth.[ix]

The U.S. Department of Health and Human Services (HHS) plays a central role in guiding and supporting efforts to collect SOGI data in child welfare. Within HHS, the Administration for Children and Families (ACF) oversees the Adoption and Foster Care Analysis and Reporting System (AFCARS), a national data system that tracks case-level information on children in foster care. Historically, AFCARS has not required the reporting of SOGI information.

However, recognizing the significant need for better data to serve LGBTQ+ youth, HHS and partnering agencies would make great strides in improving health outcomes by establishing a reporting mechanism for anonymized, aggregated SOGI data in AFCARS. These efforts would involve multiple interested parties – federal and state child welfare agencies, advocacy organizations, former foster youth, and experts in data collection and privacy – collaborating to design policies and practices that encourage SOGI data reporting.

A paramount concern in collecting SOGI information is ensuring strong privacy protections. Given the sensitive nature of sexual orientation and gender identity data, inappropriate disclosure can put youth at risk of stigma, discrimination, or even harm (for instance, some foster youth have been "outed" without consent, resulting in hostile reactions from caregivers).[x] Physicians and other healthcare professionals who care for foster youth understand the importance of confidentiality in maintaining trust; similarly, confidentiality is crucial when youth share SOGI information. The goal, therefore, is to develop data systems that yield valuable insights into LGBTQ+ foster youth's needs and the effectiveness of supportive interventions while rigorously safeguarding individual privacy. Federal guidance emphasizes that SOGI data collection must only proceed with measures to secure privacy, security, and civil rights – including robust consent practices and restrictions on data use.[xi] This report underscores the need for the establishment of a reporting mechanism for the collection of anonymized and aggregated sexual orientation and gender identity data into AFCARS and overview of privacy protections considerations.

*Unstable Policy Landscape around Collection of Data among LGBTQ+ Communities*

In recent years, the policy landscape has evolved to explicitly support the inclusion of SOGI data in foster care reporting. In 2016, under the Obama Administration, HHS's ACF issued a groundbreaking final rule to update AFCARS after over two decades; this rule would have, for the first time, required state child welfare agencies to collect and report SOGI-related data.[xii] The 2016 rule specified that youth ages 14 and older would be asked to voluntarily self-report their sexual orientation, and that agencies would report the sexual orientation of foster/adoptive parents and legal guardians, as well as whether a youth's entry into care involved family conflict related to SOGI. The ACF explained that these data points were intended to "better support children and youth in foster care who identify as LGBTQ+" by ensuring placement resources and services could be tailored to their needs. This policy marked a significant recognition at the federal level that SOGI data are integral to child welfare planning.

However, the implementation of the 2016 AFCARS SOGI data requirements was halted and reversed under the first Trump administration. The rule's effective date was delayed multiple times in 2017–2018, and by 2019 HHS proposed rescinding the SOGI elements, citing a desire to reduce reporting burden and concerns that sexual orientation data were "too sensitive and private" for a government record.[xiii] In May 2020, a final rule was issued that eliminated the collection of sexual orientation data from AFCARS entirely.[xiv] This rollback was met with strong opposition from advocacy groups and some state officials, who argued that removing SOGI data "is a huge mistake

that will harm the children we serve," making LGBTQ+ youth and their outcomes "invisible" in national statistics.[xv] Massachusetts youth advocates responded by urging their state to collect and report SOGI data on its own, condemning the federal withdrawal as an "abandonment" of responsibility to LGBTQ foster youth.[xvi] The policy back and forth between 2016 and 2020 highlighted that, absent federal requirements, efforts to gather SOGI data would rely on state-level initiative or future policy changes.

The pendulum continues to swing regarding SOGI data collection. In June 2022, President Biden issued Executive Order 14075 on Advancing Equality for LGBTQI+ Individuals, which explicitly directs federal agencies to improve SOGI data collection while safeguarding privacy.[xvii] This order led to the creation of a Federal Evidence Agenda on LGBTQI+ Equity and an HHS-led SOGI Data Action Plan in 2023.[xviii,xix] The HHS SOGI Data Action Plan calls on the entire department to enhance the health and well-being of all Americans by systematically collecting SOGI data in its programs, "whenever data on other demographic characteristics are collected."[xx] In practice, this means HHS operating divisions and staff divisions would be reviewing their data systems (including those for foster care) to add SOGI variables where feasible.[xxi] The plan urges updating binary gender categories to be more inclusive and ensuring that SOGI questions would be incorporated into demographic data collection as soon as possible.[xxii] This renewed policy emphasis from HHS leadership signaled strong support for establishing a SOGI reporting mechanism in AFCARS. Additionally, various states and localities have enacted their own policies to gather SOGI data in social services – for example, California implemented a SOGI data collection law that added SOGI fields to statewide client databases – further building momentum for broader adoption.[xxiii] However, in January 2025, President Trump rescinded Executive Order 14075 and other key policies aimed at protecting LGBTQ+ individuals, reversing federal efforts to collect SOGI data in foster care, health care, and other social services while also limiting anti-discrimination protections across multiple agencies.[xxiv,xxv]

*Benefits of Collecting SOGI Data in Foster Care*

Collecting SOGI data within AFCARS stands to yield significant benefits for the well-being of children and adolescents in foster care, particularly those who are LGBTQ+. One of the clearest benefits is the ability to identify and address health inequities and needs more accurately. LGBTQ+ youth in care face distinctive health challenges – for example, higher rates of depression, suicidal ideation, and trauma related to identity-based rejection.[xxvi] If child welfare and health care professionals know how many individuals are affected and can correlate that with health outcomes, they can better allocate mental health services, counseling, and support programs. For instance, if data reveal that a substantial percentage of foster youth identify as transgender, agencies can ensure there are clinicians trained in gender-affirming care available for consultations. Similarly, if lesbian, gay, or bisexual youth in care show higher utilization of emergency mental health services, that could prompt focused preventive interventions (such as support groups or mentoring programs to build resilience). In short, what gets measured gets addressed – by capturing SOGI information, the foster care system can move from anecdotal awareness of LGBTQ+ youths' struggles to quantitative evidence that spurs more efficient and effective health care planning and resource allocation.[xxvii,xxviii]

From a social services perspective, SOGI data helps ensure that policies and practices are inclusive. For example, knowing the proportion of youth identifying as LGBTQ+ can inform recruitment of foster families.[xxix] Agencies might invest more in recruiting affirming foster homes or training existing foster parents on LGBTQ+ issues if data show a high need. Essentially, SOGI data allows for a more individualized approach in a system that often has to take broad steps to address various challenges.

Physicians who work with foster children (e.g., pediatricians in foster care clinics, child psychiatrists) would see direct benefits too. Providing affirming sexual health counseling would benefit all of their patients, and could help close gaps for foster children, particularly those who identify as LGBTQ+. If a physician is aware that a patient is part of a population at elevated risk for certain issues, they can institute procedures and/or create systems that prompt focused screening and intervention. For example, a primary care doctor knowing their foster patient is LGBTQ+ might increase their frequency of screening for depression or anxiety. On a systemic level, health care professionals can partner with child welfare to develop trauma-informed, LGBTQ+-affirming care models when the need is documented.[xxx] Furthermore, data might reveal positive outcomes where supportive policies are in place, thereby guiding best practices that health care professionals can advocate for, and health systems can scale up.

Finally, at a human level, asking SOGI questions in a respectful manner can itself send a message of inclusion to youth of all identities. Many LGBTQ+ youth in particular report feeling invisible or misunderstood in systems of care. When a caseworker or health care professional asks about their identity in a validating way and that information is used to support them, it affirms to the young person that they are seen and valued. This can build trust in the system. Over time, as data-driven improvements take root, one would hope to see tangible benefits: reductions in homelessness among LGBTQ+ youth who have aged out of the foster care system, fewer incidences of bullying or abuse in placements, better mental health status, and more stable, affirming placements – all of which contribute to healthier outcomes.

*Privacy Protections for SOGI Data in Foster Care*

Privacy laws are a critical component that ensure sensitive information is protected. Any state that receives a grant under the Child Abuse Prevention and Treatment Act (CAPTA), "must provide an assurance that it has in effect and is enforcing a state law that includes methods to preserve the confidentiality of all child abuse and neglect reports and records in order to protect the rights of the child and the child's parents or guardians, including requirements to ensure that the information is released only to certain individuals and entities."[xxxi,xxxii]

While foster care agencies are not considered "covered entities" under the Health Insurance Portability and Accountability Act (HIPAA), the principles of health information privacy are highly relevant to the collection of SOGI data. SOGI data can be considered sensitive, similar to health information, and should be safeguarded accordingly. Under HIPAA, any individually identifiable health information, including SOGI data in medical or counseling records must be protected and disclosed only for permitted purposes.[xxxiii] In April 2024, HHS reinforced these protections, preventing disclosure of health data for investigations related to gender-affirming care, further underscoring the expectation of privacy for SOGI-related information.[xxxiv]

Since AFCARS is an administrative database rather than a public health repository, any SOGI data collected would be subject to federal confidentiality rules, which also means federal laws such as the Privacy Act of 1974 applies to AFCARS data, requiring a System of Records Notice outlining its collection and use and restricting disclosure without consent. When properly anonymized and aggregated, SOGI data falls outside the scope of personally identifiable information and is not subject to HIPAA or Privacy Act restrictions. However, the initial collection of SOGI data—when attached to a youth's case—must be carefully managed under strict confidentiality rules.

*Federal and State Legal Protections*

In recent years, several federal directives have specifically addressed SOGI data privacy. Executive Order 14075, which as mentioned above was rescinded in early 2025, instructed agencies to safeguard privacy, ensure informed consent, and limit the use of SOGI information.[xxxv] The Trump administration also rescinded the March 2021 Department of Justice (DOJ) memo providing that DOJ would apply the Supreme Court's holding in *Bostock v. Clayton County*[xxxvi] (that Title VII of the Civil Rights Act of 1964 protects employees against discrimination and unjust termination based on their sexual orientation or gender identity) in the context of Title IX and, accordingly, Section 1557, weakening protections.

However, federal civil rights laws including Title VI of the Civil Rights Act continue to prohibit discrimination based on sex, which includes sexual orientation and gender identity; reinforcing the notion that SOGI data should be used to prevent disparities, not perpetuate discrimination.

State laws also impact SOGI data collection in foster care. Child welfare information, including SOGI details, is generally protected under state confidentiality statutes, limiting access to authorized parties such as case workers and health care professionals.[xxxvii] Some states have taken proactive steps to affirm LGBTQ+ youth rights. For instance, California's Foster Youth Bill of Rights (AB 175) ensures that youth are referred to by their preferred name and gender pronouns.[xxxviii] Additionally, California's AB 959 mandates SOGI data collection across state programs, leading to its inclusion in child welfare databases like Child Welfare Services/Case Management System.[xxxix]

However, some states have enacted laws hostile to LGBTQ+ rights, such as bans on gender-affirming care or restrictions on discussing LGBTQ+ issues in schools.[xl] In such states, there are concerns that SOGI data could be misused. While foster care data is not public, legal safeguards must ensure that access to SOGI data remains restricted and not subject to improper demands. No lawful basis currently exists for law enforcement or other agencies to access SOGI data from child welfare records simply to enforce anti-LGBTQ policies. To ensure both the protection of sensitive information and the effectiveness of data collection, it is crucial to establish a secure and standardized approach.

SOGI data collection at the federal level ensures consistency, comparability, and comprehensive national oversight. Federal agencies like the CDC and HHS generally have the infrastructure, resources, and reach necessary to gather or support standardized data across states, which is essential for identifying disparities and informing equitable public health and policy interventions. While state and local governments can complement these efforts with localized data collection, relying solely on them could risk inconsistency and incomplete data due to varying political climates and resource limitations. A federal framework with assistance to state and local governments and clear guidelines and privacy protections would strike a balance, ensuring LGBTQ+ populations are accurately represented and better served nationwide.

*Addressing Privacy Concerns*

Despite safeguards, privacy risks remain. A primary concern is the unintended disclosure of a youth's LGBTQ+ status, which can lead to stigma, discrimination, or even removal from supportive placements. Reports from the Government Accountability Office highlight cases where case workers or foster parents inappropriately disclosed a youth's SOGI information, leading to harm.[xli] Additionally, in politically charged environments, concerns persist that SOGI data could be

accessed for punitive purposes, similar to efforts in some states to obtain medical records related to gender-affirming care.[xlii]

To mitigate these risks, agencies must uphold strict need-to-know access policies, ensuring SOGI data is only accessible to those directly involved in the individual's care. Courts typically receive only information relevant to a proceeding, and SOGI data should not be included unless necessary. HHS has committed to publishing only anonymized and aggregated SOGI data, ensuring no individual can be identified.

Individual consent remains a fundamental protection. The scrapped 2016 AFCARS rule framed SOGI questions as voluntary for youth age 14 and older, a principle likely to carry forward in future implementation. Research suggests that youth are more likely to disclose SOGI information when assured of confidentiality.[xliii] Agencies can further enhance privacy by requiring explicit consent before sharing SOGI data with third parties, such as foster parents.[xliv]

From a security perspective, child welfare information technology systems already incorporate firewalls, encrypted databases, and role-based access to restrict data visibility.[xlv] Confidentiality agreements and mandatory staff training on LGBTQ+ cultural appropriateness reinforce ethical data handling.[xlvi,xlvii]

*Challenges and Considerations*

Implementing SOGI data collection in foster care could present several challenges that should be addressed.

Resistance and Pushback: Some interested parties, including state and local officials, argue that sexual orientation and gender identity are private matters and question their relevance to child welfare.[xlviii] Others cite concerns about workforce burden, including training, software updates, and data entry.[xlix] Political opposition has also hindered progress, with some fearing that collecting SOGI data may be misinterpreted as encouraging LGBTQ+ identification.[l] Additionally, religious objections from foster agencies and parents further complicate data collection efforts.[li,lii]

Ethical and Community Concerns: The voluntary nature of SOGI disclosure is crucial, as individuals in foster care may not yet feel comfortable identifying or may fear repercussions. LGBTQ+ advocacy groups generally support data collection for visibility and service improvements, but concerns about misuse persist. Another concern is if SOGI data is improperly accessed, LGBTQ+ youth in foster care could become targets for discrimination, harassment, or punitive actions, particularly in states with anti-LGBTQ+ policies. Given the vulnerability of foster youth, unauthorized disclosure of their SOGI status could lead to unsafe placements, rejection by caregivers, or even legal repercussions in hostile jurisdictions, underscoring the critical need for strict privacy protections.
Agencies must engage youth, community members, and organizations most impacted to ensure ethical data practices and accountability. Furthermore, collecting this data creates an obligation to use it effectively, rather than letting it sit unused.

Balancing Data Collection with Privacy: Protecting individual privacy is a top priority. Agencies must implement strict safeguards, ensuring that only authorized personnel access SOGI information. Training caseworkers on appropriate, sensitive questioning and confidentiality protocols is essential to prevent accidental disclosures or misuse. Agencies should also monitor for breaches and adjust policies as needed.

Resource and Operational Considerations: States differ in technical capacity, and under-resourced agencies may struggle to integrate new data fields. If HHS reinstates SOGI data requirements, funding and technical support will be needed. Ensuring accuracy is also a challenge, as incorrect data entry or assumptions by caseworkers could lead to harm. Systems should allow self-reporting and updates to reflect evolving identities.

Changing Political Winds: The collection of SOGI data has been subject to policy reversals, with one administration requiring it and another rescinding it. These shifts create uncertainty for states and child welfare workers. Establishing bipartisan professional consensus, supported by organizations like the American Academy of Pediatrics and the Child Welfare League of America, can help normalize SOGI data collection as a standard child welfare practice rather than a political issue.

To navigate these challenges, transparency is key. Agencies must clearly communicate why they are collecting SOGI data, how it will be used, and the protections in place. Engaging people and organizations most impacted, addressing concerns proactively, and demonstrating the benefits—such as improved services—can help build trust. For health care professionals, these challenges mirror the initial resistance to collecting other sensitive health data, underscoring the importance of careful implementation, privacy protections, and long-term commitment to better care for LGBTQ+ foster youth.

*Current AMA policy*

The AMA has adopted several policies to support LGBTQ+ individuals in health care, foster care, and legal protections. Below is a summary of these policies.

Promoting Inclusive Gender, Sex, and Sexual Orientation Options on Medical Documentation (H-315.967)

- Supports the voluntary inclusion of biological sex, gender identity, sexual orientation, and related data in medical records in a culturally sensitive way.
- Advocates for standardized data collection in medical research to improve patient care.
- Calls for collaboration with health IT vendors to ensure equitable treatment of patients regardless of gender identity.
- Supports the use of personal health records to reduce administrative burden.
- Urges the incorporation of best practices into electronic health records at no additional cost to physicians.

Protecting the Integrity of Public Health Data Collection (H-440.817)

- Advocates for the inclusion of sexual orientation and gender identity (SOGI) data in national and state health surveys, registries, and surveillance systems.
- Opposes the removal of SOGI data from such databases without a plan for updating demographic measures.

Medical Spectrum of Gender (D-295.312)

- Works to educate the medical community and the public on the diversity of gender identities.
- Supports policies that ensure access to quality healthcare for gender-diverse individuals.

- Affirms that an individual's gender, sex, and sexual orientation may not always align, recognizing gender identity as distinct from sex assigned at birth.

Opposing Mandated Reporting of People Who Question Their Gender Identity (H-65.959)

- Opposes laws requiring disclosure of patient information related to gender identity, gender dysphoria, intersex identity, or gender transition, including for minors.

Support of Human Rights and Freedom (H-65.965)

- Supports the dignity, equal rights, and non-discrimination of all individuals, including those of diverse gender identities and sexual orientations.
- Opposes hate crimes and advocates for legal protections against discrimination.

Encouraging LGBTQ+ Representation in Medicine (D-200.972)

- Advocates for targeted recruitment of LGBTQ+ students in medical education.
- Supports including SOGI data in demographic surveys to assess representation in medicine.
- Works with medical organizations to better understand and address the unique experiences of LGBTQ+ individuals in healthcare professions.

Nondiscriminatory Policy for the Health Care Needs of LGBTQ Populations (D-65.996)

- Encourages physicians to display a nondiscrimination policy in medical offices affirming inclusivity for all patients.

Nondiscrimination Policy (H-65.983)

- Affirms that the AMA does not and has never discriminated based on sexual orientation or gender identity.

LGBTQ+ Older Adults (D-65.979)

- Promotes awareness of aging-related LGBTQ+ health issues among the public, healthcare professionals, and policymakers.
- Supports cultural competency training for clinicians caring for LGBTQ+ older adults.
- Advocates for inclusive healthcare policies and practices in all settings.
- Calls for increased funding for research on LGBTQ+ aging and health disparities.

Health Care Needs of LGBTQ+ Populations (H-160.991)

- Encourages nonjudgmental recognition of LGBTQ+ identities in medical care.
- Supports physician education on LGBTQ+ health needs at all levels, from medical school to continuing education.
- Opposes conversion therapy.
- Collaborates with organizations to enhance physician competency in LGBTQ+ healthcare, including screening for conditions such as STIs and intimate partner violence.
- Promotes partnerships with LGBTQ+ communities to improve medical understanding and care.

Antidiscrimination Protections for LGBTQ+ Youth in Foster Care (H-60.895)

- Supports federal and state policies that protect LGBTQ+ youth from discrimination in the foster care system.
- Advocates for training child welfare professionals and foster caregivers to create safe and affirming placements.
- Promotes efforts to reduce violence against LGBTQ+ youth in foster care.
- Encourages recruitment of LGBTQ+-affirming foster families.
- Supports placing gender-diverse youth in homes that respect their identities.

Equal Access for Adoption in the LGBTQ+ Community (D-60.964)

- Advocates for equal adoption rights for LGBTQ+ individuals meeting federal criteria.
- Encourages government funding for child welfare agencies that provide inclusive adoption services.

Reducing Suicide Risk Among LGBTQ+ Youth (H-60.927)

- Partners with public and private organizations to reduce suicide rates and improve mental health for LGBTQ+ youth.

Promotion of LGBTQ+ Friendly and Gender-Neutral Intake Forms (D-315.974)

- Supports the development and implementation of inclusive medical documentation and forms to ensure accurate patient data collection.

Endorsing LGBTQ+ Research IRB Training (D-460.966)

- Advocates for standardized Institutional Review Board (IRB) training on research involving LGBTQ+ populations.

Nondiscrimination in Healthcare (H-65.976)

- Encourages medical institutions to include sexual orientation and gender identity in nondiscrimination policies for patients, employees, and healthcare workers.

Preventing Anti-Transgender Violence (H-65.957)

- Calls for increased public education on hate crimes against transgender individuals, particularly Black transgender women.
- Advocates for law enforcement data collection on transgender hate crimes and improved reporting.
- Supports stronger policies to prevent bias in law enforcement interactions with transgender individuals.
- Promotes increased access to mental health care and resources for LGBTQ+ individuals.

Youth and Young Adult Suicide Prevention (H-60.937)

- Recognizes youth suicide as a serious health crisis.
- Supports physician education on suicide prevention, screening, and intervention.
- Advocates for increased mental health resources, research, and targeted programs for high-risk populations, including LGBTQ+ youth.
- Calls for public awareness and policy action to address youth mental health crises, particularly post-COVID-19.

*Conclusion*

Integrating SOGI data into AFCARS is a critical step toward a more equitable child welfare system. This report highlights the importance of collecting SOGI data with strong privacy protections to improve policies, practices, and health outcomes for LGBTQ+ youth, who are overrepresented in foster care yet remain largely invisible in national data. While some federal protections have gone away, other protections like HIPAA, the Privacy Act, and confidentiality laws ensure privacy safeguards, while modern technology enables secure and anonymized data collection.

Establishing a secure and anonymized SOGI data reporting system aligns foster care systems with broader public health goals, advancing health equity for LGBTQ+ youth. With careful implementation, this initiative can build trust, ensure safer placements, and improve long-term outcomes. Achieving these goals requires ongoing collaboration among HHS, child welfare agencies, health care professionals, and the youth themselves. Supporting SOGI data collection while upholding the highest privacy standards, would be a vital step toward a more inclusive, responsive foster care system—one that truly serves and protects all children.

**RECOMMENDATION**

The Board therefore recommends that Resolve 2 of Resolution 224-A-24 be adopted and the remainder of the report be filed:

1. That our AMA support efforts by the Department of Health and Human Services and other appropriate stakeholders to establish a reporting mechanism for the collection of anonymized and aggregated sexual orientation and gender identity data in the Adoption and Foster Care Analysis and Reporting System only when strong privacy protections exist. (New HOD Policy)

Fiscal Note: To be determined.

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REPORT OF THE BOARD OF TRUSTEES

B of T Report 21-A-25

Subject: Advocacy for More Stringent Regulations/Restrictions on Distribution of Cannabis (Res. 515-A-24)

Presented by: Michael Suk, MD, JD, MPH, MBA, Chair

Referred to: Reference Committee B

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## INTRODUCTION

At the 2024 Annual Meeting of the American Medical Association (AMA) House of Delegates (HOD), Resolution 515-A-24, "Advocacy for More Stringent Regulations/Restrictions on Distribution of Cannabis," was adopted. This resolution resulted in Policy D-95.954, which directed the AMA "to study possible legislative, legal or regulatory means to make the cannabis industry responsible for increasing costs of medical and social care for people affected by the problems caused by cannabinoids similar to regulations for smoking cessation in the United States." Delegates' testimony, while limited, focused primarily on the need to cover the costs of treatment, effects of high-potency cannabis and cannabis-derived products, and medical impacts on individuals who use cannabis and cannabis-derived products. This report provides relevant background, discusses issues raised by the resolution, cites AMA policy, and makes recommendations.

## BACKGROUND

As of the time of this report, cannabis was classified by the federal government as a Schedule I Controlled Substance. Without going into extensive detail, the Schedule I status has not prevented state-based legalization efforts. Almost every state has a robust legal and regulatory framework regulating cannabis. According to the National Conference of State Legislatures (NCSL), at least 47 states, the District of Columbia, and three territories (Guam, Puerto Rico, and the U.S. Virgin Islands) allow for the use of cannabis for medical purposes and/or low tetrahydrocannabinol (THC), and cannabidiol (CBD) products.[1] In general, each state defines the type(s) of qualifying medical condition(s) to authorize the personal use of cannabis for medical purposes. These laws have been adopted via legislative and/or ballot initiatives, and there are regulatory structures in each of these states, the District of Columbia, and the three territories, to implement the laws. All include requirements on cannabis growers, manufacturers, retailers, advertisers, home growers, and others. The NCSL also reports that at least 24 states and the District of Columbia allow for adult use of non-medical cannabis. The Board of Trustees (Board) notes that the AMA has worked closely with many medical societies on these laws.

Cannabis use is highly prevalent in the United States. In 2023, more than 43 million people over the age of 12 used cannabis in the past month, and 4.3 million people aged 12-20 used cannabis in the past month, according to the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA).[2] In 2022, nearly 62 million people used cannabis in the past year, according to SAMHSA.[3] "Teenage marijuana use is at its highest level in 30 years, and today's teens are more

likely to use marijuana than tobacco," according to the American Academy of Child and Adolescent Psychiatry,[4] and the AMA Council on Science and Public Health (CSAPH) has detailed the clinical implications and public health effects of cannabis use in multiple previous reports.[5] The Board has provided the HOD with multiple reports concerning cannabis.[6] Finally, the AMA Cannabis Task Force also was instrumental in helping design and record a multi-episode podcast series on issues ranging from cannabis pharmacology to screening tools to counseling patients.[7]

Given the resolution's reference to tobacco, the Board notes that in 1998, more than 50 state and territory attorneys general entered into a Master Settlement Agreement (MSA)[8] with the nation's four largest tobacco companies: Philip Morris, R.J. Reynolds Tobacco Company, Brown & Williamson Tobacco Corporation, and Lorillard Tobacco Company. The state attorneys general claimed that the tobacco industry engaged in a wide range of culpable activity, including deceptive marketing and advertising about tobacco-related harms, youth impacts, and more. Additional states entered into similar agreements at the same time. Several dozen additional participating manufacturers also settled pursuant to the MSA. The MSA created a wide range of restrictions on tobacco-related marketing and advertising and other requirements. The MSA provided that states would receive approximately $206 billion over the first 25 years with additional funds to follow, but public health advocates have observed that much of the money does not go to tobacco cessation or prevention programs.[9] State attorneys general continue to sue the tobacco industry for ongoing deceptive acts.[10]

DISCUSSION

*State Activity*

States have taken a wide range of actions to restrict minors' exposure to legalized cannabis and cannabis-related marketing and advertising. States that have authorized cannabis for medical use or adult use restrict such use and sales to those 21 years of age and older. Also, marketing and advertising restrictions are common in states. This includes restrictions on content targeting children; print, radio and internet advertising; ads and promotions within a certain proximity to schools; content on public transportation; event sponsorship; and more.[11] The Board also points out that CSAPH Report 1 entitled, "Cannabis Therapeutic Claims in Marketing and Advertising," which was adopted at the 2024 Interim Meeting, provided significant background, research and analysis regarding cannabis-related advertising and marketing. The CSAPH recommendations in this report included asking the AMA to continue to monitor regulatory approaches concerning cannabis advertising and marketing. Without diving too deeply into the effects of these regulations, the Board wants to emphasize that not only is it continuing to monitor regulatory approaches as recommended by CSAPH, but also that the AMA has extensive policy (see below) – as well as model state legislation and other advocacy resources to help its national, state, and national medical specialty society partners enhance marketing and advertising restrictions relating to cannabis.

*Social and Medical-Related Costs*

The data varies for cannabis-related social and medical costs. One study of 248 individuals with cancer reported a median out-of-pocket cost of $80 per month for cannabis use.[12] Another study estimated that the cost for treating cannabis use disorder ranged between $3.5-$5.5 billion in the aggregate for hospital-related costs.[13] Cannabis use also has been linked to "increased risk of psychosis or schizophrenia in some users," as well as increased risks during pregnancy.[14] The American Lung Association has collected multiple reports showing additional adverse health effects, including increased risk of bronchitis, decreased immune system response, and more.[15] Other research shows that, "a marijuana comorbidity increases the cost of treating patients with

alcohol problems and mood disorder diagnoses, implying that there may be real health consequences associated with marijuana abuse and dependence."[16]

Cannabis use has been linked to a wide range of other costs, including how "cannabis use has been shown to be associated with cognitive decline, impaired educational or occupational attainment, risk of other substance use disorders, and poor quality of life."[17] A 2024 study from the U.S. Federal Reserve Bank in Kansas City found that substance use disorders and homelessness increased in states that authorized cannabis for adult use; increased economic benefits for the states; and increased in offenses for intoxicated driving and disorderly conduct.[18] Other economic benefits include the tax revenue on U.S. sales of cannabis, which have been approximately $1.5 billion per month for several years—with projections for 2025 ranging between $30-$45 billion.[19] The cannabis beverage industry also is growing, as well. In fact, from an estimated $1.2 billion in 2023, the market is projected to grow to nearly $4 billion by 2030.[20] Depending on the type of individual cannabis or cannabis-derived product, the out-of-pocket cost to consumers can vary from $10 up to $100 (or more) for products such as pre-rolls, vapes, flowers, edibles, beverages, tinctures, oils, or topical creams. Depending on the amount purchased, a single product could cost several hundred dollars.

*Use of Cannabis Tax Revenue*

States vary significantly regarding how they distribute cannabis tax revenue. The most common allocation categories are state general funds, public health efforts (i.e., substance abuse prevention, mental health, etc.), recidivism, education, police enforcement, and transportation. While some states allocate 50 percent or more of cannabis tax revenue to public health efforts, some states allocate less than 10 percent. Most states allocate at least a portion of cannabis tax revenue to public health efforts. AMA Policy H-95.923 entitled, "Taxes on Cannabis Products," specifically "encourages states and territories to allocate a substantial portion of their cannabis tax revenue for public health purposes, including substance abuse prevention and treatment programs, cannabis-related educational campaigns, scientifically rigorous research on the health effects of cannabis, and public health surveillance efforts." The Board believes that states need to be more purposeful with respect to these allocations. As a result, the Board strongly supports public health uses for cannabis-related revenue and therefore, recommends that states enact policies to ensure that <u>at least 50 percent</u> of cannabis tax revenues are directed to these purposes.

*Who Comprises the Cannabis Industry?*

Before being able to hold an industry "responsible," per the directive contained in Resolution 515, it is important to identify who that industry represents. For example, the "cannabis industry" includes companies that manufacture cannabis products.[21] The "industry" also includes cannabis growers[22] and cannabis dispensary chains.[23] Moreover, there are numerous businesses that also fall under the definition of "cannabis industry" that provide legal, marketing, financial, and other supports to the cannabis industry—just like any other product in the United States. Unlike the large tobacco manufacturers, whose products, marketing, and other business practices were largely consistent across the nation, each cannabis company, manufacturer, and retailer is subject to the specific state (and in some cases, local) laws and regulations.

*Legal Status and Enforcement of Cannabis Laws*

The unique legal status of cannabis also deserves attention. First, the Board is aware of policy considerations at work regarding the rescheduling of cannabis. As noted above, cannabis is a Schedule I Controlled Substance, and there is no interstate commerce in cannabis. Yet, most states

have authorized its use, and the federal government will generally not interfere in a state's regulatory authority governing retail or adult use if a state has authorized either or both. It is beyond the scope of this report to speculate about the implications of potential rescheduling or even the potential impacts of reclassifying hemp-derived cannabis products as cannabis. This is not to say that the federal government has not enforced the law.[24]

There also are multiple efforts already underway to hold the various players and entities that make up the "cannabis industry" responsible for cannabis-related harms. This includes state attorneys general that have been active in enforcing state laws regulating cannabis. For example:

- Colorado's attorney general filed suit against a cannabis company for alleged illegal marketing that exposed people under the age of 21 to high-potency cannabis products.[25]
- New York's attorney general successfully sued a cannabis dispensary operating without a license. [26]
- Connecticut's attorney general sued multiple companies for alleged violations of the state Unfair Trade Practices Act, including failure to comply with testing standards and misleading packaging designed to appeal to children.[27]
- The Missouri attorney general launched inquiries into multiple businesses that sell Delta-8 and Delta-9 goods on grounds that they potentially engaged in "deception, fraud, false promise, misrepresentation, unfair practices, and/or the concealment, suppression, or omission of material facts in connection with the sale or advertisement of CBD, Delta-8, and Delta-9 THC products."[28]
- The Nebraska attorney general filed suit against a business alleging violations for "failing to implement an age verification process, selling THC products to children, and selling products designed to appeal to children; Selling THC products which grossly understate or overstate the concentration of THC contained within the product and by failing to disclose which cannabinoids are contained in the product; Employing a purchase rewards program designed to increase sale frequency of addictive and psychoactive products, including to minors; and Selling THC products which are harmful when consumed."[29]
- The California attorney general filed suit against multiple companies, alleging the sale of "illegal inhalable hemp products in violation of Assembly Bill 45, failing to include warnings required by Proposition 65 for all commercial industrial hemp products, and engaging in unfair business practices."[30]

The Board emphasizes that these examples are just a snapshot into the legal actions taken by state attorneys general to enforce existing laws. In each case, the state lawsuit is based on specific state laws and regulatory requirements in effect. The Board believes that this is appropriate and commends the state attorneys general for these efforts.

There also are robust legal actions taken by the plaintiff's bar. This includes suits based on the federal Racketeer Influenced and Corrupt Organizations Act;[31] suits for deceptive marketing;[32] and product liability suits at the state and federal levels.[33] Furthermore, there are innumerable personal injury lawyers available to consider personal injury claims arising from cannabis use. The Board believes it is important to point out that there is no shortage of legal action already being taken to hold the cannabis industry responsible for alleged and real harms, as well as violations of state and federal laws.

AMA POLICY

The AMA has extensive policy regarding multiple aspects and issues concerning cannabis. This includes the AMA encouraging "states and territories to allocate a substantial portion of their cannabis tax revenue for public health purposes, including substance abuse prevention and treatment programs, cannabis-related educational campaigns, scientifically rigorous research on the health effects of cannabis, and public health surveillance efforts." (Policy H-95.923, "Taxes on Cannabis Products")

Related to the tobacco MSA, the AMA similarly "supports efforts to ensure that a substantial portion of any local, state or national tobacco litigation settlement proceeds be directed towards preventing children from using tobacco in any form, helping current tobacco users quit, and protecting nonsmokers from environmental tobacco smoke, and that any tobacco settlement funds not supplant but augment health program funding." (Policy H-495.983, "Tobacco Litigation Settlements")

The AMA also has complementary policy related to holding the pharmaceutical industry liable for actions related to "unethical and deceptive misbranding, marketing, and advocacy of opioids," which specifically calls on the AMA to support funds derived from opioid-litigation "be used exclusively for research, education, prevention, and treatment of overdose, opioid use disorder, and pain, as well as expanding physician training opportunities to provide clinical experience in the treatment of opioid use disorders." (Policy H-95-918, "Holding the Pharmaceutical Industry Accountable for Opioid-Related Costs") Importantly, the Board believes that these policies emphasize the need for the AMA to encourage policymakers that funds related to cannabis tax revenue—or proceeds from state attorneys general lawsuits for cannabis-related violations of law—these monies be directed to public health needs.

AMA policy also addresses multiple, additional legislative and regulatory issues. This includes advocating for "for regulations requiring point-of-sale warnings and product labeling for cannabis and cannabis-based products regarding the potential dangers of use during pregnancy and breastfeeding wherever these products are sold or distributed." (Policy H-95.936, "Cannabis Warnings for Pregnant and Breastfeeding Women")

The AMA broadly encourages states "to enforce cannabis-related marketing laws and to publicize and make publicly available the results of such enforcement activities." (Policy D-95.958, "Marketing Guardrails for the "Over-Medicalization" of Cannabis Use") The AMA also has created model state legislation and advocacy materials "to help states implement the provisions of AMA policies H-95.924, "Cannabis Legalization for Adult Use" and H-95.936, "Cannabis Warnings for Pregnant and Breastfeeding People" that currently do not have such model language, including regulation of retail sales, marketing and promotion (especially those aimed at children), misleading health claims, and product labeling regarding dangers of use during pregnancy and breastfeeding." (Policy D-95.956, "Cannabis Product Safety")

The Board further highlights AMA's considerable policy concerning restrictions on tobacco, including but not limited to Policy H-495.973, "FDA to Extend Regulatory Jurisdiction Over All Non-Pharmaceutical Nicotine and Tobacco Products." Although there was limited testimony to provide specific direction, based on all of the above, the Board recommends using AMA's tobacco policy as a guide to further the AMA's cannabis-related policy and adopting new and reaffirming existing policy to respond to the directive in Resolution 515-A-24. Finally, the Board recommends that Policy D-95.954, "Advocacy for More Stringent Regulations/Restrictions on the Distribution of Cannabis," be rescinded having been accomplished with this report.

RECOMMENDATIONS

The Board of Trustees recommends that the following recommendations be adopted, and the remainder of the report be filed:

1. That our American Medical Association (AMA) will advocate that any monies paid to the states, received as a result of a settlement or judgment, or other financial arrangement or agreement as a result of litigation for cannabis-related harms or violations of law, be used exclusively for research, education, prevention, and treatment of cannabis-related harms, as well as expanding physician training opportunities to provide clinical experience in the screening, diagnosis, and treatment of cannabis misuse and cannabis use disorder. (New HOD Policy)

2. That our AMA supports legislation and/or regulation of all cannabis products that:
    a. prohibits cannabis use in all places that tobacco use is prohibited, including in hospitals and other places in which health care is delivered;
    b. applies the same marketing and sales restrictions that are applied to tobacco cigarettes, including prohibitions on television advertising, product placement in television and films, and the use of celebrity spokespeople;
    c. prohibits product claims of reduced risk or effectiveness as tobacco cessation tools, until such time that credible evidence is available, evaluated, and supported by the FDA;
    d. requires the use of secure, child- and tamper-proof packaging and design, and safety labeling on all cannabis products;
    e. establishes manufacturing and product (including e-liquids) standards for identity, strength, purity, packaging, and labeling with instructions and contraindications for use;
    f. requires transparency and disclosure concerning product design, contents, and emissions; and
    g. prohibits the use of characterizing flavors that may enhance the appeal of such products to youth. (New HOD Policy)

3. That our AMA encourage state medical associations to strengthen existing cannabis marketing and advertising restrictions, including consideration of prohibitions on marketing and advertising to children. (New HOD Policy)

4. That our AMA support the review of conditions that states have approved to authorize cannabis for medical use and recommend the removal of those conditions without scientifically valid and well-controlled clinical trials supporting the use of cannabis. (New HOD Policy)

5. That Policy H-95.923, entitled “Taxes on Cannabis Products” be reaffirmed. (Reaffirm HOD Policy)

6. That Policy D-95.954, entitled “Advocacy for More Stringent Regulations/Restrictions on the Distribution of Cannabis,” be rescinded. (Rescind HOD Policy)

Fiscal Note: Less than $500.

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AMERICAN MEDICAL ASSOCIATION

Resolution: 201
(A-25)

Introduced by: American Association of Neurological Surgeons, Congress of Neurological Surgeons, American Academy of Orthopaedic Surgeons, American College of Radiology

Subject: Inclusion of DICOM Imaging in Federal Interoperability Standards

Referred to: Reference Committee B

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Whereas, the United States Core Data for Interoperability (USCDI), maintained by the Office of the National Coordinator for Health Information Technology (ONC), establishes standardized data elements that must be accessible, exchanged, and used across electronic health records (EHRs); and

Whereas, the Digital Imaging and Communications in Medicine (DICOM) standard is universally used in medical imaging and critical to the diagnosis and treatment of patients across numerous specialties; and

Whereas, imaging data are currently not a required component of the USCDI, thereby creating barriers to the seamless and timely exchange of DICOM images between healthcare systems, potentially leading to delayed care, repeat imaging, and increased healthcare costs; and

Whereas, federal electronic health record interoperability standards have made written imaging reports readily accessible between health systems, but DICOM-based imaging, the international standard for medical imaging, is not[1]; and

Whereas, current processes that include additional paperwork, navigating multiple proprietary image archive platforms and requesting physical compact discs by mail or hand delivery from patients and families[2] in order to share imaging between health systems are burdensome for patients, families, clinicians, and staff and inevitably result in delays[2]; and

Whereas, delays or barriers to accessing DICOM imaging results in delays in clinical care, suboptimal medical decision-making, and unnecessary duplication of imaging[3] with associated additional and unnecessary radiation exposure to the patient and financial and resource waste[4,5]; and

Whereas, the inclusion of DICOM imaging in federal interoperability standards would promote improved clinical decision-making, care coordination, patient safety, and outcomes by ensuring imaging is available at the point of care across institutions; and

Whereas, the American College of Radiology and other stakeholders are actively advocating for the incorporation of DICOM imaging into the USCDI; therefore be it

RESOLVED, that our American Medical Association support the addition of DICOM imaging to federal interoperability standards, namely the United States Core Data for Interoperability (USCDI), to promote standardized, interoperable image sharing across healthcare systems (New HOD Policy); and be it further

RESOLVED, that our AMA advocate for policies and regulations requiring EHR and imaging archive system vendors to support the secure, efficient, and interoperable exchange of DICOM imaging data between healthcare entities. (Directive to Take Action)

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

Received: 4/20/25

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## RELEVANT AMA POLICY

**EHR Interoperability D-478.972**
Our American Medical Association will enhance efforts to accelerate development and adoption of universal, enforceable electronic health record (EHR) interoperability standards for all vendors before the implementation of penalties associated with the Medicare Incentive Based Payment System.
1. Our AMA supports and encourages Congress to introduce legislation to eliminate unjustified information blocking and excessive costs which prevent data exchange.
2. Our AMA will develop model state legislation to eliminate pricing barriers to EHR interfaces and connections to Health Information Exchanges.
3. Our AMA will continue efforts to promote interoperability of EHRs and clinical registries.
4. Our AMA will seek ways to facilitate physician choice in selecting or migrating between EHR systems that are independent from hospital or health system mandates.
5. Our AMA will seek exemptions from Meaningful Use penalties due to the lack of interoperability or decertified EHRs and seek suspension of all Meaningful Use penalties by insurers, both public and private.
6. Our AMA will continue to take a leadership role in developing proactive and practical approaches to promote interoperability at the point of care.
7. Our AMA will seek legislation or regulation to require the Office of the National Coordinator for Health Information Technology to establish regulations that require universal and standard interoperability protocols for electronic health record (EHR) vendors to follow during EHR data transition to reduce common barriers that prevent physicians from changing EHR vendors, including high cost, time, and risk of losing patient data.
8. Our AMA will review and advocate for the implementation of appropriate recommendations from the “Consensus Statement: Feature and Function Recommendations to Optimize Clinician Usability of Direct Interoperability to Enhance Patient Care,” a physician-directed set of recommendations, to EHR vendors and relevant federal offices such as, but not limited to, the Office of the National Coordinator, and the Centers for Medicare and Medicaid Services.
Sub. Res. 212, I-15 Reaffirmed: BOT Rep. 03, I-16 Reaffirmed: Res. 221, I-16 Reaffirmed in lieu of: Res. 243, A-17 Reaffirmed: CMS Rep. 10, A-17 Appended: BOT Rep. 45, A-18 Reaffirmed: BOT Rep. 19, A-18 Appended: Res. 202, A-18 Appended: Res. 226, I-18 Reaffirmation: A-19 Reaffirmed: CMS Rep. 7, I-20 Reaffirmed: CMS Rep. 2, A-22

**Consequences of Accepting Hospital and Health Care System Based EMRs/EHRs D-478.991**
Our AMA will: (1) educate physicians regarding the potential adverse consequences of receiving EMRs/EHRs from hospitals and health care systems; and (2) encourage interoperability of information

systems used by hospitals and health care facilities. BOT Rep. 2, I-07Modified: CMS Rep. 01, A-17

**Principles for Hospital Sponsored Electronic Health Records D-478.973**

1. Our American Medical Association will promote electronic health record (EHR) interoperability, data portability, and health IT data exchange testing as a priority of the Office of the National Coordinator for Health Information Technology (ONC).
2. Our AMA will work with EHR vendors to promote transparency of actual costs of EHR implementation, maintenance and interface production.
3. Our AMA will work with the Centers for Medicare and Medicaid Services (CMS) and ONC to identify barriers and potential solutions to data blocking to allow hospitals and physicians greater choice when purchasing, donating, subsidizing, or migrating to new EHRs.
4. Our AMA will advocate that sponsoring institutions providing EHRs to physician practices provide data access and portability to affected physicians if they withdraw support of EHR sponsorship.

**Information Technology Standards and Costs D-478.996**

1. Our American Medical Association will:
    a. encourage the setting of standards for health care information technology whereby the different products will be interoperable and able to retrieve and share data for the identified important functions while allowing the software companies to develop competitive systems.
    b. work with Congress and insurance companies to appropriately align incentives as part of the development of a National Health Information Infrastructure (NHII), so that the financial burden on physicians is not disproportionate when they implement these technologies in their offices.
    c. review the following issues when participating in or commenting on initiatives to create a NHII:
        i. cost to physicians at the office-based level;
        ii. security of electronic records; and
        iii. the standardization of electronic systems;
    d. continue to advocate for and support initiatives that minimize the financial burden to physician practices of adopting and maintaining electronic medical records.
    e. continue its active involvement in efforts to define and promote standards that will facilitate the interoperability of health information technology systems.
2. Our AMA advocates that physicians:
    a. are offered flexibility related to the adoption and use of new certified Electronic Health Records (EHRs) versions or editions when there is not a sufficient choice of EHR products that meet the specified certification standards.
    b. not be financially penalized for certified EHR technology not meeting current standards.

**National Health Information Technology D-478.995**

1. Our American Medical Associaion will closely coordinate with the newly formed Office of the National Health Information Technology Coordinator all efforts necessary to expedite the implementation of an interoperable health information technology infrastructure, while minimizing the financial burden to the physician and maintaining the art of medicine without compromising patient care.
2. Our AMA:
    a. Advocates for standardization of key elements of electronic health record (EHR) and computerized physician order entry (CPOE) user interface design during the ongoing development of this technology.
    b. Advocates that medical facilities and health systems work toward standardized login procedures and parameters to reduce user login fatigue.
    c. Advocates for continued research and physician education on EHR and CPOE user interface design specifically concerning key design principles and features that can improve the quality, safety, and efficiency of health care.
    d. Advocates for continued research on EHR, CPOE and clinical decision support systems and vendor accountability for the efficacy, effectiveness, and safety of these systems.
3. Our AMA will request that the Centers for Medicare & Medicaid Services:

   a. Support an external, independent evaluation of the effect of Electronic Medical Record (EMR) implementation on patient safety and on the productivity and financial solvency of hospitals and physicians' practices.
   b. Develop, with physician input, minimum standards to be applied to outcome-based initiatives measured during this rapid implementation phase of EMRs.
4. Our AMA will
   a. seek legislation or regulation to require all EHR vendors to utilize standard and interoperable software technology components to enable cost efficient use of electronic health records across all health care delivery systems including institutional and community based settings of care delivery.
   b. work with CMS to incentivize hospitals and health systems to achieve interconnectivity and interoperability of electronic health records systems with independent physician practices to enable the efficient and cost effective use and sharing of electronic health records across all settings of care delivery.
5. Our AMA will seek to incorporate incremental steps to achieve electronic health record (EHR) data portability as part of the Office of the National Coordinator for Health Information Technology's (ONC) certification process.
6. Our AMA will collaborate with EHR vendors and other stakeholders to enhance transparency and establish processes to achieve data portability.
7. Our AMA will directly engage the EHR vendor community to promote improvements in EHR usability.
8. Our AMA will advocate for appropriate, effective, and less burdensome documentation requirements in the use of electronic health records.
9. Our AMA will urge EHR vendors to adopt social determinants of health templates, created with input from our AMA, medical specialty societies, and other stakeholders with expertise in social determinants of health metrics and development, without adding further cost or documentation burden for physicians.

AMERICAN MEDICAL ASSOCIATION

Resolution: 202
(A-25)

Introduced by: American Association of Neurological Surgeons, Congress of Neurological Surgeons, American Academy of Neurology

Subject: Preservation of the CDC Epilepsy Program Workforce and Infrastructure

Referred to: Reference Committee B

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Whereas, the Centers for Disease Control and Prevention (CDC) Epilepsy Program has historically supported the epilepsy community through initiatives that improve public health, clinical care, education, and research; and

Whereas, this program has been instrumental in providing epidemiologic data[1], organizing educational conferences, funding epilepsy self-management programs, supporting local and national epilepsy initiatives, and contributing to key federal health reports; and

Whereas, the sudden and significant reduction in staff within the CDC Epilepsy Program has critically impaired its ability to function, placing ongoing and future projects in jeopardy; and

Whereas, loss of dedicated personnel disrupts collaborations between the CDC and professional, advocacy, and public health organizations, and may hinder evidence-based improvements in care and access for the 3.4 million Americans living with epilepsy; and

Whereas, the economic burden of epilepsy in the United States is estimated to exceed $15.5 billion annually, with direct costs (e.g., medical care, medications, hospitalizations) and indirect costs (e.g., lost productivity, unemployment, and caregiver burden) disproportionately affecting individuals with epilepsy and their families[2]; and

Whereas, people living with epilepsy are more likely to experience comorbid mental health conditions, stigma, social isolation, and barriers to education and employment[3]; and

Whereas, these challenges are particularly pronounced in underserved populations[4]; and

Whereas, discontinuation or interruption of the CDC Epilepsy Program's activities threatens the advancement of epilepsy care, limits access to essential public health data, and undermines the infrastructure necessary for coordinated national response to epilepsy-related challenges; and

Whereas, the American Medical Association has long supported funding and infrastructure for epidemiological research and public health surveillance; therefore be it

RESOLVED, that our American Medical Association advocate for the full restoration and continued support of the CDC Epilepsy Program, including its workforce and dedicated funding, to ensure its ability to support evidence-based public health initiatives in epilepsy (Directive to Take Action); and be it further

RESOLVED, that our AMA urge the Department of Health and Human Services and Congress to prioritize sustained funding and staffing for the CDC Epilepsy Program to promote ongoing

public health, clinical care advancement, and improved quality of life for people living with epilepsy. (Directive to Take Action)

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

Received: 4/21/25

**REFERENCES**

1. Zack MM, Kobau R. National and State Estimates of the Numbers of Adults and Children with Active Epilepsy - United States, 2015. *MMWR Morb Mortal Wkly Rep*. 2017;66(31):821-825.
2. Begley CE, Durgin TL. The direct cost of epilepsy in the United States: A systematic review of estimates. *Epilepsia*. 2015;56(9):1376–1387. doi:10.1111/epi.13084
3. Kobau R, Cui W, Kadima N, et al. Tracking psychosocial health in adults with epilepsy—Estimates from the 2010 National Health Interview Survey. *Epilepsy & Behavior*. 2014;41:66–73. doi:10.1016/j.yebeh.2014.08.141
4. Institute of Medicine. *Epilepsy Across the Spectrum: Promoting Health and Understanding*. Washington, DC: The National Academies Press; 2012. doi:10.17226/13379

## RELEVANT AMA POLICY

### D-440.922 Full Commitment by our AMA to the Betterment and Strengthening of Public Health Systems

1. Our American Medical Association will champion the betterment of public health by enhancing advocacy and support for programs and initiatives that strengthen public health systems, to address pandemic threats, health inequities and social determinants of health outcomes.
2. Our AMA will develop an organization-wide strategy on public health including ways in which the AMA can strengthen the health and public health system infrastructure and report back regularly on progress.
3. Our AMA will work with the Federation and other stakeholders to strongly support the legal authority of health officials to enact reasonable, evidence-based public health measures, including mandates, when necessary to protect the public from serious illness, injury, and death and actively oppose efforts to strip such authority from health officials.
4. Our AMA will advocate for
    a. consistent, sustainable funding to support our public health infrastructure.
    b. incentives, including loan forgiveness and debt reduction, to help strengthen the governmental public health workforce in recruiting and retaining staff.
    c. public health data modernization and data governance efforts as well as efforts to promote interoperability between health care and public health.
    d. efforts to ensure equitable access to public health funding and programs. [Res. 407, I-20. Modified: CSAPH Rep. 2, I-21. Reaffirmed: CMS Rep. 5, A-2]

AMERICAN MEDICAL ASSOCIATION

Resolution: 203
(A-25)

Introduced by: American Association of Neurological Surgeons, Congress of Neurological Surgeons, American Society for Regional Anesthesia Pain Medicine

Subject: Supporting SUPPORT Act Modifications to Enhance Care of Patients with Chronic Pin

Referred to: Reference Committee B

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Whereas, chronic pain remains a significant source of disability and healthcare expenditures in the United States; and

Whereas, a proportion of patients suffering from chronic pain are successfully managed on long term intrathecal therapy; and

Whereas, the sterile preservative-free mixtures of medications for intrathecal use are most often prepared by specialty compounding pharmacies; and

Whereas, for those patients who undergo pump refills in the office setting, the safest and most secure way to handle these syringes is to have the medication delivered to the managing physician's office; and

Whereas, the SUPPORT Act was passed to improve the access for patients to medications for the treatment of opioid use disorder (OUD); and

Whereas, Federal law restricts pharmacies from dispensing controlled medications to anyone except the end user. An exception to this prohibition was created by the SUPPORT act to allow direct dispensing to the practitioner, but only for medications used to treat OUD; and

Whereas, Section 3204 of the SUPPORT Act has been interpreted by DEA and DOJ as preventing pharmacies, including compounding pharmacies, from dispensing controlled substances for use in pain pumps directly to the prescribing physician; and

Whereas, this restriction raises the threat of prosecution of any physician whose practice directly receives these compounded medications for filling of intrathecal pumps; and

Whereas, the result of this has been to force patients to either receive and store the medication themselves, which is not adequately safe, or to coordinate delivery of the medication to their home with an appointment to have a healthcare provider to perform the refill at the patient's home as soon as the medication arrives; and

Whereas, The DEA and U.S. Department of Justice both recognize this issue but has stated in conversations with physicians and compounding pharmacies that the only solution is a legislative fix; therefore be it

RESOLVED, that our American Medical Association advocate for modifications to the SUPPORT Act that allow for the delivery of compounded syringes of medications intended for

the filling of intrathecal pumps directly to the prescribing physician's practice. (Directive to Take Action)

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

Received: 4/21/25

**REFERENCES**

1. https://www.finance.senate.gov/imo/media/doc/930%20AM%20Edits%2009.26.18%20Final%20Opioid%20Sec-by-Sec%20BIPART%20BICAM.pdf?utm_source=article&utm_campaign=102618article

2. https://www.aans.org/advocacy/articles/neurosurgery-writes-u-s-attorney-general-re-intrathecal-pain-pumps-controlled-substances-act/

3. https://www.grassley.senate.gov/download/2025-02-04-wc-letter-to-senate-judiciary-committee-hearing-on-fentanyl

**RELEVANT AMA POLICY**

**D-95.955 Improving Access to Post-Acute Medical Care for Patients with Substance Use Disorder (SUD)**
1.Our American Medical Association advocates to ensure that patients who require a post-acute medical care setting are not discriminated against because of their history of substance use disorder.
2.Our AMA advocates that our federal, state, and local governments remove barriers to evidence-based treatment for substance use disorders, including medications for opioid use disorder, at skilled nursing facilities.
3. Our AMA advocates that Medicare and Medicaid, including managed care organizations, remove barriers to coverage and treatment for substance use and opioid use disorder, including medications for opioid use disorder, in skilled nursing facilities [Res. 219, I-23 Reaffirmed: Res. 217, I-24]

**D-95.968 Support the Elimination of Barriers to Evidence-Based Treatment for Substance Use Disorders**

1. Our American Medical Association will:
    a. advocate for legislation that eliminates barriers to, increases funding for, and requires access to all appropriate FDA-approved medications or therapies used by licensed drug treatment clinics or facilities.
    b. develop a public awareness campaign to increase awareness that medical treatment of substance use disorder with medications for opioid use disorder (MOUD) and other evidence-based options as first-line treatments for this chronic medical disease.
2. Our AMA will support further research into how primary care practices can implement MOUD into their practices and disseminate such research in coordination with primary care specialties.
3. Our AMA Substance Use and Pain Care Task Force will increase its evidence-based educational resources focused on methadone maintenance therapy (MMT) and publicize those resources to the Federation.
4. Our AMA will support increased access to affordable, accessible transportation for individuals to obtain evidence-based treatment for substance use disorders

Res. 222, A-18Appended: BOT Rep. 02, I-19Modified: Res. 228, A-23

**H-160.889 Neuropathic Pain**
Our AMA: (1) supports the designation of neuropathic pain as a disease state distinct from nociceptive pain, encompassing metabolic, toxic, mechanical, and other injuries to nerve cells, as well as neuroplastic and neuroimmune adaptations to nerve cells in response to chronic pain; (2) encourages research related to neuropathic pain, payer coverage of treatment options for neuropathic pain, and improved resources for patients suffering with neuropathic pain; (3) encourages physicians to engage in meaningful conversation with their patients about what is known about the pathology of neuropathic pain and to set appropriate expectations collaboratively with their patients; and (4) cautions that a neuropathic pain disease designation should only be used when appropriate, not overused, and that the cause of the neuropathic pain be carefully elucidated and documented [CSAPH Rep. 2, I-20]

**H-410.950 Pain Management**
Our American Medical Association adopts the following guidelines on Invasive Pain Management Procedures for the Treatment of Chronic Pain, Including Procedures Using Fluoroscopy:
Interventional chronic pain management means the diagnosis and treatment of pain-related disorders with the application of interventional techniques in managing sub-acute, chronic, persistent, and intractable pain. The practice of pain management includes comprehensive assessment of the patient, diagnosis of the cause of the patient's pain, evaluation of alternative treatment options, selection of appropriate treatment options, termination of prescribed treatment options when appropriate, follow-up care, the diagnosis and management of complications, and collaboration with other health care providers.

Invasive pain management procedures include interventions throughout the course of diagnosing or treating pain which is chronic, persistent and intractable, or occurs outside of a surgical, obstetrical, or post- operative course of care. Invasive pain management techniques include:

1. Ablation of targeted nerves.
2. Procedures involving any portion of the spine, spinal cord, sympathetic nerves or block of major peripheral nerves, including percutaneous precision needle placement within the spinal column with placement of drugs such as local anesthetics, steroids, and analgesics, in the spinal column under fluoroscopic guidance or any other radiographic or imaging modality.
3. Surgical techniques, such as laser or endoscopic diskectomy, or placement of intrathecal infusion pumps, and/or spinal cord stimulators.

At present, invasive pain management procedures do not include major joint injections (except sacroiliac injections), soft tissue injections or epidurals for surgical anesthesia or labor analgesia.

When used for interventional pain management purposes such invasive pain management procedures do not consist solely of administration of anesthesia; rather, they are interactive procedures in which the physician is called upon to make continuing adjustments based on medical inference and judgments. In such instances, it is not the procedure itself, but the purpose and manner in which such procedures are utilized, that demand the ongoing application of direct and immediate medical judgment. These procedures are therefore within the practice of medicine, and should be performed only by physicians with appropriate training and credentialing.

Invasive pain management procedures require physician-level training. However, certain technical aspects of invasive pain management procedures may be delegated to appropriately trained, licensed or certified, credentialed non-physicians under direct and/or personal supervision of a physician who possesses appropriate training and privileges in the performance of the procedure being supervised, and in compliance with local, state, and federal regulations. Invasive pain management procedures employing radiologic imaging are within the practice of medicine and should be performed only by physicians with appropriate training and credentialing [BOT Rep. 16, A-13Reaffirmed: BOT Rep. 09, A-23]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 204
(A-25)

Introduced by: American Academy of Ophthalmology

Subject: Protecting the Prescriptive Authority of Plenary Licensed Physicians

Referred to: Reference Committee B

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Whereas, physicians holding a plenary license (MD/DO) are authorized under state and federal law to diagnose and treat all conditions and prescribe medications in the full scope of their license, irrespective of specialty designation; and

Whereas, reports from board-certified physicians in specialties such as ophthalmology and anesthesiology indicate growing instances in which pharmacists are refusing to dispense valid prescriptions—such as for sedatives, anxiolytics, or dermatologic agents—based on non-clinical objections that the medication falls “outside the prescriber's specialty”; and

Whereas, such refusals contradict American Medical Association policy opposing pharmacists’ authority to initiate, modify, or substitute medications outside a physician’s explicit direction, and amount to inappropriate intrusion into the practice of medicine; and

Whereas, pharmacists are not trained or licensed to make medical diagnoses and their scope of practice does not include the authority to override a physician’s clinical judgment or determine a patient’s treatment plan; and

Whereas, these denials disrupt patient care, compromise safety, delay medically necessary treatment, and may create liability and access issues, particularly for patients with urgent or chronic conditions; and

Whereas, AMA policy supports the right of patients to have legally valid prescriptions filled, and of physicians to prescribe, cancel, and manage medication therapy without interference; therefore be it

RESOLVED, that our American Medical Association study the national prevalence and patterns of pharmacists refusing to fill valid prescriptions from plenary licensed physicians, including impact on patient outcomes and prescriber autonomy (Directive to Take Action); and be it further

RESOLVED, that our AMA work with state medical boards, pharmacy boards, and appropriate federal agencies to protect the authority of plenary licensed physicians to prescribe all legal medications in accordance with their training and medical judgment (Directive to Take Action); and be it further

RESOLVED, that our AMA reaffirm and publicize existing policy opposing unauthorized medication substitution, inappropriate pharmacy inquiries, and unauthorized treatment modification by pharmacists (Directive to Take Action); and be it further

RESOLVED, that our AMA support legislation or regulatory action requiring pharmacists and pharmacy chains to either fill a valid prescription or immediately refer the patient to an alternative dispensing pharmacy, with notification to the prescribing physician (Directive to Take Action); and be it further

RESOLVED, that our AMA encourage interprofessional collaboration to clarify scope-of-practice boundaries, educate stakeholders on the legal authority of plenary licensure, and promote policies that ensure timely patient access to physician-directed therapy (New HOD Policy).

Fiscal Note: Moderate – between $5,000 - $10,000

Received: 4/21/25

**RELEVANT AMA POLICY**

**H-160.928 Drug Initiation or Modification by Pharmacists**
Our AMA opposes pharmacists being given the authority to initiate or modify prescription drug treatment except on a case by case basis at the specific direction of a physician.[Res. 509, A-99; Reaffirmed: CSAPH Rep. 1, A-09; Reaffirmed: CSAPH Rep. 01, A-19]

**H-125.995 Therapeutic and Pharmaceutical Alternatives by Pharmacists**
The AMA opposes legislative attempts at any level of government that would permit pharmacists, when presented with a prescription for a drug product, to:
(1) dispense instead a drug product that is administered by the same route and which contains the same pharmaceutical moiety and strength, but which differs in the salt or dosage form (pharmaceutical alternatives); and
(2) dispense a drug product containing a different pharmaceutical moiety but which is of the same therapeutic and/or pharmacological class (therapeutic substitution).
Our AMA will work with state medical associations to ensure that state pharmacy laws and medical practice acts are properly enforced so that treating physician's directions cannot be overruled or substituted without prior physician approval. [Res. 89, I-85; Reaffirmed by Sub. Res. 501, A-95; Reaffirmed by CLRPD Rep. 2, I-95; Appended by Res. 501, A-98; Reaffirmed: CSAPH Rep. 2, A-08]

**H-35.961 AMA Response to Pharmacy Intrusion Into Medical Practice**
Our American Medical Association deems inappropriate inquiries from pharmacies to verify the medical rationale behind prescriptions, diagnoses, and treatment plans to be an interference with the practice of medicine and unwarranted. [CSAPH Rep. 8, A-23]

**D-120.975 Preserving Patients' Ability to Have Legally Valid Prescriptions Filled**
Our AMA will:
(1) work with state medical societies to support legislation to protect patients' ability to have legally valid prescriptions filled;
(2) enter into discussions with relevant associations (including but not limited to the American Hospital Association, American Pharmacists Association, American Society of Health System Pharmacists, National Association of Chain Drug Stores, and National Community Pharmacists Association) to guarantee that, if an individual pharmacist exercises a conscientious refusal to dispense a legal prescription, a patient's right to obtain legal prescriptions will be protected by immediate referral to an appropriate dispensing pharmacy; and
(3) in the absence of all other remedies, work with state medical societies to adopt state legislation that will allow physicians to dispense medication to their own patients when there is no pharmacist within a thirty-mile radius who is able and willing to dispense that medication. [Sub. Res. 6, A-05; Reaffirmed: CSAPH Rep. 1, A-15]

**H-120.947 Preserving Patients' Ability to Have Legally Valid Prescriptions Filled**
1. Our AMA reaffirms our policies supporting responsibility to the patient as paramount in all situations and the principle of access to medical care for all people; and supports legislation that requires individual pharmacists or pharmacy chains to fill legally valid prescriptions or to provide immediate referral to an appropriate alternative dispensing pharmacy without interference. In the event that an individual pharmacist or pharmacy chain refers a patient to an alternative dispensing source, the individual pharmacist or the pharmacy chain should return the prescription to the patient and notify the prescribing physician of the referral.
2. Our AMA supports the concept of advance prescription for emergency contraception for all women in order to ensure availability of emergency contraception in a timely manner. [Sub. Res. 6, A-05; Appended: BOT Rep. 18, I-06; Reaffirmed and Appended: BOT Rep. 2, A-08; Reaffirmed: CMS Rep. 01, A-18]

**D-125.989 Substitution of Biosimilar Medicines and Related Medical Products**
Our American Medical Association urges that State Pharmacy Practice Acts and substitution practices for biosimilars in the outpatient arena:
1. Preserve physician autonomy to designate which biologic or biosimilar product is dispensed to their patients;
2. Allow substitution when physicians expressly authorize substitution of a biologic or biosimilar product; and
3. In the absence of express physician authorization to the contrary, allow substitution of the biologic or biosimilar product when:
a. the biologic product is highly similar to the reference product, notwithstanding minor differences in clinically inactive components; and
b. there are no data indicating clinically meaningful differences between the biological product and the reference product in terms of the safety, purity, and potency of the product; and
c. the prescribing physician has been adequately notified by the pharmacist. [Res. 918, I-08; Modified: CSAPH Rep. 1, I-11; Modified: CSAPH Rep. 4, A-14; Modified: CSAPH Rep. 05, A-24; Reaffirmed: CMS Rep. 04, I-24]

**H-120.939 Physicians Should be Able to Cancel or Rescind Renewals of Prescriptions After the Prescription has Been Delivered to the Pharmacy**
Our AMA will support legislation or regulations that:
(i) authorize physicians to cancel or rescind renewals of prescriptions previously written;
(ii) mandate pharmacies, including pharmacy benefit plans, to implement easy-to-use procedures to permit physicians to issue orders to cancel or rescind renewals of prescriptions previously written;
(iii) prevent such renewals from being filled or mailed to the patient; and
(iv) enable the pharmacy or pharmacy benefit plan to readily implement such renewal orders, when directed by the physician, regardless of the state of residence of the patient, the state of practice or licensure of the physicians, and the state of business operation of the pharmacy or the pharmacy benefit plan. [BOT Rep. 8, A-11; Reaffirmation A-15]

**D-120.923 Automatic Pharmacy-Generated Prescription Requests**
Our American Medical Association advocates that pharmacy-generated requests for changes to a prescription (quantity dispensed, refills, or substitutions) clarify whether these requests are generated by the patient or patient’s surrogates, or automatically by the pharmacy. [Res. 706, A-24]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 205
(A-25)

Introduced by: American College of Lifestyle Medicine, Oregon Medical Association, Illinois

Subject: AMA Support for Continuance of the Section 1115 - Social Security Act, Medicaid Waiver Program

Referred to: Reference Committee B

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Whereas, Section 1115 of the Social Security Act provides the USDHSS Secretary the authority to approve experimental, pilot or demonstration project that are likely to assist in promoting the objectives of the Medicaid program; and

Whereas, the purpose of this authority is to gives states additional flexibility to design, improve and evaluate state-specific policy approaches to better serve Medicaid populations[1]; and

Whereas, such waivers generally reflect priorities identified by the states and the CMS; and

Whereas, CMS additionally considers whether proposed waiver and/or expenditure authorities are appropriate and consistent with federal policies; and

Whereas, such demonstrations must be “budget neutral” to the Federal government (i.e., Federal Medicaid expenditures will not be more than federal spending without the demonstration); and

Whereas, such demonstrations are approved for an initial five-year period and can be extended for up to an additional three to five years[2]; and

Whereas, examples of such demonstrations have included care for seniors in Wisconsin, HIV/AIDs care in Maine, managed medical assistance in Florida, healthcare transformation and quality improvement in Texas as well as COVID-19 public health emergencies, 60 days post-partum related Medicaid coverage, transition-related strategies supporting community reentry for incarcerated persons in multiple states[3]; therefore be it

RESOLVED, that our American Medical Association work aggressively to advocate for, and assure, the continuance of the Section 1115 Medicaid Waiver Program as a critical safety net for our underserved and disadvantaged populations. (Directive to Take Action)

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

Received: 4/18/25

**REFERENCES**

1. CMS. About Section 1115 Demonstrations. 2024. <https://www.medicaid.gov/medicaid/section-1115-demonstrations/about-section-1115-demonstrations/index.html>
2. National Association of Medicaid Directors. How 1115 Waivers Work. 2024. <https://medicaiddirectors.org/resource/how-1115-waivers-work>
3. Kaiser Family Foundation. Medicaid Waiver Tracker. January 14, 2025. <https://www.kff.org/report-section/section-1115-waiver-tracker-definitions/#:~:text=Pre%2DRelease%20Coverage:%20In%20April,eligibility%20and%20premium%20assistance%20programs>
4. Medicaid Cuts a Likely Result of Congressional Budget Negotiations https://www.medpagetoday.com/publichealthpolicy/medicaid/114286?xid=nl_mpt_DHE_2025-02-19&mh=0f2e4d4ae65ba05d0b0ffcb2474fd35c&zdee=gAAAAABm4wrEzP7mYhZ3X22RS_Fg3kGqnZ8Rtb2pHgPkTDZxOfjeBlCd7c1hO-ScyFx2mlWAh9ZTxLoVbKRmcAKSMZgGknWLRTIHO2QxS8d_RfNP8hTuzJw%3D&utm_source=Sailthru&utm_medium=email&utm_campaign=Daily%20Headlines%20Evening%20-%20Randomized%202025-02-19&utm_term=NL_Daily_DHE_dual-gmail-definition

## RELEVANT AMA POLICY

**Improving Medicaid and CHIP Access and Affordability H-290.954** Our American Medical Association opposes premiums, copayments, and other cost-sharing methods for Medicaid and the Children's Health Insurance Program, including Section 1115 waiver applications that would allow states to charge premiums or copayments to Medicaid beneficiaries**.**
Our AMA encourages the Centers for Medicare & Medicaid Services to amend existing Section 1115 waivers to disallow states the ability to charge premiums or copayments to Medicaid beneficiaries.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 206
(A-25)

Introduced by: American College of Lifestyle Medicine, Oregon Medical Association, Illinois

Subject: AMA Support for Renewal of Section 1115 - Social Security Act, Medicaid Waiver Demonstration Projects Supporting Food and Nutrition Services

Referred to: Reference Committee B

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Whereas, Section 1115 of the Social Security Act provides the USDHSS Secretary the authority to approve experimental, pilot or demonstration project that are likely to assist in promoting the objectives of the Medicaid program[1-2]; and

Whereas, segment populations of Medicaid recipients experience food insecurity; and

Whereas, changes in food prices over the past four years have increased beyond the rate of general inflation in the US, and this particular economic factor has significantly increased the number of food insecure individuals; and

Whereas, an additional food access issue has been the growing grocery store gap limiting healthy food options leading to negative health outcomes including predictors of obesity; and

Whereas, the US Department of Agriculture has determined that diet-related chronic diseases affect food insecure communities at a higher rate with almost 90% of health care spending linked to diet-related chronic disease; and

Whereas, deploying additional Medicaid funding for nutrition services and supports could improve health outcomes, reduce health disparities and be cost effective supplements to traditional Medicaid medical services; and

Whereas, under the 1115 Demonstration and Waiver, expanding eligibility for nutritional services to food insecure populations will test whether such additions will improve health outcomes and utilization of appropriate care[1-2]; and

Whereas, a number of states, such as New York, Massachusetts, Oregon, North Carolina, the District of Columbia, have provided such nutritional services to underserved and disadvantaged populations with support from a Section 1115 Waiver[3]; and

Whereas, such states have applied for extensions for their existing Section 1115 Waivers for food and nutritional services[4]; therefore be it

RESOLVED, that our American Medical Association aggressively advocate for, and support, the renewals and extensions of any and all Section 1115 Waivers supporting food and nutritional services as a counter to the issues of food insecurity in many of our Medicaid beneficiaries. (Directive to Take Action)

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

Received: 4/18/2025

**REFERENCES**

1. CMS. About Section 1115 Demonstrations. 2024. <https://www.medicaid.gov/medicaid/section-1115-demonstrations/about-section-1115-demonstrations/index.html>
2. National Association of Medicaid Directors. How 1115 Waivers Work. 2024. <https://medicaiddirectors.org/resource/how-1115-waivers-work>
3. Kaiser Family Foundation. Medicaid Waiver Tracker. January 14, 2025. <https://www.kff.org/report-section/section-1115-waiver-tracker-definitions/#:~:text=Pre%2DRelease%20Coverage:%20In%20April,eligibility%20and%20premium%20assistance%20programs>
4. Medicaid Cuts a Likely Result of Congressional Budget Negotiations https://www.medpagetoday.com/publichealthpolicy/medicaid/114286?xid=nl_mpt_DHE_2025-02-19&mh=0f2e4d4ae65ba05d0b0ffcb2474fd35c&zdee=gAAAAABm4wrEzP7mYhZ3X22RS_Fg3kGqnZ8Rtb2pHgPkTDZxOfjeBlCd7c1hO-ScyFx2mlWAh9ZTxLoVbKRmcAKSMZgGknWLRTIHO2QxS8d_RfNP8hTuzJw%3D&utm_source=Sailthru&utm_medium=email&utm_campaign=Daily%20Headlines%20Evening%20-%20Randomized%202025-02-19&utm_term=NL_Daily_DHE_dual-gmail-definition

## RELEVANT AMA POLICY

### Improving Medicaid and CHIP Access and Affordability H-290.954

Our American Medical Association opposes premiums, copayments, and other cost-sharing methods for Medicaid and the Children's Health Insurance Program, including Section 1115 waiver applications that would allow states to charge premiums or copayments to Medicaid beneficiaries**.**

Our AMA encourages the Centers for Medicare & Medicaid Services to amend existing Section 1115 waivers to disallow states the ability to charge premiums or copayments to Medicaid beneficiaries.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 207
(A-25)

Introduced by: American College of Surgeons

Subject: Abolishing Venue Shopping

Referred to: Reference Committee B

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Whereas, Venue Shopping is a legal strategy where plaintiffs' attorneys file medical malpractice cases in jurisdictions known for awarding large monetary awards or settlements, even if the case has no connection to that location; and

Whereas, Venue Shopping has led to certain Courts being overwhelmed with lawsuits, delays in resolutions of disputes, and dramatically increased awards or settlements for plaintiffs' attorneys; and

Whereas, in 2002, more than 1,600 physicians were forced to participate in the Pennsylvania Joint Underwriter Association, the insurer of last resort, as the state of Pennsylvania was reduced to only two medical malpractice insurance carriers because of large (>40%) rate hikes, owing in large part to Venue Shopping; and

Whereas, Venue Shopping was rendered illegal in Pennsylvania in 2002 by The Medical Care Availability and Reduction of Error ("Mcare") act leading to a stabilization of the medical malpractice insurance market in Pennsylvania; and

Whereas, in August 2022, The Pennsylvania Supreme Court reversed the ban on Venue Shopping by passing a rule allowing plaintiffs to sue in any Pennsylvania county in which care occurred, where a defendant could be served, or where any transaction or occurrence giving rise to the suit took place; and

Whereas, the widespread use of telehealth greatly expands the footprint of care opening the door to even greater abuses of Venue Shopping; and

Whereas, immediately following the reversal of the ban on Venue Shopping, there was a four – fold increase in the number of malpractice lawsuits filed in Philadelphia County, and between January and April, 2023, 43% of 657 medical malpractice complaints initiated in Philadelphia County were based on care provided outside the city; and

Whereas, changes to malpractice law in Pennsylvania can herald similar changes in neighboring states and in the entire United States; therefore be it

RESOLVED, that our American Medical Association fiercely advocate against Venue Shopping in medical professional liability actions in collaboration with all interested state medical and specialty societies (Directive to Take Action); and be it further

RESOLVED, that our AMA urgently draft model state and federal legislation rendering venue shopping illegal in medical professional liability actions. (Directive to Take Action)

Fiscal Note: Moderate – between $5,000 - $10,000

Received: 4/14/25

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 208
(A-25)

Introduced by: American Psychiatric Association

Subject: Binding Arbitration in Health Insurance Contracts

Referred to: Reference Committee B

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Whereas, binding arbitration clauses in health insurance contracts can have significant impacts on physicians; and

Whereas, these clauses typically require that disputes be settled outside the court system, with physicians bound by decisions made in arbitration, often not allowing for appeals. This limits the ability of the physician to seek legal recourse or challenge decisions that are unfavorable and contributes to a sense of powerlessness; and

Whereas, arbitration is often viewed as more cost-effective than court trials, it still involves expenses that can place a financial burden on physicians. Health insurers have significant bargaining power which could result in arbitration outcomes that favor insurers, potentially reducing reimbursement rates and leading to higher premium; and

Whereas, arbitration clauses in health insurance contracts often favor the insurer. Physicians, especially small practices or individual clinicians, have little negotiating power regarding the inclusion of arbitration clauses in their contracts; and

Whereas, the financial stress and operational challenges that arise from disputes over insurance claims and arbitration can affect how physicians interact with their patients; and

Whereas, current AMA policy (H-435.945) only addresses binding arbitration between patients and physicians, not physicians and insurance companies; therefore be it

RESOLVED, that our American Medical Association study the effects of binding arbitration in health insurance contracts with physicians. (Directive to Take Action)

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

Received: 4/22/25

**RELEVANT AMA POLICY**

**Binding Arbitration H-435.945**
Our American Medical Association supports the utilization of pre-dispute binding arbitration that is agreed to by a patient and a physician prior to non-emergent treatment as an effective method of doctor-patient conflict resolution

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 209
(A-25)

Introduced by: American Society of Addiction Medicine

Subject: Reducing Risk of Federal Investigation or Prosecution for Prescribing Controlled Addiction Medications for Legitimate Medical Purposes

Referred to: Reference Committee B

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Whereas, addiction medications, such as medications for opioid use disorder (MOUD), are lifesaving treatments for addiction;[1] and

Whereas, in 2023, fewer than 20% of people with OUD in the US received MOUD;[2] and

Whereas, several reasons exist for the underutilization of MOUD, including practitioners' fear of intrusion into clinical practice by the US Department of Justice (DOJ), including the Drug Enforcement Administration (DEA);[3-9] and

Whereas, practitioners fear they will be investigated or prosecuted for well-intentioned prescribing of controlled medications that violate ambiguous federal law; and

Whereas, federal regulations implementing the federal Controlled Substances Act (CSA) authorize the prescribing of controlled substances, like buprenorphine, for "a legitimate medical purpose by an individual practitioner acting in the usual course of his professional practice;"[10] and

Whereas, federal circuit courts are divided on whether a CSA violation requires proof of both a (1) lack of legitimate medical purposes and (2) deviation from the usual course of professional practice (i.e., a conjunctive standard),[11-12] or whether proof of just one of these two conditions is sufficient (i.e., a disjunctive standard);[13-19] and

Whereas, case law suggests "legitimate medical purpose" under the CSA means having the intention to improve a patient's health-related condition;[12,14,20-23] and

Whereas, a disjunctive standard allows for prosecution based solely on a violation of the "usual course of professional practice;"[13-19] and

Whereas, the phrase "usual course of professional practice" is amorphous and ambiguous, with the meaning potentially varying among well-intentioned practitioners due to the heterogeneity of state regulations governing the practice of addiction medicine,[24,25] as well as the heterogeneity of patients with substance use disorder (SUD),[26] practitioners who treat SUD, and practice settings; and

Whereas, DOJ personnel do not typically have the requisite medical expertise to accurately evaluate the totality of the circumstances that may explain differences in prescribing practices across practitioners; and

Whereas, the DOJ's expertise would best be utilized by focusing on practitioners prescribing for improper reasons – that is, without a legitimate medical purpose; and

Whereas, it is important to consider Congressional intent in passing the CSA, which was to prevent the trafficking or dealing of drugs, not to ensure good quality medical treatment;[27] therefore be it

RESOLVED, that our American Medical Association support legislative, regulatory, and other advocacy efforts that (1) advance the adoption of a conjunction standard in the context of "legitimate medical purpose by an individual practitioner acting in the usual course of his professional practice" under the federal Controlled Substances Act and implementing regulations and (2) address relevant federal regulations to clarify that "legitimate medical purpose" means "for the purpose of preventing, treating, or managing a patient's health-related condition." (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Received: 4/21/25

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11. United States v. Feingold, 454 F.3d 1001, 1012 (9th Cir. 2006).
12. United States v. Smith, 573 F.3d 639 (8th Cir. 2009).
13. United States v. Ruan, 966 F.3d 1101 (11th Cir. 2020), vacated and remanded, 597 U.S. 450, 142 S. Ct. 2370, 213 L. Ed. 2d 706 (2022), and cert. granted, judgment vacated sub nom. Couch v. United States, 142 S. Ct. 2895, 213 L. Ed. 2d 1109 (2022), and adhered to in part, 56 F.4th 1291 (11th Cir. 2023).
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15. United States v. Heaton, 59 F.4th 1226, n17 (11th Cir. 2023).
16. United States v. Duldulao, 87 F.4th 1239 (11th Cir. 2023).
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18. United States v. Nelson, 383 F.3d 1227 (10th Cir. 2004).
19. United States v. Naum, 832 F. App'x 137 (4th Cir. 2020), cert. granted, judgment vacated, 142 S. Ct. 2893, 213 L. Ed. 2d 1108 (2022).
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21. United States v. Moore, 423 U.S. 122, 126, 96 S. Ct. 335, 46 L. Ed. 2d 333 (1975).
22. United States v. Tran Trong Cuong, 18 F.3d 1132 (4th Cir. 1994).
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## RELEVANT AMA POLICY

### Protection for Physicians Who Prescribe Pain Medication H-120.960

Our AMA supports the following:
(1) the position that physicians who appropriately prescribe and/or administer controlled substances to relieve intractable pain should not be subject to the burdens of excessive regulatory scrutiny, inappropriate disciplinary action, or criminal prosecution. It is the policy of the AMA that state medical societies and boards of medicine develop or adopt mutually acceptable guidelines protecting physicians who appropriately prescribe and/or administer controlled substances to relieve intractable pain before seeking the implementation of legislation to provide that protection; (2) education of medical students and physicians to recognize addictive disorders in patients, minimize diversion of opioid preparations, and appropriately treat or refer patients with such disorders; and (3) the prevention and treatment of pain disorders through aggressive and appropriate means, including the continued education of doctors in the use of opioid preparations.

Our AMA opposes harassment of physicians by agents of the Drug Enforcement Administration in response to the appropriate prescribing of controlled substances for pain management.

### DEA Regulations and the Ability of Physicians to Prescribe Controlled Medication Rationally, Safely, and Without Undue Threat of Prosecution D-120.979

Our AMA supports ongoing constructive dialogue between the DEA and clinicians, including physicians, regarding a proper balance between the needs of patients for treatment and the needs of the government to provide oversight and regulation to minimize risks to public health and safety.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 210
(A-25)

Introduced by: American Society for Gastrointestinal Endoscopy, American Gastroenterological Association, The Society of Thoracic Surgeons

Subject: Impact of Tariffs on Healthcare Access and Costs

Referred to: Reference Committee B

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Whereas, tariffs on foreign countries will add to the costs for medical equipment and devices, pharmaceuticals, and other healthcare-related goods in the United States, thereby raising the overall cost of healthcare delivery; and

Whereas, tariffs intended to encourage domestic production of medical equipment, devices, pharmaceuticals and other healthcare-related goods must account for the feasibility, capacity and timelines for such domestic production in order to prevent product shortages and increased healthcare costs; and

Whereas, in the short-term, tariffs on medical equipment, devices and supplies may not be appropriately accounted for in Medicare physician and hospital reimbursement, forcing health care providers to administer services at a financial loss; and

Whereas, elevated healthcare costs may result in reduced patient access to essential medical services; and

Whereas, the American Medical Association is committed to advocating for policies that ensure affordable and equitable access to healthcare for all individuals; therefore be it

RESOLVED, that our American Medical Association actively monitor and assess the impact of current and proposed tariffs on healthcare costs and patient access to medical services (Directive to Take Action); and be it further

RESOLVED, that our AMA engage with relevant stakeholders, including policymakers and industry leaders, to advocate for trade policies that do not adversely affect the affordability and availability of medical supplies and pharmaceuticals (Directive to Take Action); and be it further

RESOLVED, that our AMA support legislative efforts aimed at mitigating the negative effects of tariffs on the healthcare system, ensuring that patient care remains accessible and affordable (Directive to Take Action); and be it further

RESOLVED, that our AMA conduct a study evaluating the short- and long-term impacts of U.S. tariffs on the healthcare delivery system, including effects on cost, supply chains, patient outcomes, and healthcare disparities, and, given the urgency associated with the issue, report its findings no later than the November 2025 interim meeting of the House of Delegates. (Directive to Take Action)

Fiscal Note: Moderate – between $5,000 - $10,000

Received: 4/22/25

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 211
(A-25)

Introduced by: California, Alabama, Colorado, Connecticut, Florida, Hawaii, Minnesota, Missouri, Nebraska, New Hampshire, New Mexico, North Dakota, Oklahoma, Oregon, Tennessee, Vermont, Washington, West Virginia, Integrated Physician Practice Section

Subject: Support for State Provider and Managed Care Organization Taxes to Sustain Federal Medicaid Matching Funding

Referred to: Reference Committee B

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Whereas, the Medicaid program is a partnership between the federal government and the states to cover nearly 80 million low-income, vulnerable Americans – making it the largest source of health care coverage in the nation; and

Whereas, the federal government and the states share responsibility for financing Medicaid with the federal government guaranteeing federal matching payments to the states while the states are permitted to finance the non-federal share through state general funds, health-care related taxes (provider and managed care organization taxes) and local government funds; and

Whereas for two decades, all states except Alaska finance some of the state costs with taxes on health care providers (hospitals and nursing homes) and 20 states partially finance state costs with taxes on managed care organizations (MCOs) with 68% of state Medicaid funding coming from state general funds and 32% from local governments and provider/MCO taxes; Reliance on provider and MCO taxes have grown during economic downturns to cover higher state Medicaid costs; and

Whereas, under federal law and with the approval of state legislatures, states assess, usually voluntary, levies on hospitals, nursing homes and MCOs to generate state funds to match with federal Medicaid dollars, increasing the overall funding available to care for Medicaid patients, which has also increased all provider reimbursement rates; and

Whereas, federal rules set guidelines on how states can use provider and MCO taxes, ensuring they are 1) broad-based by applying to all providers or plans within a specific class and cannot be imposed only on providers or plans that primarily treat Medicaid patients; 2) uniform by applying to all providers or plans within a specific class (i.e., the tax cannot be higher on Medicaid revenue than non-Medicaid revenue; and 3) states cannot guarantee that providers or plans will receive their tax revenues back unless the tax revenues comprise 6% or less of net patient revenues from treating patients; and

Whereas, the provider and MCO assessments are applied to hospital, nursing home, and health plan revenues rather than directly to physician practices, do not impose costs on physicians or patients, and often result in increased physician and hospital reimbursement rates which improve Medicaid patients' access to care; and

Whereas, these financing mechanisms are structurally distinct from direct involuntary taxes on physician services, physician-owned facilities, or pass-through taxes - which are opposed by

AMA policy H-385.925, D-165.961, H 385.941 - because they do not create financial liabilities for physician practices but instead help to sustain funding for Medicaid patients and strengthen the viability of physicians and other providers; and

Whereas, recent Congressional proposals have suggested limiting or eliminating states' ability to use provider or MCO levies to finance their Medicaid programs – a cut of up to $630 billion nationally over ten years (CBO) - which would threaten health care coverage for millions of low-income children, pregnant women, veterans, the disabled and elderly, and would destabilize the provider safety net as well as the entire health care system; therefore be it

RESOLVED, that our American Medical Association support the use of broad-based, uniform Provider (hospital and nursing home) and Managed Care Organization (MCO) taxes to generate state funds to match with federal Medicaid funding that sustain or improve Medicaid patients' access to care while not financially burdening physician practices (New HOD Policy); and be it further

RESOLVED, that our AMA oppose federal proposals that would restrict or eliminate states' ability to assess Provider (hospital and nursing home) and Managed Care Organization Taxes to finance their Medicaid programs and protect patient access to care, as long as physician practices are not financially harmed (New HOD Policy); and be it further

RESOLVED, that our AMA amend policy H-385.925 as follows:
1. Our American Medical Association strongly opposes the imposition of a selective revenue tax on physicians ~~and other health care providers~~.
2. Our AMA will continue to work with state medical societies on issues relating to physician ~~and other provider~~ taxes, providing assistance and information as appropriate.
3. Our AMA strongly opposes the use of ~~provider~~ physician taxes or fees to fund health care programs or to accomplish health system reform.
4. Our AMA believes that the cost of taxes which apply to medical services should not be borne by physicians, but through adequate broad-based taxes for the appropriate funding of Medicaid and other government health care programs (Modify Current HOD Policy); and be it further

RESOLVED, that our AMA amend policy D-165.961 as follows:
Our AMA will (1) proactively and vigorously oppose taxes on physician services, physician-owned facility taxes or "pass-through" taxes on physician medical services; and (2) work closely with national specialty societies and state medical societies to assist with advocacy efforts to combat existing and proposed taxes on physician services and physician-owned facilities (Modify Current HOD Policy); and be it further

RESOLVED, that our AMA amend policy H-385.941 as follows:
Our AMA strongly: (1) opposes any attempt on the part of the federal or state governments or other entities to impose user fees, provider taxes, access fees, or bed taxes on physicians ~~and other health care providers~~ to subsidize or fund any health care program; (2) opposes any directive from the CMS to slow down the rate of payment of Medicare claims or reduce administrative services to patients, physicians, and other health care providers; and (3) urges Congress to appropriate sufficient funds to enable the CMS and its carriers to carry out their statutorily required functions. (Modify Current HOD Policy)

Fiscal Note: Moderate – between $5,000 - $10,000

Received: 4/22/25

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## RELEVANT AMA POLICY

**Selective Revenue Taxation of Physicians and Other Health Care Providers H-385.925**
1. Our American Medical Association strongly opposes the imposition of a selective revenue tax on physicians and other health care providers.
**2.** Our AMA will continue to work with state medical societies on issues relating to physician and other provider taxes, providing assistance and information as appropriate.
3. Our AMA strongly opposes the use of provider taxes or fees to fund health care programs or to accomplish health system reform.
4. Our AMA believes that the cost of taxes which apply to medical services should not be borne by physicians, but through adequate broad-based taxes for the appropriate funding of Medicaid and other government health care programs.
Sub. Res. 258, A-92Reaffirmed: Res. 134, A-93Res. 207, I-93Reaffirmation A-99Reaffirmation A-00Appended Res. 132, A-01Reaffirmation A-05Consolidated and Renumbered: CMS Rep. 7, I-05Reaffirmed: CMS Rep. 6, I-11Reaffirmed: CMS Rep. 1, A-21

**Physician Taxes D-165.961**
Our AMA will (1) proactively and vigorously oppose taxes on physician services, physician-owned facility taxes or "pass-through" taxes on medical services; and (2) work closely with national specialty societies and state medical societies to assist with advocacy efforts to combat existing and proposed taxes on physician services and physician-owned facilities.
Res. 728, I-04Reaffirmation A-05Reaffirmed: CMS Rep. 1, A-15

**Opposition to CMS User Fees H-385.941**
Our AMA strongly: (1) opposes any attempt on the part of the federal or state governments or other entities to impose user fees, provider taxes, access fees, or bed taxes on physicians and other health care providers to subsidize or fund any health care program; (2) opposes any directive from the CMS to slow down the rate of payment of Medicare claims or reduce administrative services to patients, physicians, and other health care providers; and (3) urges Congress to appropriate sufficient funds to enable the CMS and its carriers to carry out their statutorily required functions.
Sub. Res. 201, A-98Reaffirmation A-05Reaffirmed: CMS Rep. 1, A-15

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 212
(A-25)

Introduced by: Illinois

Subject: Setting Standards for Forensic Toxicology Laboratories Used in Litigation

Referred to: Reference Committee B

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Whereas, forensic toxicology laboratories are called upon to analyze substances in bodily fluid matrices for litigation purposes; and

Whereas, litigation using bodily fluid matrices (e.g., workers' compensation arbitration, DUI legal actions) is often primarily dependent on the accuracy of drug/toxicology testing analyses (which is usually assumed to be reliable and precise); and

Whereas, the equipment utilized by forensic toxicology laboratories is similar to that used in hospital clinical chemistry laboratories for medical diagnostic and therapeutic purposes; and

Whereas, accreditation and licensure programs are designed to improve safety, promote a consistently high level of service, and advance the quality of laboratory services; laboratory licensure and accreditation are an assurance that the laboratory has met or exceeded a certifying agency's high standards of excellence; and

Whereas, proficiency testing is a regular, independent assessment of a laboratory's ability to generate accurate and precise test results and is a key component of a Quality Control Program which is used as an evaluation tool to guide performance improvement; Licensing and accrediting agencies incorporate proficiency findings into their overall compliance monitoring assessment of a laboratory; and

Whereas, there are a multitude of certification requirements for medical clinical chemistry laboratory accreditation and/or their personnel proficiency which may include but are not limited to Clinical Laboratory Improvement Amendments of 1988 (CLIA), College of American Pathologists (CAP) Laboratory Accreditation program (LAP), American Society for Clinical Pathology (ASCP), American Board of Clinical Chemistry (ABCC) – which are usually not achieved by forensic toxicology laboratories; and

Whereas, the laboratory director/certifying scientist of the forensic toxicology laboratories used by law enforcement and the judicial system may not be a licensed physician (with proper board certification) or a scientist with a relevant advanced graduate degree; and

Whereas, the University of Illinois Chicago (UIC) Analytical Forensic Testing Laboratory has been recently accused of providing flawed test results in cases of driving-under the influence of marijuana, many of them resulting in motorists being convicted and sent to jail; the lab has subsequently been the subject of allegations of a cover-up, and stopped doing tests for marijuana in law enforcement cases; and

Whereas, the UIC Analytical Forensic Testing Laboratory this same UIC laboratory lost the Racetrack Medication and Testing Consortium (RMTC) accreditation in early September 2024 due to non-compliance issue in racehorse blood bicarbonate testing; and

Whereas, any laboratory analysis of bodily fluids by forensic toxicology laboratories should have the same degree of accuracy and reliability as any hospital based clinical chemistry/toxicology laboratory; therefore be it

RESOLVED, that our American Medical Association pursue legislative or regulatory changes to require:

1. Forensic toxicology laboratories that analyze drugs in bodily fluids to follow the same protocols and obtain equivalent certifications as their clinical chemistry counterparts based in hospitals; and
2. CLIA – exempt forensic toxicology laboratories to obtain relevant accreditations and certifications such as CAP Forensic Drug Testing accreditation program (CAP FDT, formerly FUDT or Forensic Urine Drug Testing Accreditation Program]) the American Board of Forensic Toxicology Laboratory Accreditation Program (ABFT LAP), the American Society of Crime Laboratory Directors Laboratory Accreditation Board (ASCLD/LAB) or other related certification program (as their clinical chemistry counterparts in hospitals are required) which are publicly displayed; and
3. forensic toxicology laboratories to follow relevant state codes and regulations addressing testing of breath, blood, and urine for alcohol, other drugs, and intoxicating compounds; and
4. a Laboratory Director and/or Certifying Scientist who reviews all protocols and laboratory manuals and signs off on each result electronically to be a licensed physician (with proper and current board certification) or a scientist with an appropriate advanced graduate degree and certification; and
5. that results of laboratory proficiency testing and Quality Control Programs be available to the court and its litigants for review to assist in verifying forensic laboratory results. (Directive to Take Action)

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

Received: 4/21/25

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8. Bissell, Michael G. "Regulatory issues in accreditation of toxicology laboratories." Clinics in Laboratory Medicine 32, no. 3 (2012): 525-542.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 213
(A-25)

Introduced by: Indiana

Subject: Emergency Department Designation Requires Physician on Site

Referred to: Reference Committee B

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Whereas, due to the legislative efforts of the Indiana State Medical Association, new legislation was added to Indiana Code in 2023, IC 16-21-2-14.5, which requires that “a hospital with an emergency department must have at least one physician on site and on duty who is responsible for the emergency department at all times the emergency department is open” but this law does not account for freestanding emergency departments (FSEDs); and

Whereas, “freestanding health facilities” are specifically excluded from the statutory definition of “hospital” in Indiana Code, IC 16-18-2-179; and

Whereas, numerous models of freestanding emergency care exist around the country including independently operated FSEDs, specialty emergency hospitals, physician and proprietary owned facilities, off-campus hospital-affiliated emergency departments, and joint venture partnerships between FSEDs and hospitals; and

Whereas, the prevalence of FSEDs has grown exponentially from 1% in 2001 to 11% in 2016 of all emergency departments nationwide; and

Whereas, patients may assume that any and all facilities which are referred to as emergency departments (EDs) or emergency rooms (ERs) can provide emergency medical care by a physician; therefore be it

RESOLVED, that our American Medical Association create model legislation for all states, as a matter of truth and transparency in the scope of available emergency medical services, which requires that all facilities using the designation “emergency department” mandate the presence of at least one physician on-site and on-duty who is responsible for the emergency department at all times. (Directive to Take Action)

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

Received: 4/16/25

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3. https://www.annemergmed.com/article/S0196-0644(19)30237-9/fulltext
4. https://iga.in.gov/laws/2023/ic/titles/16#16-18-2-179
5. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7234700/#

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 214
(A-25)

Introduced by: Indiana

Subject: United Health Care and InterQual Monopoly

Referred to: Reference Committee B

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Whereas, United Health care, through its Optum subsidiary, recently purchased Change Healthcare, which owns InterQual; and

Whereas, InterQual defines the medical criteria by which necessity of medical services is determined by payers; and

Whereas, United Health care now solely controls defining criteria of medical necessity and thereby qualification of medical services for payment across all payers; and

Whereas, multiple hospitals are struggling financially in part due to insurance company denials of payment for care; and

Whereas, many of these struggling hospitals are in medically underserved areas including rural hospitals; therefore be it

RESOLVED, that our American Medical Association oppose managed care utilization review systems and tools that have anticompetitive effects, create undue influence over medical necessity criteria, or negatively impact fair access to the delivery and payment of medical services. (New HOD Policy)

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

Received: 4/16/25

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 215
(A-25)

Introduced by: Minority Affairs Section

Subject: Support for Changing Standards for Minors Working in Agriculture

Referred to: Reference Committee B

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Whereas, child labor regulations differ between agricultural and non-agricultural sectors, with agricultural work being exempt from certain provisions of the federal Fair Labor Standards Act (FLSA)[1]; and

Whereas, in non-agricultural work, the FLSA mandates that minors aged 14 and 15 are restricted to working no more than 3 hours on school days and 18 hours during a school week, agricultural workers of the same age face no such limitations on hours worked[2,3]; and

Whereas, children aged 16 and older are permitted to work in hazardous jobs in agriculture that involve dangerous machinery, exposure to pesticides, hazardous environments, and strenuous labor, while workers in all other industries must be 18 years and older to undertake similarly classified hazardous work[1,3]; and

Whereas, the safety of child workers in agriculture, beyond the small protections provided by federal law, is subject to the discretion of individual states, resulting in significant variability in child labor protections across the country[1,2]; and

Whereas, The National Children's Center for Rural and Agricultural Health and Safety in the United States reported that from 2001 to 2015, 48% of all fatal injuries to young workers occurred in agriculture with 33 children injured daily, and deaths occurring every 3 days[4]; and

Whereas, in North Carolina, which follows only federal regulations for child farmworkers, studies reveal significant risks: 29% of adolescent farmworkers experience musculoskeletal injuries, many are exposed to harmful pesticides linked to adverse health and neurodevelopmental effects, and all workers face heightened risks of heat-related illnesses due to strenuous work conditions and lack of regulatory protections[5-7]; and

Whereas, child farmworkers experience educational disruptions due to the demands of agricultural labor, leading to lower academic achievement and higher dropout rates compared to their peers in other industries[8]; and

Whereas, the physical and mental demands of agricultural work, combined with poor living conditions for many child farmworkers, contribute to significant mental health challenges, which are often unaddressed due to limited access to healthcare services[9]; and

Whereas, the Children's Act for Responsible Employment and Farm Safety Care Bill (CARE Act) was introduced in 2023 to amend the Fair Labor Standards Act to raise labor standards and

protections for child farmworkers to the same level set for all children in other occupations, strengthening existing regulations and their enforcement[3,10-13]; and

Whereas, the CARE Act closes loopholes in current law relating to age, work restrictions, and expanding workplace health and safety standards that protect against exposure to dangerous pesticides and unsafe equipment [3,10-13]; and.

Whereas, AMA policy H-60.962 covers the illegal employment of children but does not support the expansion of protection for all children legally working in agriculture; therefore be it

RESOLVED, that our American Medical Association strongly supports federal and state efforts to ensure that child labor protections uniformly apply to children working in agriculture, including raising the minimum age of employment, work hour restrictions, and extending workplace health and safety standards against exposures to hazardous substances and unsafe equipment. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Date Received: 4/21/25

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**RELEVANT AMA POLICY**

**H-10.984 Farm Related Injuries**
Our AMA (a) emphasizes the need for more complete data on farm-related and other types of traumatic and occupational injuries; (b) reaffirms its support of regional medical facilities and programs having well-trained medical personnel and emergency care facilities capable of responding effectively to farm-related and other types of injuries; (c) advises manufacturers to improve machinery and farm implements so they are less likely to injure operators and others. Safety instructions should accompany each sale of a machine such as a power auger or tractor. Hazard warnings should be part of each power implement; (d) encourages parents, teachers, physicians, agricultural extension agencies, voluntary farm groups, manufacturers, and other sectors of society to inform children and others about the risks of agricultural injuries and about approaches to their prevention; (e) endorses the concept of making injury surveillance and prevention programs ongoing activities of state and local departments of public health; (f)encourages the inclusion of farm-related injury issues as part of the training program for medical students and residents involved in a rural health experience. [BOT Rep. U, A-91Reaffirmed: Sunset Report, I-01Reaffirmed: CSAPH Rep. 1, A-11Reaffirmed: CSAPH Rep. 1, A-21]

**H-365.986 US Efforts to Address Health Problems Related to Agricultural Activities**
Our AMA supports the endeavors of the U.S. Surgeon General and the National Institute of Occupational Safety and Health of CDC to address health problems related to agricultural activities. [Res. 212, A-91Reaffirmed: Sunset Report, I-01Reaffirmed: CSAPH Rep. 1, A-11Reaffirmed: BOT Rep. 7, A-21]

**H-60.962 Enforcement of Child Labor Laws**
Our AMA will work in conjunction with all appropriate organizations and specialty societies to enhance physician awareness of the problems and dangers associated with the illegal employment of children. [Sub. Res. 222, I-92 Reaffirmed by BOT Rep. 24, A-97 Reaffirmed: BOT Rep. 33, A-07 Reaffirmed: BOT Rep. 22, A-17]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 216
(A-25)

Introduced by: Medical Student Section, American Academy of Child & Adolescent Psychiatry

Subject: Support for Aging-Out Foster Youth with Mental Health and Psychotropic Needs

Referred to: Reference Committee B

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Whereas, foster care youth are 62% more likely to have serious mental health issues from adverse childhood experiences (ACEs), experience polypharmacy, and have inadequate medical supervision and documentation[1-4]; and

Whereas, youth "age-out" of foster care at 18-25, as mandated by the Department of Children and Families (DCF), and are vulnerable to dependence on psychotropic medications, which can hinder future independence, compounded by their struggles to access and navigate healthcare services such as Medicaid despite eligibility [5,6,9]; and

Whereas, there is a lack of data on continued mental health services for former foster children with complex needs, and limited funding is allocated to support youths aging out of foster care, underscoring the need for better resources during their transition to adulthood[7,8]; and

Whereas, the John Chafee program, provides federal funding and oversight to support states, territories, and Indian tribal entities in helping youth transition out of foster care, including programs that offer education assistance, employment services, financial guidance, housing, and life skills training,[10,11]; and

Whereas, nearly 80% of eligible youths aging-out don't utilize the John Chafee program due to low awareness of offerings, inadequate time for navigating transition services, learned helplessness, and lack of trust, leading to adverse socioeconomic outcomes [5,12–14,16]; and

Whereas, despite the John Chafee program's expansion, existing federal and state funded programs lack comprehensive mental health support for aging-out foster youths, forcing community organizations to fill the gaps[7,8,10,14,15]; and

Whereas, California's use of the Chafee program, along with the state's Transitional Housing Program, successfully supports aging-out foster youth mental health, with 70% of these youth showing improved outcomes as they transition to adulthood[16]; and

Whereas, in Massachusetts, agencies overseeing Chafee funds have collaborated with the Department of Mental Health to increase access for transition-age youth to mental health and substance use treatment[17]; therefore be it

RESOLVED, that our American Medical Association support federal and state initiatives aimed at increasing funding and enhancing accessibility to services designed to help youths as they

transition out of foster care; especially for youths requiring mental health support and access to psychotropic medications. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Date Received: 4/21/25

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## RELEVANT AMA POLICY

### H-60.897 Improved Foster Care Services for Children

Our American Medical Association will (a) encourage and support state, territorial, and tribal activities to implement changes to the child welfare system directed toward keeping children with their families when appropriate and the children's safety is assured, (b) support federal and state efforts to expand access to evidence-based treatment, counseling, mental health services, substance use disorder treatment, in-home parent skills-based services, and other services, (c) encourage and support state efforts expanding use of kinship and family foster care placement and state efforts to eliminate the use of non-therapeutic congregate foster care placement, (d) support both federal and state funding for improvements to the child welfare system which minimize harm to the child and help provide additional services to families that will safely prevent child separation from the family, (e) support government maintenance of a continuously

updated and comprehensive list of evaluated and tested prevention services and for families at risk for entry into the child welfare system. [Res. 216, A-23]

**H-60.910 Addressing Healthcare Needs of Children in Foster Care**
Our American Medical Association advocates for comprehensive, and evidence-based, trauma-informed care that addresses the specific mental, developmental, and physical health care needs of children in foster care. [Res. 907, I-17 Modified: Res. 420, A-23]

**D-350.977 Addressing the Longitudinal Healthcare Needs of American Indian Children in Foster Care**
Our American Medical Association (a) recognizes the Indian Child Welfare Act of 1978 as a model in American Indian and Alaska Native child welfare legislation, (b) supports federal legislation preventing the removal of American Indian and Alaska Native children from their homes by public and private agencies without cause, (c) will work with local and state medical societies and other relevant stakeholders to support legislation preventing the removal of American Indian and Alaska Native children from their homes by public and private agencies without cause, (d) supports state and federal funding opportunities for American Indian and Alaska Native child welfare systems, (e) will support the construction of health information systems to enhance information exchange between both tribal and non-tribal child welfare agencies and health care professionals, (f) will advocate for the designation of medical teams, and/or committees to longitudinally follow children in foster care, including to ensure the provision of continuity of care for children who are at the age of transition out of foster care, (g) will advocate for oversight of local, tribal, and state child welfare systems by physicians with expertise in pediatrics and child psychiatry, (h) will promote existing medical homes which provide continuity of care to children in foster care when feasible, (i) will support the appointment of a licensed pediatrician or family medicine physician (with substantial pediatric experience) in each state with experience in child welfare to the position of medical director of child welfare and a psychiatrist with substantial child and adolescent psychiatric experience to the position of psychiatric medical director of child welfare for each Title IV-E agency. [Res. 443, A-22Appended: Res. 930, I-22]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 217
(A-25)

Introduced by: Medical Student Section

Subject: Regulation and Oversight of the Troubled Teen Industry

Referred to: Reference Committee B

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Whereas, the Troubled Teen Industry includes youth residential programs such as treatment centers, wilderness programs, boot camps, and therapeutic boarding schools, housing about 120,000–200,000 adolescents as of 2020, with around 50,000 privately placed by parents[1-3]; and

Whereas, under the 2018 Family First Prevention Services Act, these programs are only required to follow federal and scientific standards if federally funded or state-run, however many are privately run, and are not held to these standards, leading to the use of unproven and potentially harmful practices[1,4]; and

Whereas, regulation of these programs is primarily left to state legislatures, leading to inconsistent oversight, while the out-of-state placement of many children further hinders effective monitoring and accountability by resource-limited non-profit organizations[3,5,6]; and

Whereas, many programs prioritize punitive methods over evidence-based treatments like cognitive behavioral therapy or trauma-informed care, leading to thousands of allegations of abuse, including false imprisonment, forced labor, solitary confinement, and physical and sexual abuse, all of which contribute to lasting trauma and, in some cases, death[1-2,7-11]; and

Whereas, the Troubled Teen Industry as a whole has a disproportionate impact on BIPOC children, children with disabilities and children who identify as part of the LGBTQ+ community[5,12]; and

Whereas, despite repeated efforts over the past decade, significant federal legislation, including the Stop Child Abuse in Residential Programs for Teens Act, has consistently failed to pass in Congress[13]; and

Whereas, H.R. 2955, the Stop Institutional Child Abuse Act, proposes the creation of a Federal Work Group on Youth Residential Programs to implement best practices for the health, safety, care, treatment, and placement of youth, but the bill has remained in committee since its introduction in April 2023[14]; and

Whereas, current advocacy for youth residential programs often does not extend to other aspects of the Troubled Teen Industry, such as wilderness therapy programs, which are less regulated due to their classification as shorter-term solutions[15]; and

Whereas, there are about 40 wilderness therapy programs in the U.S., part of the 2,000 "troubled teen" programs, and the New York Times reported at least 31 deaths in these programs since 1980, with many more cases reported since then[15,16]; and

Whereas, California has recently passed and will soon implement California's Accountability in Children's Treatment Act, which expanded current regulations on residential facilities to include short term residential therapeutic programs, like wilderness therapy programs[17]; and

Whereas, current AMA policy Youth Residential Treatment Program Regulation (H-60.896) specifically advocates for regulation of youth residential facilities which does not account for all aspects of the Troubled Teen Industry; therefore be it

RESOLVED, that our American Medical Association amend Policy H-60.896 "Youth Residential Treatment Program Regulation" by addition to read as follows:

**Youth Residential and Other Treatment Program Regulation**

1. Our American Medical Association recognizes the need for licensing standards for all youth residential treatment facilities (including private and juvenile facilities) as well as other treatment facilities (including wilderness therapy programs and other programs aimed at treating behavioral and mental health issues in youths) to ensure basic safety and well-being standards for youth.
2. Our AMA supports recommendations including, but not limited to, patient placement criteria and clinical practice guidelines, as developed by of nonprofit health care medical associations and specialty societies, as the standard for regulating youth residential treatment and other relevant youth programs.
3. Our AMA opposes the use of any non-evidence-based therapies and abusive measures in Youth Residential and Other Treatment Programs and supports that only appropriately qualified and certified child and adolescent medical and mental health professionals provide services to participants, and support oversight and review by licensed physicians, mental health professionals, and any other appropriate healthcare professionals
4. Our AMA supports efforts to improve information sharing between states on promising practices for preventing and addressing maltreatment in residential facilities.

(Modify Current HOD Policy)

Fiscal Note: Minimal – less than $1,000

Date Received: 4/21/25

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**RELEVANT AMA POLICY**

**H-60.896 Youth Residential Treatment Program Regulation**

1. Our American Medical Association recognizes the need for licensing standards for all youth residential treatment facilities (including private and juvenile facilities) to ensure basic safety and well-being standards for youth.
2. Our AMA supports recommendations including, but not limited to, patient placement criteria and clinical practice guidelines, as developed by of nonprofit health care medical associations and specialty societies, as the standard for regulating youth residential treatment programs. [Res. 218, I-23]

**H-170.972 Role of Physicians in Improving Adolescent Health**

The American Medical Association supports programs that encourage teen health and supports the involvement of medical students, residents, and other physicians in educational efforts to enhance teen health. [Res. 431, A-94; Reaffirmed and Modified: CSA Rep. 6, A-04; Modified: CSAPH Rep. 1, A-14; Reaffirmed: CSAPH Rep. 01, A-24]

**H-95.965 Residential Treatment for Women with Substance Use Disorder**

Our AMA encourages state medical societies to support an exemption in public aid rules that would allow for the coverage of residential drug treatment programs for women with child-bearing potential. [Res. 405, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11; Modified: CSAPH Rep. 1, A-21]

**H-60.981 Adolescent Health**

It is the policy of the AMA to work with other concerned health, education, and community groups in the promotion of adolescent health to: (1) develop policies that would guarantee access to needed family support services, psychosocial services and medical services; (2) promote the creation of community-based adolescent health councils to coordinate local solutions to local problems; (3) promote the creation of health and social service infrastructures in financially disadvantaged communities, if comprehensive continuing health care providers are not available; and (4) encourage members and medical societies to work with school administrators to facilitate the transformation of schools into health enhancing institutions by implementing comprehensive health education, creating within all schools a designated

health coordinator and ensuring that schools maintain a healthy and safe environment. [Res. 252, A-90; Reaffirmed by BOT Rep. 24, A-97; Reaffirmed: CSAPH Rep. 3, A-07; Reaffirmed: CSAPH Rep. 01, A-17]

**H-515.981 Family Violence-Adolescents as Victims and Perpetrators**

1. Our American Medical Association:
    a. encourages physicians to screen adolescents about a current or prior history of maltreatment. Special attention should be paid to screening adolescents with a history of alcohol and drug misuse, irresponsible sexual behavior, eating disorders, running away, suicidal behaviors, conduct disorders, or psychiatric disorders for prior occurrences of maltreatment.
    b. urges physicians to consider issues unique to adolescents when screening youths for abuse or neglect.
2. Our AMA encourages state medical society violence prevention committees to work with child protective service agencies to develop specialized services for maltreated adolescents, including better access to health services, improved foster care, expanded shelter and independent living facilities, and treatment programs.
3. Our AMA will investigate research and resources on effective parenting of adolescents to identify ways in which physicians can promote parenting styles that reduce stress and promote optimal development.
4. Our AMA will alert the national school organizations to the increasing incidence of adolescent maltreatment and the need for training of school staff to identify and refer victims of maltreatment.
5. Our AMA urges youth correctional facilities to screen incarcerated youth for a current or prior history of abuse or neglect and to refer maltreated youth to appropriate medical or mental health treatment programs.
6. Our AMA encourages the National Institutes of Health and other organizations to expand continued research on adolescent initiation of violence and abuse to promote understanding of how to prevent future maltreatment and family violence. [CSA Rep. I, A-92; Reaffirmed: CSA Rep. 8, A-03; Modified: CSAPH Rep. 1, A-13; Reaffirmed: CSAPH Rep. 08, A-23]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 218
(A-25)

Introduced by: Medical Student Section, American College of Physicians, American College of Preventive Medicine, International Medical Graduates Section, Integrated Physician Practice Section

Subject: Distribution of Resident Slots Commensurate with Shortages

Referred to: Reference Committee B

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Whereas, by 2036, the Health Resources & Services Administration (HRSA) projects an overall shortage of 139,940 physicians, with family medicine physicians, general internal medicine physicians, pediatricians, OBGYNs, and psychiatrists comprising 83% of the overall shortage[1]; and

Whereas, American Medical Association Policy H-200.949, “Principles of and Actions to Address Primary Care Workforce,” includes general internal medicine, family medicine, pediatrics, and OB/GYN as "primary care” specialties; and

Whereas, the National Health Service Corps considers general internal medicine, family medicine, pediatrics, OB/GYN, as well as psychiatry as specialties in shortage that preferentially receive scholarship support and loan repayment[2]; and

Whereas, preventive medicine physicians are another smaller primary care specialty not formally included in projections whose clinical scope can also help reduce the primary care shortage, in addition to their highly important role bolstering our public health workforce[3]; and

Whereas, our elderly population of over age 64 has been growing at the fastest rate since the 1800s, with an estimate of 55.8 million people, which represents a 38.6% increase in the last 10 years, resulting in increased demand for primary care services[4]; and

Whereas, primary care and psychiatry physician shortages are even more drastic than projected, because estimates like those from the HRSA assume that a large number of physician assistants and nurse practitioners will be hired instead of physicians to meet need[1]; and

Whereas, in both developing and developed countries, a sufficient primary care and psychiatry workforce has been associated with increased access to healthcare services, better health outcomes and decrease use in hospitalization and ED visits[6]; and

Whereas, based on HRSA data, the bipartisan Senate Finance Committee Medicare GME Working Group recently proposed allocating 25% of new Medicare GME slots to primary care and 15% to psychiatry, which are reasonable distributions considering that shortages in those fields are far more drastic[7]; and

Whereas, AMA action in the past has opposed allocating residency positions specifically to primary care and psychiatry, citing concerns about potential future shortages in other specialties

and emphasizing the need for flexibility to address regional demands and has also cosigned comments by the GME Advocacy Coalition, highlighting concerns about shortages across both primary care and specialties[8,9]; and

Whereas, the AMA's position does not align with the data on the extreme shortages in primary care and psychiatry, as the proposal's respective 25% and 15% slot allocations are far below their respective 53% and 30% shares of the physician shortage[1]; therefore be it

RESOLVED, that our American Medical Association support preferential distribution of new residency slots to general internal medicine, family medicine, preventive medicine, pediatrics, obstetrics and gynecology, and psychiatry, commensurate with their relative need and expected shortages. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Date Received: 4/21/25

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## RELEVANT AMA POLICY

**H-200.949 Principles of and Actions to Address Primary Care Workforce**
1. Our patients require a sufficient, well-trained supply of primary care physicians--family physicians, general internists, general pediatricians, and obstetricians/gynecologists--to meet the nation's current and projected demand for health care services.
[CME Rep. 04, I-18; Reaffirmed: CMS Rep. 08, A-24]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 219
(A-25)

Introduced by: Medical Student Section

Subject: Opposing Unwarranted National Institutes of Health Research Institute Restructuring

Referred to: Reference Committee B

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Whereas, in June 2024, the House Energy and Commerce Committee's National Institutes of Health (NIH) Reform Report proposed reducing the number of NIH institutes from 27 to 15, many of which are crucial for addressing specific medical conditions and public health challenges[1-3]; and

Whereas, in April 2025, a leaked draft of the 2026 budget proposal reveals that the current administration plans to go further by cutting the NIH's $47 billion budget to $26 billion and consolidate its 27 institutes and centers into just eight[14]; and

Whereas, recent terminations of long-term NIH contracts, as well as firing or reassignment of NIH institutes and centers' directors, have lacked transparency and clarity, indicating that reforms may proceed without input from physicians, scientists, researchers, academics and other interest and patient advocacy groups[4,5]; and

Whereas, the proposed restructuring and consolidation of the NIH may disproportionately affect research in pediatrics, maternal health and infectious diseases, shift funding away from rare diseases and health disparities, disrupt ongoing studies, reduce funding for specialized research—particularly for underrepresented groups—and redirect support from long-term to short-term projects[1,6]; and

Whereas, the current administration has not committed to maintaining total NIH funding or proportional funding across consolidated institutes and centers; and

Whereas, restructuring to larger research institutes does not necessarily improve productivity, as shown by the Fogarty International Center (FIC), which, despite having the smallest budget, publishes over 20 peer-reviewed manuscripts per $1 million and funds 500 projects at 100 U.S. universities, along with global partnerships in infectious disease, Alzheimer's research, and biodiversity that could be lost through consolidation[7-9]; and

Whereas, public investment in the NIH has generated $94.5 billion in economic activity in 2024 alone, yielding $2.56 for every $1 invested, and supports over 400,000 jobs which underscores its vital role in driving innovation, job growth, and supporting the biotech and pharmaceutical industries[10-12]; and

Whereas, previous NIH reform efforts created commissions to periodically advise additional reforms in the future, such as the Scientific Management Review Board, but have not been utilized in the current restructuring and reorganization[13]; therefore be it

RESOLVED, that our American Medical Association support efforts to promote the inclusion of direct input from allopathic and osteopathic physicians and the scientific community, particularly researchers and academics, in decisions pertaining to the restructuring of the NIH. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Date Received: 4/22/25

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## RELEVANT AMA POLICY

**H-460.965 Viability of Clinical Research Coverages and Reimbursement**

1. Our American Medical Association believes that legislation and regulatory reform should be pursued to mandate third party payer coverage of patient care costs (including co-pays/co-insurance/deductibles) of nationally approved (e.g., NIH, VA, ADAMHA, FDA), scientifically based research protocols or those scientifically based protocols approved by nationally recognized peer review mechanisms.
2. Our AMA believes that third party payers should formally integrate the concept of risk/benefit analysis and the criterion of availability of effective alternative therapies into their decision making processes.
3. Our AMA believes that third party payers should be particularly sensitive to the difficulty and complexity of treatment decisions regarding the seriously ill and provide flexible, informed and expeditious case management when indicated.
4. Our AMA believes that its efforts to identify and evaluate promising new technologies and potentially obsolete technologies should be enhanced.
5. Our AMA believes that its current efforts to identify unproven or fraudulent technologies should be enhanced.
6. Our AMA believes that sponsors (e.g., NIH, pharmaceutical firms) of clinical research should finance fully the incremental costs added by research activities (e.g., data collection,

investigators' salaries, data analysis) associated with the clinical trial. Investigators should help to identify such incremental costs of research.

7. Our AMA believes that supports monitoring present studies and demonstration projects, particularly as they relate to the magnitude (if any) of the differential costs of patient care associated with clinical trials and with general practice.
8. Our AMA believes that results of all trials should be communicated as soon as possible to the practicing medical community maintaining the peer reviewed process of publication in recognized medical journals as the preferred means of evaluation and communication of research results.
9. Our AMA believes that funding of biomedical research by the federal government should reflect the present opportunities and the proven benefits of such research to the health and economic well being of the American people.
10. Our AMA believes that the practicing medical community, the clinical research community, patient advocacy groups and third party payers should continue their ongoing dialogue regarding issues in payment for technologies that benefit seriously ill patients and evaluative efforts that will enhance the effectiveness and efficiency of our nation's health care system.
11. Our AMA believes that legislation and regulatory reform should be supported that establish program integrity/fraud and abuse safe harbors that permit sponsors to cover co-pays/coinsurance/ deductibles, otherwise not covered clinical care, and non-clinical ancillary costs in the context of nationally approved clinical trials.

[CSA Rep. F, I-89 Reaffirmed: Joint CMS/CSA Rep., I-92 Reaffirmed: BOT Rep.40, I-93 Reaffirmed: CSA Rep. 13, I-99 Reaffirmation A-00 Reaffirmed: CMS Rep. 4, A-02 Reaffirmed: CMS Rep. 4, A-12 BOT Action in response to referred for decision: Res. 813, I-15 BOT Action in response to referred for decision: Res. 823, I-15 Reaffirmation: I-18 Modified: Res. 226, A-22]

**H-460.994 Support for Careers in Research**

Our AMA: (1) supports joining with other public and private bodies in encouraging multiple approaches at local, state and national levels in support of the development of physician-investigators, and specifically encourages research and training grants without a pay-back provision; (2) encourages the several specialty boards through the Interspecialty Advisory Board to allow one or more years of clinical investigative training, as long as it has some relevance to that specialty, in lieu of a year of post-doctoral clinical experience, where appropriate; and (3) encourages the NIH to increase the stipends for NIH research traineeships and fellowships without reducing the actual number of available positions. [CSA Rep. G, A-80 Reaffirmed: CLRPD Rep. B, I-90 Reaffirmed: Sunset Report, I-00 Reaffirmation A-09 Reaffirmed: CSAPH Rep. 01, A-19]

**H-460.975 Support for NIH Research Facilities**

1. Our American Medical Association urges the enactment of federal legislation which would grant to the National Institutes of Health (NIH) funding authority to expand, remodel, and renovate existing biomedical research facilities and to construct new research facilities.
2. Our AMA urges that the authority be granted to the NIH Director and not fragmented at the categorical institute level.
3. Our AMA urges that institutions be required to match federal funding for this program in a systematic way.

[BOT Rep. S, I-88 Reaffirmed: Sunset Report, I-98 Reaffirmation A-00 Reaffirmed: BOT Rep. 6, A-10 Reaffirmed: BOT Rep. 7, A-21]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 220
(A-25)

Introduced by: New England

Subject: Strengthening AMA Policy on Noncompete Clauses in Ownership Transitions

Referred to: Reference Committee B

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Whereas, noncompete clauses (also known as restrictive covenants or covenants-not-to-compete) restrict physician mobility, impede patient continuity of care, and may force patients to seek alternative providers—thereby adversely affecting the quality and accessibility of care (AMA Code of Ethics 11.2.3.1); and

Whereas, such clauses have been shown to exacerbate healthcare workforce shortages, particularly in rural or underserved communities, by limiting physician ability to relocate or establish practices where needed; and

Whereas, numerous states have enacted outright bans on or strict limitations for physician noncompete agreements, including California, Delaware, New Hampshire, New Mexico, Rhode Island, Massachusetts, Minnesota, North Dakota, and Oklahoma; and

Whereas, pending legislation in several states, including Arkansas, Pennsylvania, Indiana, Maryland, and Louisiana, aims either to ban or further restrict the enforcement of physician noncompete clauses in employment contracts; and

Whereas, there is significant evidence that noncompete clauses become especially problematic in the event of ownership transitions, such as mergers, acquisitions (whether structured as a purchase of practice, stock acquisition, or asset sale), or reorganization, which can result in a material change in the employer that should not automatically transfer restrictive covenants unless explicitly agreed to in writing (as seen in Pennsylvania case law regarding assignment clauses and in cases like *Joyner Sports Medicine v. Stejbach*); and

Whereas, several states (e.g., Pennsylvania) prohibit the automatic assignment or transfer of noncompete clauses in the event of an ownership transfer, merger, or acquisition unless explicitly stated in the contract, thereby protecting physicians from being bound by covenants negotiated with a previous employer; and

Whereas, the National Labor Relations Board (NLRB) has argued that noncompete clauses may violate federal labor law by chilling employee mobility; and

Whereas, in 2024 the Federal Trade Commission (FTC) issued a rule banning noncompete clauses for employees in for-profit companies, although this ban was later struck down by a federal judge, reflecting ongoing concerns at the federal level about anti-competitive practices in employment; and

Whereas, case law, including *Valley Medical Specialists v. Farber* (Arizona) and *Mercy Health Sys. v. Bicak* (Arkansas), demonstrates that restrictive covenants can be overly burdensome when they impede patient choice and continuity of care, especially when applied following

dismissals or changes in ownership (Farber Case), thereby reinforcing the need for legislative and regulatory reform; and

Whereas, physicians who are dismissed by their employer, whether in the old or new ownership context, should not be penalized by noncompete clauses that were negotiated under different employment conditions (Connecticut Statute and Pennsylvania Act 67, 2023); and

Whereas, the disruption of patient continuity of care during ownership transitions is a serious public health concern that warrants strong advocacy and clear policy recommendations from the AMA; therefore be it

RESOLVED, that our American Medical Association strongly oppose the enforcement of noncompete clauses (restrictive covenants) following any material change in practice ownership or control, including but not limited to private equity acquisitions, hospital mergers, stock acquisitions, asset sales, or reorganizations, that do not receive explicit, renewed, and informed physician consent (New HOD Policy); and be it further

RESOLVED, that our AMA advocate at both the state and federal levels for legislative and regulatory solutions that prohibit the assignment or automatic transfer of noncompete clauses in the event of ownership transitions, mergers, or acquisitions, thereby preventing such clauses from being imposed on physicians without fresh contract negotiations (Directive to Take Action); and be it further

RESOLVED, that our AMA support policies that render any noncompete clause void if the physician is dismissed by the employer or group, whether under the old or new ownership, and support amendments to state laws to that effect (New HOD Policy); and be it further

RESOLVED, that our AMA support that all physicians be provided with clear, comprehensible disclosures regarding any noncompete or assignment clauses contained in contracts, including detailed explanations of how such clauses would (or would not) be applied in the event of a merger, acquisition, or other ownership change. (New HOD Policy)

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

Received: 4/15/25

**RELEVANT AMA POLICY**

**H-160.885 Impact of Integration and Consolidation on Patients and Physicians**
1) Our American Medical Association will continue to monitor the impact of hospital-physician practice and hospital-hospital mergers and acquisitions on health care prices and spending, patient access to care, potential changes in patient quality outcomes, and physician wages and labor.
2) Our AMA will continue to monitor how provider mix may change following mergers and acquisitions and how non-compete clauses may impact patients and physicians.
3) Our AMA will support efforts to collect relevant information regarding hospital-physician practice and hospital-hospital mergers and acquisitions in states or regions that may fall below the Federal Trade Commission (FTC)/Department of Justice review threshold.
4) Our AMA will encourage state and local medical associations, state specialty societies, and physicians to contact their state attorney general with concerns of anticompetitive behavior.
5) Our AMA will encourage physicians to share their experiences with mergers and acquisitions, such as those between hospitals and/or those between hospitals and physician practices, with the FTC via their online submission form.

**H-265.987 Prohibiting Covenants Not-to-Compete**
1) Our American Medical Association opposes all restrictive covenants between employers and physician employees and regularly update its state restrictive covenant legislative template.
2) Our AMA will continue to assist interested state medical associations and specialty societies in developing strategies for physician employee retention.

**D-383.978 Restrictive Covenants of Large Health Care Systems**
Our AMA, through its Organized Medical Staff Section, will educate medical students, physicians-in-training, and physicians entering into employment contracts with large health care system employers on the dangers of aggressive restrictive covenants, including but not limited to the impact on patient choice and access to care.

**H-265.988 Prohibiting Covenants Not-To-Compete in Physician Contracts**
1) Our American Medical Association support policies, regulations, and legislation that prohibits covenants not-to-compete for all physicians in clinical practice who hold employment contracts with for-profit or non-profit hospital, hospital system, or staffing company employers.
2) Our AMA will oppose the use of restrictive covenants not-to-compete as a contingency of employment for any physician-in-training, regardless of the ACGME accreditation status of the residency/fellowship training program.
3) Our AMA will study and report back on current physician employment contract terms and trends with recommendations to address balancing legitimate business interests of physician employers while also protecting physician employment mobility and advancement, competition, and patient access to care - such recommendations to include the appropriate regulation or restriction of a) Covenants not to compete in physician contracts with independent physician groups that include time, scope, and geographic restrictions; and b) De facto non-compete restrictions that allow employers to recoup recruiting incentives upon contract termination.

**AMA Code of Ethics 11.2.3.1 Restrictive Covenants**
1) Competition among physicians is ethically justifiable when it is based on such factors as quality of services, skill, experience, conveniences offered to patients, fees, or credit terms.
2) Covenants-not-to-compete restrict competition, can disrupt continuity of care, and may limit access to care.
3) Physicians should not enter into covenants that: (a) Unreasonably restrict the right of a physician to practice medicine for a specified period of time or in a specified geographic area on termination of a contractual relationship; and (b) Do not make reasonable accommodation for patients' choice of physician.
4) Physicians in training should not be asked to sign covenants not to compete as a condition of entry into any residency or fellowship program.

**D-215.980 Support Before, During, and After Hospital Closure or Reduction in Services**
1) Our American Medical Association will work with appropriate federal and state bodies to assure that whenever there is a threatened, or actual, hospital closure a process be instituted to safeguard the continuity of patient care and preserve the physician-patient relationship. Such a process should: a) assure adequate capacity exists in the immediate service area surrounding the hospital closure, including independent health resources, physicians, and support personnel to provide for the citizens of that area; b) allow that in said circumstances, restrictive covenants, records access, and financial barriers which prevent the movement of physicians and their patients to surrounding hospitals should be waived for an appropriate period of time; and c) ensure financial reserves exist, and are sufficient to cover any previous contractual obligations to physicians, e.g., medical liability tail coverage.
2) Our AMA will proactively offer support to physicians, residents and fellows, patients, and civic leaders affected by threatened or actual healthcare facility closures, change in ownership, or significant reductions in services via provision of information, resources, and effective, actionable advocacy.

**H-160.891 Corporate Investors**
Physicians should have a clear understanding of compensation agreements, mechanisms for conflict resolution, processes for exiting corporate investor partnerships, and application of restrictive covenants.

**H-310.929 Principles for Graduate Medical Education**
7) COMPENSATION OF RESIDENT PHYSICIANS. All residents should be compensated. Residents should receive fringe benefits, including, but not limited to, health, disability, and professional liability insurance and parental leave and should have access to other benefits offered by the institution. Residents must be informed of employment policies and fringe benefits, and their access to them. Restrictive covenants must not be required of residents or applicants for residency education.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 221
(A-25)

Introduced by: New England, Association for Clinical Oncology

Subject: Preservation of Medicaid

Referred to: Reference Committee B

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Whereas, Medicaid provides healthcare coverage to 80 million Americans, including pregnant women, children, adults, seniors, people with disabilities, and many others[1]; and

Whereas, Medicaid coverage continues to improve health outcomes, with recent expansion linked to a 6% reduction in all-cause mortality, a 23% increase in self-reported excellent health, and 41% higher likelihood of having a usual source of care[2–9]; and

Whereas, Medicaid finances 40% of all births, insures 40% of individuals under 18 years of age, is the largest payer for behavioral health services, and is the largest payer of long-term care[10–13]; and

Whereas, rural physicians are more likely to serve patient populations who rely on Medicaid funding and would be disproportionately impacted by federal funding cuts[14]; and

Whereas, prior efforts to cut Medicaid spending via work requirements did not increase employment and led to increased medical debt, delayed care, and poorer medication compliance[15,16]; and

Whereas, the federal government finances 69% of Medicaid nationally, ensuring states can provide care without excessive fiscal burden[17]; and

Whereas, reductions to federal funding of Medicaid or changes to Medicaid eligibility at the federal level would lead to substantial loss of coverage for millions of Americans; and

Whereas, the U.S. Congress is considering cutting federal Medicaid spending by adopting a per-capita financing model, reducing the federal match rate, imposing work requirements on certain enrollees, and other policies that are likely to cause coverage reductions[18]; therefore be it

RESOLVED, that our American Medical Association make preservation of federal funding and eligibility for Medicaid one of its top and urgent legislative advocacy priorities, effective immediately, and request report back on the Board of Trustees' actions at I-25 (Directive to Take Action); and be it further

RESOLVED, that our AMA strongly oppose federal and state efforts to reduce eligibility and funding for all public health insurance programs, including Medicaid and CHIP. (New HOD Policy)

Fiscal Note: Moderate – between $5,000 - $10,000

Received: 4/15/25

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## RELEVANT AMA POLICY

### Medicaid Expansion D-290.979

1. Our American Medical Association, at the invitation of state medical societies, will work with state and specialty medical societies in advocating at the state level to expand Medicaid eligibility to 133% (138% FPL including the income disregard) of the Federal Poverty Level as authorized by the ACA and will advocate for an increase in Medicaid payments to physicians and improvements and innovations in Medicaid that will reduce administrative burdens and deliver healthcare services more effectively, even as coverage is expanded.
2. Our AMA will: a. continue to advocate strongly for expansion of the Medicaid program to all states and reaffirm existing policies D-290.979, H 290.965 and H-165.823. b. work with interested state medical associations and national medical specialty societies to provide AMA resources on Medicaid expansion and covering the uninsured to health care professionals to inform the public of the importance of expanded health insurance coverage to all.

### Improving Medicaid and CHIP Access and Affordability H-290.954

1. Our American Medical Association opposes premiums, copayments, and other cost-sharing methods for Medicaid and the Children's Health Insurance Program, including Section 1115 waiver applications that would allow states to charge premiums or copayments to Medicaid beneficiaries.
2. Our AMA encourages the Centers for Medicare & Medicaid Services to amend existing Section 1115 waivers to disallow states the ability to charge premiums or copayments to Medicaid beneficiaries.

**Pediatric Specialty Medicaid Reimbursement D-290.972**
1. Our American Medical Association will make increasing Medicaid reimbursement for pediatric specialists a significant part of its plan for continued progress toward health equity.
2. Our AMA will advocate for payment parity with Medicare for the same or similar services provided to pediatric patients under Medicaid.
3. Our AMA will work with specialty societies to develop a value-based payment model that makes pediatric specialist practices sustainable and promotes access to care and health equity among the pediatric patients.
4. Our AMA will work with interested state parties to support the implementation of the value-based payment model for pediatric specialists in state Medicaid programs.
5. Our AMA will advocate for any demonstration projects undertaken to modernize Medicaid payment using value based payment models developed by the AMA and pediatric specialty societies be exempt from Medicaid demonstration project budget neutrality requirements.

**Opposition to Medicaid Work Requirements H-290.961**
Our AMA opposes work requirements as a criterion for Medicaid eligibility.

**Federal Medicaid Funding H-290.963**
1. Our AMA opposes caps on federal Medicaid funding.
2. Our AMA will advocate that Congress and the Department of Health and Human Services seek and take into consideration input from our AMA and interested state medical associations, national medical specialty societies, governors, Medicaid directors, mayors, and other stakeholders during the process of developing federal legislation, regulations, and guidelines on Medicaid funding.

**Expanding AMA Payment Reform Work and Advocacy to Medicaid and Other Non-Medicare Payment Models for Pediatric Health Care and Specialty Populations H-385.901**
1. Our American Medical Association supports appropriate demonstration projects, carve outs, and adjustments for pediatric patients and services provided to pediatric patients within the payment reform arena.
2. Our AMA will extend ongoing payment reform research, education, and advocacy to address the needs of specialties and patient populations not served by current CMMI models or other Medicare-focused payment reform efforts.
3. Our AMA will support and work with national medical specialty societies that are developing alternative payment models for specific conditions or episodes, target patient populations including pediatric populations, and medical and surgical specialties and continue to advocate that the Centers for Medicare and Medicaid Services, including the Center for Medicare and Medicaid Innovation; state Medicaid agencies; and other payers implement physician-developed payment models.
4. Our AMA will consider improved Medicaid payment rates to be a priority given the critical impact these payment rates have on patient care and patient access to care.
5. Our AMA will support and collaborate with state and national medical specialty societies and other interested parties on the development and adoption of physician-developed alternative payment models for pediatric health care that address the distinct prevention and health needs of children and take long-term, life-course impact into account.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 222
(A-25)

Introduced by: New York

Subject: Need for Separate H1B Pathway for IMG Doctors in the USA

Referred to: Reference Committee B

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Whereas, International Medical Graduates (IMGs) constitute a significant portion of the U.S. physician workforce, particularly in underserved areas and critical specialties; and

Whereas, IMG doctors face significant barriers under the current H1B visa system, including delays due to visa caps and the lottery process, which impact their ability to provide consistent care; and

Whereas, the complexity and duration of the current H1B visa and its 3-year renewal process impose undue burdens on IMG doctors, potentially interrupting their work and patient care; and

Whereas, the U.S. is projected to face a shortage of up to 124,000 physicians by 2034, making it imperative to ensure that IMG doctors remain a stable and uninterrupted part of the healthcare workforce; and

Whereas, several countries, including Canada and the UK, have established streamlined visa pathways for foreign-trained physicians, recognizing their vital role in addressing healthcare workforce shortages; therefore be it

RESOLVED, that our American Medical Association advocate for an expedited H-1B visa application and renewal process for International Medical Graduate physicians. (Directive to Take Action)

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

Received: 4/22/25

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   AILA provides insight into the challenges of the 3-year H1B renewal process for professionals
2. U.S. Citizenship and Immigration Services (USCIS). H1B Visa Renewal Guidelines.
   Explains the process and potential delays associated with H1B visa renewals.
3. U.S. Department of Homeland Security. H1B Visa Cap and Lottery System.
   Details on the complexities of the H1B visa process, including visa caps and the lottery.
4. Migration Policy Institute. H1B Visas: A Primary Tool for Hiring High-Skilled Foreign Workers. This article discusses how H1B restrictions affect healthcare providers
5. Government of Canada. Federal Skilled Worker Program: Medical Professionals Stream.
   Canada's immigration pathways for foreign-trained physicians.
6. UK Home Office. Shortage Occupation List and Skilled Worker Visa Route for Doctors.
   The UK's visa process designed to attract healthcare professionals, including foreign-trained doctors.
7. Association of American Medical Colleges (AAMC). The Complexities of Physician Supply and Demand: Projections from 2019 to 2034.This report highlights the role of IMGs in addressing physician shortages in the U.S., especially in rural and underserved areas.
8. American Medical Association (AMA). IMGs in the U.S. Workforce. AMA statistics on the contribution of IMGs to the U.S. healthcare system

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 223
(A-25)

Introduced by: New York

Subject: Preservation of Medicaid

Referred to: Reference Committee B

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Whereas, Medicaid provides healthcare coverage to 80 million low-income Americans, including pregnant women, children, adults, seniors, people with disabilities, and LGBTQIA+ individuals[1]; and

Whereas, Medicaid improves health outcomes, with expansion linked to a 6% reduction in all-cause mortality, a 23% increase in self-reporting health as excellent, and 41% higher likelihood of having a usual care source[2–9]; and

Whereas, Medicaid finances 40% of all births (including nearly 50% of births in rural communities), insures 40% of individuals under 18 years of age, is the largest single payer for behavioral health services, including substance use disorder (SUD) treatment, and is the largest payer of long term care services in the United States[10–13]; and

Whereas, women physicians are more likely to serve patient populations who rely heavily on Medicaid funding and would be disproportionately impacted by federal funding cuts[14]; and

Whereas, previous efforts to cut Medicaid spending via work requirements did not increase employment and instead led to problems paying off medical debt, delayed care, and delayed taking medications due to cost[15,16]; and

Whereas, the federal government finances 69% of Medicaid nationally, ensuring states can provide care without excessive fiscal burden[17]; and

Whereas, reductions to federal funding of Medicaid or changes to Medicaid eligibility at the federal level would lead to substantial loss of coverage for millions of Americans; and

Whereas, U.S. Congress is considering cutting federal Medicaid spending by adopting a per-capita financing model, reducing the federal match rate, and imposing work requirements on certain enrollees —policies shown to force coverage reductions[18]; therefore be it

RESOLVED, that our American Medical Association strongly supports maintaining and expanding Medicaid coverage to ensure access to comprehensive healthcare for vulnerable populations (New HOD Policy); and be it further

RESOLVED, that our AMA opposes any state or federal efforts to impose work requirements as a condition of Medicaid eligibility (New HOD Policy); and be it further

RESOLVED, that our AMA opposes increasing cost-sharing requirements for Medicaid enrollees (New HOD Policy); and be it further

RESOLVED, that our AMA makes preservation of federal funding and eligibility for Medicaid an urgent and top legislative advocacy priority (Directive to Take Action); and be it further

RESOLVED, that our AMA strongly oppose federal and state efforts to restrict eligibility and funding for all public health insurance programs, including Medicaid and CHIP. (New HOD Policy)

Fiscal Note: Moderate – between $5,000 - $10,000

Received: 4/22/25

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 224
(A-25)

Introduced by: New York

Subject: Support SAVE Plan and Public Service Loan Forgiveness (PLSF) Applications

Referred to: Reference Committee B

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Whereas, the SAVE plan is an income-driven repayment plan that grants forgiveness on subsidized and unsubsidized federal loans after 120 months of qualifying payments[1]; and

Whereas, the SAVE plan provides an interest benefit preventing interest from accruing if the income-driven monthly payment does not cover the interest; and

Whereas, repayment length is based on the principal amount of the loan and level of study (graduate vs. undergraduate), with a cap of 25 years; and

Whereas, the average medical student graduates with $234,579 in medical school-associated debt[2]; and

Whereas, a federal court has placed an injunction on the SAVE plan, preventing borrowers from applying to SAVE and placing currently enrolled borrowers in involuntary forbearance[3]; therefore be it

RESOLVED, that our American Medical Association supports the reinstatement of the SAVE plan or a replacement program with similar income-based payments, interest benefits, and loan forgiveness and allows those with 120 qualifying payments to submit a PSLF application (New HOD Policy); and be further

RESOLVED, that this resolution be submitted to the American Medical Association for consideration and advocacy, ensuring that the AMA supports and promotes the reinstatement of the SAVE plan or a similar program at the national level. (Directive to Take Action)

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

Received: 4/22/25

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 225
(A-25)

Introduced by: New York

Subject: The Private Practice Physicians in the Community

Referred to: Reference Committee B

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Whereas, I am a member and represent the endangered species of Medicine: The Private Practice Physicians which today comprise only 17% of practicing physicians. Recently the number has rapidly declined to near extinction levels. Many have gone into early retirement; others have joined the hospital or companies which offer employment opportunities; and

Whereas, there are several specific reasons for this decline, including the decline in reimbursements. This year a 2.83% cut in the physician payment schedule has occurred, the 5th straight year of cuts, a devastating decline in physician reimbursement that stretches beyond two decades; and

Whereas, private practice physicians are affected to a much larger degree than hospitalists as the hospital donors and state funding largely subtracts from the physician apportion; and

Whereas, hospitals and large group practices have greater market share due to ability to buy up practices in the community and claim enough member lives to negotiate higher reimbursement.The unregulated, unfettered urgent care and minute clinics also compete for business from the private physicians; and

Whereas, Direct care, concierge, and traditional personalized patient care in a private practice setting where the physician has greater flexibility and continuity with the patient fosters a stronger physician-patient relationship, which likely promotes better patient satisfaction and improved outcomes. The private practice physician has been the cornerstone and backbone of the healthcare system for the past few hundred years; and

Whereas, physicians have no reasonable labor protection, cannot unionize or strike unlike the hospitalists who can strike and unionize for better wages, are unable to share information about our contracts due to fear of accusations of “collusion”; and

Whereas, Corporate hospitals and large groups have taken over medicine with their bottom line agenda. In the year 2000 there were only a few hundred hospitalists, today there are 60,000 hospitalists, a number that is rapidly growing; therefore be it

RESOLVED, that our American Medical Association advocate for legislation, regulation or other policy mechanisms make it a priority to halt the constant yearly physician cutbacks in a climate of skyrocketing inflation and a high cost of living, in fact COLA should be built into ALL fee schedules (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate to The Centers for Medicare and Medicaid Services (CMS) and Congress to decrease the need for time consuming prior authorizations, decrease

the use of audits and recoupment and retrieving funds from physicians already burdened by ever increasing overhead and continual payment cutbacks. (Directive to Take Action)

Fiscal Note: Moderate – between $5,000 - $10,000

Received: 4/22/25

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 226
(A-25)

Introduced by: Pennsylvania

Subject: Regulations for Algorithmic-Based Health Insurance Utilization Review

Referred to: Reference Committee B

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Whereas, utilization review by health insurance companies was originally intended to involve comprehensive examination of patient records by medical experts to ensure fair and objective decisions[1]; and

Whereas, there is growing concern regarding the use of algorithmic systems in utilization review, which bypass traditional medical review steps and rely on automated processes to make claim denial decisions[1]; and

Whereas, the utilization of artificial intelligence (AI) and machine learning algorithms in utilization review processes by insurance companies raises concerns regarding their technical limitations, longitudinal unreliability, and propensity for biass[2]; and

Whereas, AI algorithms may exhibit limitations in accurately assessing complex medical data and making informed utilization review decisions, particularly in cases where the underlying data is incomplete, unrepresentative, ambiguous, or subject to interpretation[2]; and

Whereas, AI algorithms may exhibit bias in their decision-making processes, reflecting and perpetuating existing disparities and inequities in healthcare access and outcomes, particularly for marginalized and underserved populations[2]; and

Whereas, the opacity and lack of interpretability of AI algorithms may hinder the identification and mitigation of bias and may lead to an overreliance on algorithmic predictions, leading to possibly unfair and discriminatory utilization review practices by insurance companies[2]; and

Whereas, the utilization of algorithmic systems, such as Cigna's PXDX, has raised questions about the transparency, accountability, and fairness in their assessment of medical claims, as these systems lack human oversight and may lead to erroneous denials of medically necessary care[3,4]; and

Whereas, even after investigations by the U.S. Department of Labor, congressional committees, and journalists, the usage of algorithms in utilization review has not been transparently disclosed to physicians, patients, and the general public[3,4]; and

Whereas, insurance companies such as UnitedHealth have been found to use restrictive algorithms and medical staff coercion to limit Medicare patients' access to rehabilitation care, resulting in a lawsuit and pressure from US Representatives to prompt CMS oversight of use of AI in Medicare Advantage plans[5]; and

Whereas, the improper use of utilization management programs have been found to lead to inappropriate denials, thereby resulting in delays in patient care, clinician burnout, and

increased administrative burden to appeal such denials with a substantial portion of denials ultimately overturned in providers' favor[6]; and

Whereas, consumers facing wrongful insurance denials often encounter significant obstacles in navigating the appeals process, leading to low rates of appeal and potentially, underreporting of violations[6,7]; and

Whereas, the utilization of algorithmic systems in medical review processes may undermine patient trust in insurance providers and the healthcare system as a whole, leading to medical mistrust and dissatisfaction[6]; and

Whereas, the financial consequences of payment delays and denials for medically necessary care have placed significant strains on health systems with billions of dollars in delayed or potentially unpaid claims reported[1,6]; and

Whereas, delays in patient care have been linked to serious adverse events including hospitalizations, disabilities; and even deaths, as reported by physicians[6]; and

Whereas, there is extensive documentation of insurance companies violating numerous state laws aimed at protecting consumers from unfair insurance denials, including denials for life-saving cancer medications and necessary surgeries[7]; and

Whereas, state insurance departments tasked with enforcing these laws often lack the resources and manpower necessary to effectively conduct thorough audits or investigations into violations[7]; and

Whereas, The American Medical Association (AMA) has conducted extensive research on utilization management programs, like prior authorization, revealing their detrimental impact on patient care delays, administrative costs, and workflow disruptions, highlighting the urgent need for reform[8]; and

Whereas, surveys of practicing physicians have consistently indicated that prior authorization requirements interfere with patient care, and limit progress in reforming health plans[8]; and

Whereas, The American Medical Association House of Delegates adopted the following five policies since 2022 to address the use of AI in reviewing patient claims and prior authorization requests: H-285.998 Managed Care (2024); H-320.968 Approaches to Increase Payer Accountability (2024); H-390.849 Physician Payment Reform (2023); H-480.935 Assessing the Potentially Dangerous Intersection Between AI and Misinformation (2023), and H-480.939 Augmented Intelligence (2022); therefore be it

RESOLVED, that our American Medical Association advocate for state and federal oversight of and/or legislative activity to assure the transparency, patient safety, and biases involved in algorithm usage in utilization review by insurance companies (Directive to Take Action); and be it further

RESOLVED, that our AMA reaffirm the following policies:
H-285.998 Managed Care (2024)
H-320.968 Approaches to Increase Payer Accountability (2024)
H-390.849 Physician Payment Reform (2023)

H-480.935 Assessing the Potentially Dangerous Intersection Between AI and Misinformation (2023)
H-480.939 Augmented Intelligence (2022). (Reaffirm HOD Policy)

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

Received: 4/7/25

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## RELEVANT AMA POLICY

### Managed Care H-285.998

1. Introduction The needs of patients are best served by free market competition and free choice by physicians and patients between alternative delivery and financing systems, with the growth of each system determined not by preferential regulation and subsidy, but by the number of persons who prefer that mode of delivery or financing.
2. Definition "Managed care" is defined as those processes or techniques used by any entity that delivers, administers, and/or assumes risk for health care services in order to control or influence the quality, accessibility, utilization, or costs and prices or outcomes of such services provided to a defined enrollee population.
3. Techniques Managed care techniques currently employed include any or all of the following: (a) prior, concurrent, or retrospective review of the quality, medical necessity, and/or appropriateness of services or the site of services; (b) controlled access to and/or coordination of services by a case manager; (c) efforts to identify treatment alternatives and to modify benefits for patients with high cost conditions; (d) provision of services through a network of contracting providers, selected and deselected on the basis of standards related to cost-effectiveness, quality, geographic location, specialty, and/or other criteria; (e) enrollee financial incentives and disincentives to use such providers, or specific service sites; and (f) acceptance by participating providers of financial risk for some or all of the contractually obligated services, or of discounted fees.
4. Case Management Health plans using the preferred provider concept should not use coverage arrangements which impair the continuity of a patient's care across different treatment settings. With the increased specialization of modern health care, it is advantageous to have one individual with overall responsibility for coordinating the medical care of the patient. The physician is best suited by professional preparation to assume this leadership role. The primary goal of high-cost case management or benefits management programs should be to help to arrange for the

services most appropriate to the patient's needs; cost containment is a legitimate but secondary objective. In developing an alternative treatment plan, the benefits manager should work closely with the patient, attending physician, and other relevant health professionals involved in the patient's care. Any health plan which makes available a benefits management program for individual patients should not make payment for services contingent upon a patient's participation in the program or upon adherence to treatment recommendations.

5. Utilization Review The medical protocols and review criteria used in any utilization review or utilization management program must be developed by physicians. Public and private payers should be required to disclose to physicians on request the screening and review criteria, weighting elements, and computer algorithms utilized in the review process, and how they were developed. Physician of the same specialty must be involved in any decision by a utilization management program to deny or reduce coverage for services based on questions of medical necessity. All health plans conducting utilization management or utilization review should establish an appeals process whereby physicians, other health care providers, and patients may challenge policies restricting access to specific services and decisions to deny coverage for services, and have the right to review of any coverage denial based on medical necessity by a physician independent of the health plan who is of the same specialty and has appropriate expertise and experience in the field. A physician whose services are being reviewed for medical necessity should be provided the identity of the reviewing physician on request. Any physician who makes judgments or recommendations regarding the necessity or appropriateness of services or site of services should be licensed to practice medicine and actively practicing in the same jurisdiction as the practitioner who is proposing or providing the reviewed service and should be professionally and individually accountable for their decisions. All health benefit plans should be required to clearly and understandably communicate to enrollees and prospective enrollees in a standard disclosure format those services which they will and will not cover and the extent of coverage for the former. The information disclosed should include the proportion of plan income devoted to utilization management, marketing, and other administrative costs, and the existence of any review requirements, financial arrangements or other restrictions that may limit services, referral or treatment options, or negatively affect the physician's fiduciary responsibility to their patients. It is the responsibility of the patient and their health benefits plan to inform the treating physician of any coverage restrictions imposed by the plan.

All health plans utilizing managed care techniques should be subject to legal action for any harm incurred by the patient resulting from application of such techniques. Such plans should also be subject to legal action for any harm to enrollees resulting from failure to disclose prior to enrollment any coverage provisions; review requirements; financial arrangements; or other restrictions that may limit services, referral, or treatment options, or negatively affect the physician's fiduciary responsibility to their patient.

When inordinate amounts of time or effort are involved in providing case management services required by a third party payer which entail coordinating access to other health care services needed by the patient, or in complying with utilization review requirements, the physician may charge the payer or the patient for the reasonable cost incurred. "Inordinate" efforts are defined as those "more costly, complex and time-consuming than the completion of standard health insurance claim forms, such as obtaining preadmission certification, second opinions on elective surgery, certification for extended length of stay, and other authorizations as a condition of payer coverage."

Any health plan or utilization management firm conducting a prior authorization program should act within two business days on any patient or physician request for prior authorization and respond within one business day to other questions regarding medical necessity of services. Any health plan requiring prior authorization for covered services should provide enrollees subject to such requirements with consent forms for release of medical information for utilization review purposes, to be executed by the enrollee at the time services requiring prior authorization are recommended by the physicians.

In the absence of consistent and scientifically established evidence that preadmission review is cost-saving or beneficial to patients, the AMA strongly opposes the use of this process.

Joint CMS/CLRPD Rep. I-91 Reaffirmed: CMS Rep. I-93-5 Reaffirmed: Res. 716, A-95 Modified: CMS Rep. 3, I-96 Modified: CMS Rep. 4, I-96 Reaffirmation A-97 Reaffirmed: CMS Rep. 3, I-97 Reaffirmed: CMS Rep. 9, A-98 Reaffirmed: Sub. Res. 707, A-98 Reaffirmed: CMS Rep. 13, I-98 Reaffirmed: Res. 717, A-99 Reaffirmation A-00 Reaffirmation A-02 Reaffirmation I-04 Reaffirmed in lieu of Res. 839, I-08 Reaffirmation A-09 Reaffirmed: Sub. Res. 728, A-10 Reaffirmation I-10 Reaffirmation A-11 Reaffirmed: Res. 709, A-12 Reaffirmed: CMS Rep. 07, A-16 Reaffirmed: CMS Rep. 08, A-17 Reaffirmed: CMS Rep. 04, A-18 Reaffirmation: A-19 Reaffirmed: CMS Rep. 4, A-21 Reaffirmation: A-22 Reaffirmation: A-23 Modified: Speakers Rep. 02, I-24

**Approaches to Increase Payer Accountability H-320.968**
Our AMA supports the development of legislative initiatives to assure that payers provide their insureds with information enabling them to make informed decisions about choice of plan, and to assure that payers take responsibility when patients are harmed due to the administrative requirements of the plan. Such initiatives should provide for disclosure requirements, the conduct of review, and payer accountability.

1. Disclosure Requirements. Our American Medical Association supports the development of model draft state and federal legislation to require disclosure in a clear and concise standard format by health benefit plans to prospective enrollees of information on:
    a. Coverage provisions, benefits, and exclusions.
    b. Prior authorization or other review requirements, including claims review, which may affect the provision or coverage of services.
    c. Plan financial arrangements or contractual provisions that would limit the services offered, restrict referral or treatment options, or negatively affect the physician's fiduciary responsibility to their patient.
    d. Medical expense ratios.
    e. Cost of health insurance policy premiums. (Ref. Cmt. G, Rec. 2, A-96; Reaffirmation A-97)
2. Conduct of Review. Our AMA supports the development of additional draft state and federal legislation to:
    a. Require private review entities and payers to disclose to physicians on request the screening criteria, weighting elements and computer algorithms utilized in the review process, and how they were developed.
    b. Require that any physician who recommends a denial as to the medical necessity of services on behalf of a review entity be of the same specialty as the practitioner who provided the services under review.
    c. Require every organization that reviews or contracts for review of the medical necessity of services to establish a procedure whereby a physician claimant has an opportunity to appeal a claim denied for lack of medical necessity to a medical consultant or peer review group which is independent of the organization conducting or contracting for the initial review.
    d. Require that any physician who makes judgments or recommendations regarding the necessity or appropriateness of services or site of service be licensed to practice medicine in the same jurisdiction as the practitioner who is proposing the service or whose services are being reviewed.
    e. Require that review entities respond within 48 hours to patient or physician requests for prior authorization, and that they have personnel available by telephone the same business day who are qualified to respond to other concerns or questions regarding medical necessity of services, including determinations about the certification of continued length of stay.
    f. Require that any payer instituting prior authorization requirements as a condition for plan coverage provide enrollees subject to such requirements with consent forms for release of medical information for utilization review purposes, to be executed by the enrollee at the time services requiring such prior authorization are recommended or proposed by the physician.
    g. Require that payers compensate physicians for those efforts involved in complying with utilization review requirements that are more costly, complex and time consuming than

the completion of standard health insurance claim forms. Compensation should be provided in situations such as obtaining preadmission certification, second opinions on elective surgery, and certification for extended length of stay.

3. Accountability. Our AMA believes that draft federal and state legislation should also be developed to impose similar liability on health benefit plans for any harm to enrollees resulting from failure to disclose prior to enrollment the information on plan provisions and operation specified under Section 1 (a)-(d) above.

BOT Rep. M, I-90 Reaffirmed by Res. 716, A-95 Reaffirmed by CMS Rep. 4, A-95 Reaffirmation I-96 Reaffirmed: Rules and Cred. Cmt., I-97 Reaffirmed: CMS Rep. 13 , I-98 Reaffirmation I-98 Reaffirmation A-99 Reaffirmation I-99 Reaffirmation A-00 Reaffirmed in lieu of Res. 839, I-08 Reaffirmation A-09 Reaffirmed: Sub. Res. 728, A-10 Modified: CMS Rep. 4, I-10 Reaffirmation A-11 Reaffirmed in lieu of Res. 108, A-12 Reaffirmed: Res. 709, A-12 Reaffirmed: CMS Rep. 07, A-16 Reaffirmed in lieu of: Res. 242, A-17 Reaffirmed in lieu of: Res. 106, A-17 Reaffirmation: A-17 Reaffirmation: I-17 Reaffirmation: A-18 Reaffirmation: A-19 Reaffirmed: Res. 206, I-20 Reaffirmation: A-22 Modified: Speakers Rep. 02, I-24

**Physician Payment Reform H-390.849**

1. Our American Medical Association will advocate for the development and adoption of physician payment reforms that adhere to the following principles:
    a. Promote improved patient access to high-quality, cost-effective care.
    b. Be designed with input from the physician community.
    c. Ensure that physicians have an appropriate level of decision-making authority over bonus or shared-savings distributions.
    d. Not require budget neutrality within Medicare Part B.
    e. Be based on payment rates that are sufficient to cover the full cost of sustainable medical practice.
    f. Ensure reasonable implementation timeframes, with adequate support available to assist physicians with the implementation process.
    g. Make participation options available for varying practice sizes, patient mixes, specialties, and locales.
    h. Use adequate risk adjustment methodologies.
    i. Incorporate incentives large enough to merit additional investments by physicians.
    j. Provide patients with information and incentives to encourage appropriate utilization of medical care, including the use of preventive services and self-management protocols.
    k. Provide a mechanism to ensure that budget baselines are reevaluated at regular intervals and are reflective of trends in service utilization.
    l. Attribution processes should emphasize voluntary agreements between patients and physicians, minimize the use of algorithms or formulas, provide attribution information to physicians in a timely manner, and include formal mechanisms to allow physicians to verify and correct attribution data as necessary.
    m. Include ongoing evaluation processes to monitor the success of the reforms in achieving the goals of improving patient care and increasing the value of health care services.
2. Our AMA opposes bundling of payments in ways that limit medically necessary care, including institutional post-acute care, or otherwise interfere with a physician's ability to provide high quality care to patients.
3. Our AMA supports payment methodologies that redistribute Medicare payments among providers based on outcomes (including functional improvements, if appropriate), quality and risk-adjustment measures only if measures are scientifically valid, reliable, and consistent with national medical specialty society- developed clinical guidelines/standards.
4. Our AMA will continue to monitor health care delivery and physician payment reform activities and provide resources to help physicians understand and participate in these initiatives.
5. Our AMA supports the development of a public-private partnership for the purpose of validating statistical models used for risk adjustment.

CMS Rep. 6, A-09 Reaffirmation A-10 Appended: Res. 829, I-10 Appended: CMS Rep. 1, A-11 Appended: CMS Rep. 4, A-11 Reaffirmed in lieu of Res. 119, A-12 Reaffirmed in lieu of Res. 122, A-12 Modified: CMS Rep. 6, A-13 Reaffirmation I-15 Reaffirmation: A-16 Reaffirmed in lieu of: Res. 712, A-17 Reaffirmed: BOT Action in response to referred for decision: Res. 237, I-17 Reaffirmation: A-19 Reaffirmed: BOT Action in response to referred for decision Res. 111, A-19 Reaffirmed: BOT Action in response to referred for decision Res. 132, A-19 Reaffirmed: Res. 212, I-21 Reaffirmed: Res. 240, A-22 Reaffirmation: A-22 Modified: CMS Rep. 04, A-23 Reaffirmed: Res. 214, A-23 Reaffirmation: A-23

**Assessing the Potentially Dangerous Intersection Between AI and Misinformation H-480.935**

1. Our American Medical Association will study and develop recommendations on the benefits and unforeseen consequences to the medical profession of large language models (LLM) such as, generative pretrained transformers (GPTs), and other augmented intelligence-generated medical advice or content, and that our AMA propose appropriate state and federal regulations with a report back at A-24.
2. Our AMA will work with the federal government and other appropriate organizations to protect patients from false or misleading AI-generated medical advice.
3. Our AMA will encourage physicians to educate our patients about the benefits and risks of consumers facing LLMs including GPTs.
4. Our AMA will support publishing groups and scientific journals to establish guidelines to regulate the use of augmented intelligence in scientific publications that include detailing the use of augmented intelligence in the methods, exclusion of augmented intelligence systems as authors, and the responsibility of authors to validate the veracity of any text generated by augmented intelligence.

Res. 247, A-23

**Augmented Intelligence H-480.939**

Our American Medical Association 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.
    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.
    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.
    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.

BOT Rep. 21, A-19 Reaffirmation: A-22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 227
(A-25)

Introduced by: Private Practice Physicians Section

Subject: Payment Recoupment—Let Sanity Prevail

Referred to: Reference Committee B

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Whereas, insurance companies not only create barriers to care and payment, but manage to bamboozle physicians into retrospective recovery or claim recoupment with bolder and more outlandish schemes; and

Whereas, insurance companies often claim errors that are not the fault of the physician as the reason for recoupment; and

Whereas, insurance companies often try to cover up their mistakes and errors by imposing the costs on physicians for services legitimately performed for a medically necessary condition; and

Whereas, insurance companies recoup money for payments made “in error” due to a “coordination of benefits” error that is the fault of the insurance company; and

Whereas, medical practices are not debt collectors for insurance companies where debts belong to the patient or another insurance company; and

Whereas, claim recoupment is administratively costly to physician practices, has no meaningful due process, and is not overseen by any third party as claim-related appeals cannot be referred for outside appeals under most health plan provisions; and

Whereas, claim recovery or recoupment has a significant impact on the financial viability of medical practices with billions of dollars recurred in costs and billions unjustly stolen from physicians; and

Whereas, AMA policy D-385.944, “ERISA Preemption of State Laws Regulating Pharmacy Benefit Managers” refers to the US Supreme Court holding in Rutledge v. PCMA, which gives the states the ability to regulate certain administrative aspects of health plans that do not relate to “a particular scheme of substantive coverage” which includes claim recoupment and payment recovery; therefore be it

RESOLVED, that our American Medical Association advocates for legislation and regulations compliant with the Supreme Court holding in *Rutledge v. PCMA* (Directive to Take Action); and be it further

RESOLVED, that our AMA advocates for legislation and regulations that stipulate that if payment recovery or recoupment is due to coordination of benefit failure, the payer seeks recovery from the patient and/or the correct insurance company or primary payer responsible for the claim (Directive to Take Action); and be it further

RESOLVED, that our AMA advocates for legislation and that whenever a health plan seeks recoupment or payment recovery for overpayment or wrong payment from a physician, a detailed and comprehensive explanation for the payment recoupment/recovery must be provided (Directive to Take Action); and be it further

RESOLVED, that our AMA advocates for legislation and regulation that if the reason for claim recovery or recoupment is not due to physician error, the health plan may not seek recovery from the physician and that health plans must seek resolution from the patient on whose behalf the insurance company paid the claim and who has a contract with the insurance company or the third party responsible for the payment involved in claim recovery or recoupment (Directive to Take Action); and be it further

RESOLVED, that our AMA report back at the 2026 Annual Meeting on the progress of the implementation of this resolution (Directive to Take Action).

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

Received: 4/22/25

**RELEVANT AMA POLICY**

**ERISA Preemption of State Laws Regulating Pharmacy Benefit Managers D-385.944**
Our American Medical Association will study, and create resources for states, on the implication of *Rutledge, Attorney General Of Arkansas v. Pharmaceutical Care Management Association*, and any other relevant legal decisions from the last several years, in reference to potentially allowing more successful challenges to the actions of healthcare plans protected by the Employee Retirement Income Security Act of 1974 (ERISA) when the quality of care or healthcare outcomes are questioned.
Citation: Res. 224, I-23

**Insurance Companies Use of Contractors to Recover Payments D-385.965**
1. Our AMA will seek legislation to limit insurance companies, their agents, or any contractors from requesting payment back on paid claims to no more than 90 days after payment is made.
(a) Such legislation would require insurance companies, their agents, or any contractors to have a defined and acceptable process for physicians to dispute these maneuvers to get payment back on claims already processed, verified, and paid.
(b) Such legislation would ban insurance companies, their agents or contractors from using re-pricers and re-reviewers and to adhere to their own pricing and reviewing guidelines as agreed upon in their contracts with physicians.
2. Our AMA will pursue legislation to regulate self-insured plans in this regard and apply the same rules to Medicare and other federal plans.
Citation: Res. 215, A-09; Reaffirmed: BOT Rep. 09, A-19

**Creating a Fair and Balanced Medicare and Medicaid RAC Program D-320.991**
1. Our AMA will continue to monitor Medicare and Medicaid Recovery Audit Contractor (RAC) practices and recovery statistics and continue to encourage the Centers for Medicare and Medicaid Services (CMS) to adopt new regulations which will impose penalties against RACs for abusive practices.
2. Our AMA will continue to encourage CMS to adopt new regulations which require physician review of all medical necessity cases in post-payment audits, as medical necessity is quintessentially a physician determination and judgment.
3. Our AMA will encourage CMS to discontinue the denial of payments or imposition of negative action during an audit due to the absence of specific words in the chief complaint when the note provides adequate documentation of the reason for the visit and services rendered.
4. Our AMA will assist states by providing recommendations regarding state implementation of Medicaid RAC rules and regulations in order to lessen confusion among physicians and to ensure that

states properly balance the interest in overpayment and underpayment audit corrections for Recovery Contractors.
5. Our AMA will petition CMS to amend CMS' rules governing the use of extrapolation in the RAC audit process, so that the amended CMS rules conform to Section 1893 of the Social Security Act Subsection (f) (3) - Limitation on Use of Extrapolation; and insists that the amended rules state that when an RAC initially contacts a physician, the RAC is not permitted to use extrapolation to determine overpayment amounts to be recovered from that physician by recoupment, offset, or otherwise, unless (as per Section 1893 of the Social Security Act) the Secretary of Health and Human Services has already determined, before the RAC audit, either that (a) previous, routine pre- or post-payment audits of the physician's claims by the Medicare Administrative Contractor have found a sustained or high level of previous payment errors, or that (b) documented educational intervention has failed to correct those payment errors.
6. Our AMA, in coordination with other stakeholders such as the American Hospital Association, will seek to influence Congress to eliminate the current RAC system and ask CMS to consolidate its audit systems into a more balanced, transparent, and fair system, which does not increase administrative burdens on physicians.
7. Our AMA will: (A) seek to influence CMS and Congress to require that a physician, and not a lower level provider, review and approve any RAC claim against physicians or physician-decision making, (B) seek to influence CMS and Congress to allow physicians to be paid any denied claim if appropriate services are rendered, and (C) seek the enactment of fines, penalties and the recovery of costs incurred in defending against RACs whenever an appeal against them is won in order to discourage inappropriate and illegitimate audit work by RACs.
8. Our AMA will advocate for penalties and interest to be imposed on the auditor and payable to the physician when a RAC audit or appeal for a claim has been found in favor of the physician.
Citation: Res. 215, I-11; Appended: Res. 209, A-13; Appended: Res. 229, A-13; Appended: Res. 216, I-13; Reaffirmed: Res. 223, I-13; Appended: Res. 213, I-16; Reaffirmed: CMS Rep. 08, A-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 228
(A-25)

Introduced by: Resident and Fellow Section, American Academy of Family Physicians, American College of Obstetricians and Gynecologists

Subject: CHIP Coverage of OTC Medications

Referred to: Reference Committee B

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Whereas, the Children's Health Insurance Program (CHIP) is a joint federal and state program that provides health coverage to uninsured children in families with incomes too high to qualify for Medicaid, but too low to afford private coverage[1]; and

Whereas, CHIP was originally passed into law under the Balanced Budget Act of 1997, and was most recently extended through federal fiscal year 2027[2]; and

Whereas, in order for a child to be eligible for CHIP, they must be 1) under 19 years of age, 2) uninsured, 3) a citizen or meet immigration requirements, 4) a resident of the state where they are applying, and 5) eligible within the state's CHIP incoming range based on family income)[3]; and

Whereas, in 2009, the Children's Health Insurance Program Reauthorization Act (CHIRPA) amends the act to expand coverage to pregnant women, including coverage during the 60-day postpartum period[4]; and

Whereas, each state administers their own CHIP program with their own distinct rules and regulations, within federal guidelines, to meet the needs of their constituents[5]; and

Whereas, CHIP currently covers routine check-ups, immunizations, doctor visits, dental and vision care, inpatient and outpatient hospital care, lab and imaging services, emergency services, and prescription medications[6]; and

Whereas, since CHIP was enacted the uninsured rate for children 18 and under has fallen by 67.9% from 14.9 to 4.8%[7]; and

Whereas, 7.6 million children are currently enrolled in CHIP based on a 2021 report[8]; and

Whereas, CHIP beneficiaries can receive a range of prescription coverage; however, states may choose to limit coverage of over-the-counter (OTC) medications based on specific medication categories or require physician prescription for coverage of OTC medicines[9,10]; and

Whereas, CHIP currently imposes coverage limitations with respect to certain drug classes[11]; and

Whereas, the cost of medications, including OTC medications, are a significant contributor to overall cost for patients, especially for children with medical complexity[12]; and

Whereas, research has shown families who spent more on out-of-pocket costs for medications were more sensitive to high medication costs and had an immediate reduction in adherence when started on high-cost, long-term medications[13]; and

Whereas, the availability of OTC medication to treat mild conditions creates substantial savings for the US health system[14]; therefore be it

RESOLVED, that our American Medical Association advocate for expanding coverage of FDA-approved and/or medically necessary over-the-counter medications under the Children's Health Insurance Program (CHIP) for enrolled individuals, including by expanding medication classes covered under CHIP (Directive to Take Action); and be it further

RESOLVED, that our AMA oppose arbitrary limitations on the quantity of FDA-approved over-the-counter medications covered by the Children's Health Insurance Program for enrolled individuals (New HOD Policy); and be it further

RESOLVED, that our AMA oppose copayment requirements for over-the-counter medications for patients enrolled in CHIP. (New HOD Policy)

Fiscal Note: Moderate – between $5,000 - $10,000

Received: 4/21/25

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14. *Value of OTC Medcines to the U.S. Healthcare System*. https://www.chpa.org/sites/default/files/media/docs/2020-10/Value-of-OTC-Medicines-to-the-US-Healthcare-System-03012019.pdf

**RELEVANT AMA POLICY:**

**Medicaid Payment for Over-The-Counter Drugs When They are the Drug of Choice H-125.990**
The AMA supports over-the-counter drug benefits under Medicaid that provide physician-prescribed medications to enrollees. Cost-conscious OTC drug programs should satisfy the criteria contained in Policy 110.997 for AMA support of programs designed to contain the rising costs of prescription drugs and follow AMA Policy 125.991 on development and implementation of drug formularies. [CMS Rep. 12, A-94; Reaffirmed: CMS Rep. 7, I-97; Reaffirmed: CMS Rep. 9, A-07; Reaffirmed: CMS Rep. 01, A-17]

**Health Plan Coverage for Over-the-Counter Drugs H-185.956**
Our AMA: (1) opposes mandated health plan coverage for over-the-counter (OTC) pharmaceuticals, including those that had previously been available only with a prescription; (2) encourages health insurers and health plans to cover medically necessary OTC drugs for which no prescription alternative exists; and (3) continues to support efforts to study the effects of converting medically necessary drugs from prescription to over-the-counter status on the costs and access to such medications.
[CMS Rep. 1, I-98; Renumbered: CMS Rep. 7, I-05; Reaffirmed: CMS Rep. 1, A-15]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 229
(A-25)

Introduced by: Senior Physicians Section

Subject: Guaranteeing Timely Delivery and Accessibility of Federal Health Data

Referred to: Reference Committee B

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Whereas, a memorandum was issued on January 21, 2025 to all thirteen Operating Divisions within the U.S. Dept. of Health & Human Services including the Food and Drug Administration, the Centers for Disease Control and Prevention, the Center for Medicare & Medicaid Services (CMS) and the National Institutes of Health, as well as other lesser-known health agencies[1]; and

Whereas, the CDC (Centers for Disease Control and Prevention) and the NIH (National Institutes of Health) had an almost three-month embargo imposed on data, which delayed physicians' access to essential information needed to provide timely and effective patient care; and

Whereas, lack of access to vital health data undermines the integrity and training of physicians, hindering their ability to provide optimal care to patients; and

Whereas, the CDC was established to minimize potential health risks while ensuring continuous, unrestricted access to critical data for both scientists and the general public; and

Whereas, tracking emerging infectious disease trends — including and not limited to those such as malaria, Zika, Chagas, tuberculosis, syphilis, H5N1 influenza virus (aka bird flu), gonorrhea and chlamydia — provides invaluable insights into how diseases spread, identifies vulnerable populations, and helps assess the effectiveness of prevention measures or treatments[2]; and

Whereas, judicial mandates and executive orders that directly delay or restrict access to important health data directly conflict with medical ethics, as they force physicians to wait for potentially harmful outcomes; therefore be it

RESOLVED, that our American Medical Association advocate for the immediate removal of restrictions on the CDC, NIH and other pertinent federal agencies' to disseminate critical health information, as withholding such critical information from physicians impedes their ability to deliver the highest standard of care and exposes all patients who are receiving care to less than optimal outcomes (Directive to Take Action); and be it further

RESOLVED, that our AMA promote the recognition of the CDC, NIH, and other federal agencies in their efforts to minimize the risks of emerging infections, beginning this year and continuing into the future. (Directive to Take Action)

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

Received: 4/20/25

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2. Associated Press (February 11, 2025). Judge Tells Agencies To Restore Webpages and Data Removed After Trump's Executive Order. Retrieved February 17, 2025, https://apnews.com/article/trump-cdc-fda-doctors-for-america-5263fc6b6cbc723ca0c86c4460d02f33
3. Centers for Disease Control and Prevention (CDC). (n.d.). Tracking trends in disease incidence provides valuable data to understand how diseases spread, identify at-risk populations, and evaluate the effectiveness of prevention programs or treatments. Retrieved February 17, 2025, https://www.cdc.gov

## RELEVANT AMA POLICY

### H-440.813 Public Health Surveillance

1. Our American Medical Association recognizes public health surveillance as a core public health function that is essential to inform decision making, identify underlying causes and etiologies, and respond to acute, chronic, and emerging health threats.
2. Our AMA recognizes the important role that physicians play in public health surveillance through reporting diseases and conditions to public health authorities.
3. Our AMA encourages state legislatures to engage relevant state and national medical specialty societies as well as public health agencies when proposing mandatory reporting requirements to ensure they are based on scientific evidence and meet the needs of population health.
4. Our AMA recognizes the need for increased federal, state, and local funding to modernize our nation's public health data systems to improve the quality and timeliness of data.
5. Our AMA supports the CDC's data modernization initiative, including electronic case reporting, which alleviates the burden of case reporting on physicians through the automatic generation and transmission of case reports from electronic health records to public health agencies for review and action in accordance with applicable health care privacy and public health reporting laws.
6. Our AMA will advocate for incentives for physicians to upgrade their EHR systems to support electronic case reporting as well as incentives to submit case reports that are timely and complete.
7. Our AMA will share updates with physicians and medical societies on public health surveillance and the progress made toward implementing electronic case reporting.
8. Our AMA will advocate for increased federal coordination and funding to support the modernization and standardization of public health surveillance systems data collection by the Centers for Disease Control and Prevention and state and local health departments.
9. Our AMA supports data standardization that provides for minimum national standards, while preserving the ability of states and other entities to exceed national standards based on local needs and/or the presence of unexpected urgent situations.
[CSAPH Rep. 1, I-19; Reaffirmed: Res. 219, A-21; Appended: Alt. Res. 402, A-21; Modified: CSAPH Rep. 2, I-21]

### H-440.847 Pandemic Preparedness

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

personal protective equipment directly to tribal communities and the Indian Health Service for effective preparedness and to respond to a pandemic or other major public emergency.

5.urges the CDC to develop and disseminate electronic instructional resources on procedures to follow in an epidemic, pandemic, or other serious public health emergency, which are tailored to the needs of health care personnel in direct patient care settings;

6. supports the position that:

a. relevant national and state agencies (such as the CDC, NIH, and the state departments of health) continue to plan and test distribution activities in advance of a public health emergency, to assure that physicians, nurses, other health care personnel, and first responders having direct patient contact, receive any appropriate vaccination or medical countermeasure in a timely and efficient manner, in order to reassure them that they will have first priority in the event of such a pandemic.

b. such agencies should publicize now, in advance of any such pandemic, what the plan will be to provide immunization to health care providers.

7. will monitor progress in developing a contingency plan that addresses future vaccine production or distribution problems and in developing a plan to respond to a pandemic in the United States.

8. will encourage state and federal efforts to locate the manufacturing of goods used in healthcare and healthcare facilities in the United States.

9. will support federal efforts to encourage the purchase of domestically produced personal protective equipment.

[CSAPH Rep. 5, I-12; Reaffirmation A-15; Modified: Res. 415, A-21; Reaffirmed: CSAPH Rep. 1, I-22; Appended: Res. 924, I-22]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 230
(A-25)

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| Introduced by: | The Endocrine Society, American Association of Clinical Endocrinology, American Society for Reproductive Medicine, American Society for Metabolic and Bariatric Surgery, Obesity Medicine Association, American College of Physicians |
| Subject: | Advocating to Expand Private insurance Coverage of Anti-obesity Medications (AOM) |
| Referred to: | Reference Committee B |

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Whereas, the American Medical Association has declared that obesity is a disease[1]; and

Whereas, the Centers for Disease Control and Prevention (CDC) has reported that more than 2 in 5 U.S. adults have obesity[2]; and

Whereas, the CDC has reported health care for obesity is expensive for patients and the health care system. In 2019 dollars, annual medical costs for adults with obesity were $1,861 higher per person than adults with healthy weight. For adults with severe obesity, the excess costs were $3,097 per person. This accounts for nearly $173 billion in medical expenditures in 2019 dollars[3]; and

Whereas, the CDC has reported that many adults with obesity have other serious chronic diseases that are caused by obesity. For example, 58% of U.S. adults with obesity have high blood pressure, a risk factor for heart disease. Also, approximately 23% of U.S. adults with obesity have diabetes[4]; and

Whereas, clinical obesity across the lifespan continues to be a more serious problem with each passing year. Recent data show that obesity rates continue to be at record high levels with at least one in five adults in every U.S. state living with obesity[5]; and

Whereas, when combined with lifestyle and behavior changes, prescription medications help many people lose weight and maintain weight loss. On average, after 1 year, adults who take prescription medications as part of a lifestyle program lose 3% to 12% more of their starting body weight than people in a lifestyle program who do not take medication[6]; and

Whereas, Kaiser Family Foundation (KFF) analysis has found fewer than 20% of large employer firms currently do not cover GLP-1 drugs for weight loss and coverage in ACA Marketplace plans remains limited[7,8]; and

Whereas, tirzepatide has been shown to affect a mean weight reduction of 20.9% at 36 weeks and semaglutide has been shown to affect a mean weight reduction of 14.9% at 68 weeks 10[9,10]; therefore be it

RESOLVED, that our American Medical Association amend policy H-440.801, Advocacy Against Obesity-Related Bias by Insurance Providers, by addition to read as follows:

1. Our American Medical Association will urge individual state delegations to directly advocate for their state insurance agencies and insurance providers in their jurisdiction to:
    a. Revise their policies to ensure that bariatric surgery <u>is</u> covered for patients who meet the appropriate medical criteria.
    b. Eliminate criteria that place unnecessary time-based mandates that are not clinically supported nor directed by the patient's medical provider.
    c. Ensure that insurance policies in their states do not discriminate against potential metabolic surgery patients based on age, gender, race, ethnicity, socioeconomic status.
    d. Advocate for the cost-effectiveness of all **obesity** treatment modalities in reducing healthcare costs and improving patient outcomes.
    e. <u>Eliminate coverage exclusions for the pharmacologic treatment of obesity.</u>
    f. <u>Reduce the prior authorization burden for the coverage of anti-obesity medications, to include not requiring a new prior authorization for every dose change or requiring "step therapy".</u>
    g. <u>Support and cover chronic treatment with anti-obesity medications to maintain weight loss.</u>
    h. <u>Allow a patient's physician to prescribe anti-obesity medication and have it covered by insurance, without a requirement that patients must receive the prescription only from contracted disease management companies.</u>
2. Our AMA will support and provide resources to state delegations in their efforts to advocate for the reduction of bias against patients that suffer from **obesity** for the actions listed. (Modify Current HOD Policy)

Fiscal Note: Minimal – less than $1,000

Received: 4/21/25

**REFERENCES**

1. H-440.842.
2. Adult Obesity Facts. Centers for Disease Control and Prevention, Centers for Disease Control and Prevention, www.cdc.gov/obesity/adult-obesity-facts/index.html.
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4. New CDC Data Show Adult Obesity Prevalence Remains High. Centers for Disease Control and Prevention, Centers for Disease Control and Prevention, www.cdc.gov/media/releases/2024/p0912-adult-obesity.html.
5. New CDC Data Show Adult Obesity Prevalence Remains High. Centers for Disease Control and Prevention, Centers for Disease Control and Prevention, www.cdc.gov/media/releases/2024/p0912-adult-obesity.html.

6. Prescription Medications to Treat Overweight & Obesity – NIDDK. National Institute of Diabetes and Digestive and Kidney Diseases, U.S. Department of Health and Human Services, www.niddk.nih.gov/health-information/weight-management/prescription-medications-treat-overweight-obesity.
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9. Aronne LJ, Sattar N, Horn DB, et al. Continued Treatment with Tirzepatide for Maintenance of Weight Reduction in Adults With Obesity: The SURMOUNT-4 Randomized Clinical Trial. *JAMA.* 2024;331(1):38–48.
10. John P.H. Wilding, D.M., Rachel L. Batterham, M.B., B.S., Ph.D., et al. Once-Weekly Semaglutide in Adults with Overweight or Obesity. N Engl J Med 2021;384:989-1002.

**RELEVANT AMA POLICY:**

**H-440.842 Recognition of Obesity as a Disease**
Our American Medical Association recognizes obesity as a disease state with multiple pathophysiological aspects requiring a range of interventions to advance obesity treatment and prevention. [Res. 420, A-13Reaffirmed: CSAPH Rep. 08, A-23]

**H-440.801 Advocacy Against Obesity-Related Bias by Insurance Providers**
1. Our American Medical Association will urge individual state delegations to directly advocate for their state insurance agencies and insurance providers in their jurisdiction to:
    a. Revise their policies to ensure that bariatric surgery are covered for patients who meet the appropriate medical criteria.
    b. Eliminate criteria that place unnecessary time-based mandates that are not clinically supported nor directed by the patient's medical provider.
    c. Ensure that insurance policies in their states do not discriminate against potential metabolic surgery patients based on age, gender, race, ethnicity, socioeconomic status.
    d. Advocate for the cost-effectiveness of all obesity treatment modalities in reducing healthcare costs and improving patient outcomes.
2. Our AMA will support and provide resources to state delegations in their efforts to advocate for the reduction of bias against patients that suffer from obesity for the actions listed. [Res. 224, A-23]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 231
(A-25)

Introduced by: Washington State

Subject: Preventing Venue Shopping in Medical Liability to Protect Physician Practices and Access to Care

Referred to: Reference Committee B

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Whereas, venue shopping in medical liability cases occurs when plaintiffs' attorneys select jurisdictions perceived to be more favorable for large verdicts, leading to increased healthcare costs and higher burnout for physicians; and

Whereas, physicians practicing in rural hospitals often have fewer resources, limited staff, and less advanced medical equipment compared to those within larger healthcare systems, and venue shopping may cause these physicians to reduce services, relocate, or retire, which especially impacts access to care in underserved areas; and

Whereas, Philadelphia, the preferred venue of plaintiffs, saw 544 medical malpractice cases filed in 2023 up from 275 cases in 2022, following reversal of Rule 1006(a.1) in January 2023, which stopped venue shopping and frivolous lawsuits; and

Whereas, higher rates of hospital closures and financial challenges increase health disparities that disproportionately affect maternal and infant care in rural areas; and

Whereas, the American Medical Association advocates for a balanced and fair legal process that protects physicians from unnecessary liability risks and ensures continued access to quality care for our patients; therefore be it

RESOLVED, that our American Medical Association advocate that claims be filed in the county where the alleged medical liability occurred (Directive to Take Action); and be it further

RESOLVED, that our AMA study and report on the impact of venue rule changes on medical liability case filings, healthcare costs, and access to care, particularly in rural and underserved areas (Directive to Take Action); and be it further

RESOLVED, that our AMA work with state medical societies to develop model legislation that protects against venue shopping while ensuring fair access to the legal system for patients with legitimate claims. (Directive to Take Action)

Fiscal Note: Moderate – between $5,000 - $10,000

Received: 4/9/25

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 232
(A-25)

Introduced by: Women Physicians Section

Subject: Preservation of Medicaid

Referred to: Reference Committee B

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Whereas, Medicaid provides healthcare coverage to 80 million low-income Americans, including pregnant women, children, adults, seniors, people with disabilities, and LGBTQIA+ individuals[1]; and

Whereas, Medicaid improves health outcomes, with expansion linked to a 6% reduction in all-cause mortality, a 23% increase in self-reporting health as excellent, and 41% higher likelihood of having a usual care source[2–9]; and

Whereas, Medicaid finances 40% of all births (including nearly 50% of births in rural communities), insures 40% of individuals under 18 years of age, is the largest single payer for behavioral health services, including substance use disorder (SUD) treatment, and is the largest payer of long term care services in the United States[10–13]; and

Whereas, women physicians are more likely to serve patient populations who rely heavily on Medicaid funding and would be disproportionately impacted by federal funding cuts[14]; and

Whereas, previous efforts to cut Medicaid spending via work requirements did not increase employment and instead led to problems paying off medical debt, delayed care, and delayed taking medications due to cost[15,16]; and

Whereas, the federal government finances 69% of Medicaid nationally, ensuring states can provide care without excessive fiscal burden[17]; and

Whereas, reductions to federal funding of Medicaid or changes to Medicaid eligibility at the federal level would lead to substantial loss of coverage for millions of Americans; and

Whereas, U.S. Congress is considering cutting federal Medicaid spending by adopting a per-capita financing model, reducing the federal match rate, and imposing work requirements on certain enrollees —policies shown to force coverage reductions[18]; therefore be it

RESOLVED, that our American Medical Association make preservation of federal funding and eligibility for Medicaid an urgent and top legislative advocacy priority, effective immediately at the conclusion of the Annual 2025 House of Delegates Meeting (Directive to Take Action); and be it further

RESOLVED, that our AMA strongly opposes federal and state efforts to restrict eligibility and funding for all public health insurance programs, including Medicaid and CHIP. (New HOD Policy)

Fiscal Note: Moderate – between $5,000 - $10,000

Date Received: 04/21/2025

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2. Impact of the Medicaid Coverage Gap: Comparing States That Have and Have Not Expanded Eligibility. doi:10.26099/vad1-s645
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4. Chu RC, Peters C, Buchmueller T. Medicaid: The Health and Economic Benefits of Expanding Eligibility. Published online 2024.
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17. Williams E, Mudumala A, Rudowitz R, Published AB. Medicaid Financing: The Basics. KFF. January 29, 2025. Accessed February 17, 2025. https://www.kff.org/medicaid/issue-brief/medicaid-financing-the-basics/
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## RELEVANT AMA POLICY

### Medicaid Expansion D-290.979

1. Our American Medical Association, at the invitation of state medical societies, will work with state and specialty medical societies in advocating at the state level to expand Medicaid eligibility to 133% (138% FPL including the income disregard) of the Federal Poverty Level as authorized by the ACA and will advocate for an increase in Medicaid payments to physicians and improvements and innovations in Medicaid that will reduce administrative burdens and deliver healthcare services more effectively, even as coverage is expanded.
2. Our AMA will:
    a. continue to advocate strongly for expansion of the Medicaid program to all states and reaffirm existing policies D-290.979, H 290.965 and H-165.823.

b. work with interested state medical associations and national medical specialty societies to provide AMA resources on Medicaid expansion and covering the uninsured to health care professionals to inform the public of the importance of expanded health insurance coverage to all.

[Res. 809, I-12 Reaffirmed: CMS Rep. 02, A-29 Reaffirmed: CMS Rep. 5, I-20 Reaffirmed: CMS Rep. 3, A-21 Reaffirmed: CMS Rep. 9, A-21 Reaffirmed: CMS Rep. 3, I-21 Reaffirmed: Joint CMS/CSAPH Rep. 1, I-21 Appended: Res. 122, A-22]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 233
(A-25)

Introduced by: Young Physicians Section

Subject: Increasing Transparency of AMA Medicare Payment Reform Strategy

Referred to: Reference Committee B

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Whereas, the American Medical Association House of Delegates (HOD) recently identified Medicare payment reform as the top priority through a referendum; and

Whereas, since this resolution, the AMA has consistently communicated via emails and position statements that Medicare payment reform remains the top priority; and

Whereas, despite these communications, there appears to have been relatively little progress in advancing Medicare payment reform when compared to the extent of communication; and

Whereas, the continued need of substantial progress on Medicare payment reform necessitates an in-depth analysis to identify potential barriers and opportunities for enhancement of the current strategy; therefore be it

RESOLVED, that our American Medical Association provide a summary of findings and actionable recommendations from both internal and external advocacy consultants regarding Medicare payment reform. The report must primarily focus on barriers identified, gaps in the current strategy, and specific recommendations for improving and accelerating advocacy efforts (Directive to Take Action); and be it further

RESOLVED, that our AMA share with its members comprehensive reports on our Medicare payment reform advocacy efforts, including consultant findings on major barriers, strategy gaps, and recommendations for improvement, at both the Interim and Annual Meetings beginning at I-25, and more frequently as legislative dynamics dictate. (Directive to Take Action)

Fiscal Note: $108,308

Received: 04/21/2025

**REFERENCES**

American Medical Association, 2024. Medicare Physician Payment Reform Has Never Been More Urgent. Accessed 10/04/2024. https://www.ama-assn.org/about/leadership/medicare-physician-payment-reform-has-never-been-more-urgent

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 234
(A-25)

Introduced by: International Medical Graduates Section

Subject: Protection for International Medical Graduates

Referred to: Reference Committee B

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Whereas, the American Medical Association recognizes the contributions of international medical graduates (IMG) to US healthcare, to medical education, residency and fellowship programs, and patient care, especially in underserved areas[1]; and

Whereas, the majority of IMGs spend a large portion of their careers requiring non-immigrant visas, immigrant visas or other protective immigration statuses; and

Whereas, the AMA recognizes that immigrant status is a public health issue (D-350.975) and social determinant of health (H-65.938) significantly affecting persons physical and mental wellbeing with limited support systems (https://www.nydailynews.com/2021/07/17/nyc-doctor-suicides-raise-concerns-about-treatment-of-resident-physicians-at-bronx-hospital/); and

Whereas, immigration status is a tool that can be weaponized systemically to push IMGs to accept abusive contracts and discriminatory conditions, discourages IMGs from reporting and seeking help; and

Whereas, unannounced visits by Immigration and Customs Enforcement (ICE) agents to medical offices and hospitals can disrupt patient care, create undue anxiety, and interfere with the physician-patient relationship[2]; therefore be it

RESOLVED, that our American Medical Association supports the designation of medical or mental healthcare facilities, such as a hospital, doctor's office, health clinic, vaccination or testing site, urgent care center, site that serves pregnant individuals, or community health center as a protected area, avoiding, when possible, targeted immigration enforcement, in order to preserve the continuity of patient care and medical education (New HOD Policy); and be it further

RESOLVED, that our AMA work with relevant stakeholders to develop a confidential mechanism through which IMG physicians can report workplace immigration related interviews, enforcement actions, or audits, in order to identify and address potential instances of unfair treatment or targeting of IMG physicians. (Directive to Take Action)

Fiscal Note: Moderate – between $5,000 - $10,000

Received: 4/22/25

**REFERENCES**

1. D-255.980 Impact of Immigration Barriers on the Nation's Health | AMA [Internet]. [cited 2025 Feb 7]. Available from: https://policysearch.ama-assn.org/policyfinder/detail/Visa?uri=%2FAMADoc%2Fdirectives.xml-D-255.980.xml
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3. H175.997 Disruptive Visits to Medical Offices by Government Investigators and Agents AMA [Internet] [cited 2025 Feb 7]. Available from: https://www.ama-assn.org/system/files/2021-04/j21-bot07.pdf
4. H-255.988 AMA Principles on International Medical Graduates | AMA [Internet]. [cited 2025 Feb 7]. Available from: https://policysearch.ama-assn.org/policyfinder/detail/IMG?uri=%2FAMADoc%2FHOD.xml-0-1790.xml

## RELEVANT AMA POLICY

### Impact of Immigration Barriers on the Nation's Health D-255.980

1. Our American Medical Association recognizes the valuable contributions and affirms our support of international medical students and international medical graduates and their participation in U.S. medical schools, residency and fellowship training programs and in the practice of medicine.
2. Our AMA will oppose laws and regulations that would broadly deny entry or re-entry to the United States of persons who currently have legal visas, including permanent resident status (green card) and student visas, based on their country of origin and/or religion.
3. Our AMA will oppose policies that would broadly deny issuance of legal visas to persons based on their country of origin and/or religion.
4. Our AMA will advocate for the immediate reinstatement of premium processing of H-1B visas for physicians and trainees to prevent any negative impact on patient care.
5. Our AMA will advocate for the timely processing of visas for all physicians, including residents, fellows, and physicians in independent practice.
6. Our AMA will work with other stakeholders to study the current impact of immigration reform efforts on residency and fellowship programs, physician supply, and timely access of patients to health care throughout the U.S.
   (Alt. Res. 308, A-17; Modified: CME Rep. 01, A-18; Reaffirmation: A-19; Reaffirmed: CME Rep. 4, A-21; Reaffirmed: Res. 234, A-22; Reaffirmed: Res. 210, A-23)

### Visa Complications for IMGs in GME D-255.991

1. Our American Medical Association will work with the ECFMG to minimize delays in the visa process for International Medical Graduates applying for visas to enter the US for postgraduate medical training and/or medical practice promote regular communication between the Department of Homeland Security and AMA IMG representatives to address and discuss existing and evolving issues related to the immigration and registration process required for International Medical Graduates.
2. Our AMA work through the appropriate channels to assist residency program directors, as a group or individually, to establish effective contacts with the State Department and the Department of Homeland Security, in order to prioritize and expedite the necessary procedures for qualified residency applicants to reduce the uncertainty associated with considering a non-citizen or permanent resident IMG for a residency position.
   Our AMA International Medical Graduates Section will continue to monitor any H-1B visa denials as they relate to IMGs? inability to complete accredited GME programs.
3. Our AMA will study, in collaboration with the Educational Commission on Foreign Medical Graduates and the Accreditation Council for Graduate Medical Education, the frequency of such J-1 Visa reentry denials and its impact on patient care and residency training.
4. Our AMA will, in collaboration with other stakeholders, advocate for unfettered travel for IMGs for the duration of their legal stay in the US in order to complete their residency or fellowship training to prevent disruption of patient care.
   (Res. 844, I-03; Reaffirmation A-09; Reaffirmation I-10; Appended: CME Rep. 10, A-11; Appended: Res. 323, A-12; Reaffirmation: A-19; Reaffirmed: Res. 234, A-22)

**Disruptive Visits to Medical Offices by Government Investigators and Agents H-175.977**

1. Our American Medical Association supports legislation and/or other appropriate means to ensure that State and Federal investigators, and/or agents, give a physician written notice prior to a visit to a medical office, so that such visit may be scheduled upon mutual agreement at a time when patients are not present in the medical office.
2. Our AMA, in any circumstances which lawfully permit a visit to a medical office without notice, such as a search warrant, arrest warrant or subpoena, investigators and/or agents should be required to initially identify themselves to appropriate medical staff quietly and confidentially that allows the physician an opportunity to comply in a manner that is
least disruptive and threatening to the patients in the medical office.
3. Our AMA encourages physicians to report incidents of inappropriate intrusions into
their medical offices to the AMA's Office of the General Counsel and consider development of a hotline for implementation.
(Res. 211, A-99; Reaffirmation I-01; Reaffirmed: BOT Rep. 22, A-11; Reaffirmed: BOT Rep. 7, A-21)

**AMA Principles on International Medical Graduates H-255.988**

1. Our American Medical Association supports current U.S. visa and immigration requirements applicable to foreign national physicians who are graduates of medical schools other than those in the United States and Canada.
2. Our AMA supports current regulations governing the issuance of exchange visitor visas to foreign national IMGs, including the requirements for successful completion of the USMLE.
3. Our AMA reaffirms its policy that the U.S. and Canada medical schools be accredited by a nongovernmental accrediting body.
4. Our AMA supports cooperation in the collection and analysis of information on medical schools in nations other than the U.S. and Canada.
5. Our AMA supports continued cooperation with the ECFMG and other appropriate organizations to disseminate information to prospective and current students in foreign medical schools. An AMA member, who is an IMG, should be appointed regularly as one of the AMA's representatives to the ECFMG Board of Trustees.
6. Our AMA supports working with the Accreditation Council for Graduate Medical Education (ACGME) and the Federation of State Medical Boards (FSMB) to assure that institutions offering accredited residencies, residency program directors, and U.S. licensing authorities do not deviate from established standards when evaluating graduates of foreign medical schools.
7. In cooperation with the ACGME and the FSMB, our AMA supports only those modifications in established graduate medical education or licensing standards designed to enhance the quality of medical education and patient care.
8. Our AMA continues to support the activities of the ECFMG related to verification of education credentials and testing of IMGs.
9. Our AMA supports that special consideration be given to the limited number of IMGs who are refugees from foreign governments that refuse to provide pertinent information usually required to establish eligibility for residency training or licensure.
10. Our AMA supports that accreditation standards enhance the quality of patient care and medical education and not be used for purposes of regulating physician manpower.
11. Our AMA representatives to the ACGME, residency review committees and to the ECFMG should support AMA policy opposing discrimination. Medical school admissions officers and directors of residency programs should select applicants on the basis of merit, without considering status as an IMG or an ethnic name as a negative factor.
12. Our AMA supports the requirement that all medical school graduates complete at least one year of graduate medical education in an accredited U.S. program in order to qualify for full and unrestricted licensure. State medical licensing boards are encouraged to allow an alternate set of criteria for granting licensure in lieu of this requirement: completion of medical school and residency training outside the U.S.;
extensive U.S. medical practice; and evidence of good standing within the local medical community.

13. Our AMA supports publicizing existing policy concerning the granting of staff and clinical privileges in hospitals and other health facilities.
14. Our AMA supports the participation of all physicians, including graduates of foreign as well as U.S. and Canadian medical schools, in organized medicine.
15. Our AMA offers encouragement and assistance to state, county, and specialty medical societies in fostering greater membership among IMGs and their participation in leadership positions at all levels of organized medicine, including AMA committees and councils, the Accreditation Council for Graduate Medical Education and its review committees, the American Board of Medical Specialties and its specialty boards, and state boards of medicine, by providing guidelines and non-financial incentives, such as recognition for outstanding achievements by either individuals or organizations in promoting leadership among IMGs.
16. Our AMA supports studying the feasibility of conducting peer-to-peer membership recruitment efforts aimed at IMGs who are not AMA members.
17. Our AMA membership outreach to IMGs to include using its existing publications to highlight policies and activities of interest to IMGs, stressing the common concerns of all physicians; publicizing its many relevant resources to all physicians, especially to nonmember IMGs; identifying and publicizing AMA resources to respond to inquiries from IMGs; and expansion of its efforts to prepare and disseminate information about requirements for admission to accredited residency programs, the availability of positions, and the problems of becoming licensed and entering full and unrestricted medical practice in the U.S. that face IMGs. This information should be addressed to college students, high school and college advisors, and students in foreign medical schools.
18. Our AMA supports recognition of the common aims and goals of all physicians, particularly those practicing in the U.S., and support for including all physicians who are permanent residents of the U.S. in the mainstream of American medicine.
19. Our AMA supports its leadership role to promote the international exchange of medical knowledge as well as cultural understanding between the U.S. and other nations.
20. Our AMA supports institutions that sponsor exchange visitor programs in medical education, clinical medicine and public health to tailor programs for the individual visiting scholar that will meet the needs of the scholar, the institution, and the nation to which he will return.
21. Our AMA supports informing foreign national IMGs that the availability of training and practice opportunities in the U.S. is limited by the availability of fiscal and human resources to maintain the quality of medical education and patient care in the U.S., and that those IMGs who plan to return to their country of origin have the opportunity to obtain GME in the United States.
22. Our AMA supports U.S. medical schools offering admission with advanced standing, within the capabilities determined by each institution, to international medical students who satisfy the requirements of the institution for matriculation.
23. Our AMA supports the Federation of State Medical Boards, its member boards, and the ECFMG in their willingness to adjust their administrative procedures in processing IMG applications so that original documents do not have to be recertified in home countries when physicians apply for licenses in a second state.
24. Our AMA supports continued efforts to protect the rights and privileges of all physicians duly licensed in the U.S. regardless of ethnic or educational background and opposes any legislative efforts to discriminate against duly licensed physicians on the basis of ethnic or educational background.
25. Our AMA supports continued study of challenges and issues pertinent to IMGs as they affect our country's health care system and our physician workforce.
26. Our AMA supports advocacy to Congress to fund studies through appropriate agencies, such as the Department of Health and Human Services, to examine issues and experiences of IMGs and make recommendations for improvements.
(BOT Rep. Z, A-86; Reaffirmed: Res. 312, I-93; Modified: CME Rep. 2, A-03; Reaffirmation I-11; Reaffirmed: CME Rep. 1, I-13; Modified: BOT Rep. 25, A-15; Modified: CME Rep. 01, A-16; Appended: Res. 304, A-17; Modified: CME Rep. 01, I-17; Reaffirmation: A-19; Modified: CME Rep. 2, A-21; Modified: CME Rep. 1, A-22; Modified: CCB/CLRPD Rep. 1, A-22; Reaffirmed: CME Rep. 03, A-23)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 235
(A-25)

Introduced by: Association for Clinical Oncology, American College of Rheumatology

Subject: CMS Payment Monitoring Following Government Staff Reductions

Referred to: Reference Committee B

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Whereas, the Department of Health and Human Services (HHS) is implementing a large-scale restructuring, including a significant reduction in its workforce and plans to eliminate 10,000 employees in addition to 10,000 HHS employees who have already departed (20,000 total), thereby reducing the workforce from approximately 82,000 to 62,000; and

Whereas, the Centers for Medicare & Medicaid Services (CMS) initially eliminated 300 CMS positions, including at the Office of Program Operations and Local Engagement (OPOLE), which works with providers and health plans that serve Medicare recipients to ensure they're in compliance with CMS requirements and helps manage case work for Medicare Advantage (MA) and the Patient Protection and Affordable Care Act (ACA) Marketplace patients, which could impact providers' and patient access; and

Whereas, HHS also announced that it would consolidate the department's 28 divisions into 15 (including agencies such as CMS and the Food and Drug Administration (FDA), and HHS offices such as the Office of the Assistant Secretary of Legislation (ASL)), cut five of the 10 regional offices, and centralize core administrative functions; therefore be it

RESOLVED, that our American Medical Association will monitor federal staffing reductions with a focus on those at the Centers for Medicare & Medicaid Services (CMS) (Directive to Take Action); and be it further

RESOLVED, that our AMA offers a method whereby providers can report CMS payment delays and/or new or additional obstacles to timely receipt of reimbursement to our AMA, and that our AMA should use the information collected to inform advocacy efforts to protect physicians from unreasonable CMS payment delays and notify CMS of slowing payments and/or obstacles. (Directive to Take Action)

Fiscal Note: Moderate – between $5,000 - $10,000

Received: 4/22/25

**REFERENCES**

1. HHS's Restructuring: What Happens Next? - McDermott+
2. Layoffs begin at US health agencies | AP News
3. Widespread firings start at federal health agencies including many in leadership: Shots - Health News: NPR

## RELEVANT AMA POLICY

**Congressional Oversight Hearings and Legislative Reform of CMS H-330.910**
Our AMA will: (1) seek immediate and periodic Congressional oversight hearings of the CMS on issues related to the administration of the Medicare and Medicaid programs and additionally will seek legislation to reform CMS; and (2) undertake and support activities that would hold state and federal agencies, their contractors, and employees dealing with health care issues to the same level of accountability as are physicians.

**Physician Payment Reform H-390.849**

1. Our American Medical Association will advocate for the development and adoption of physician payment reforms that adhere to the following principles:
    a. Promote improved patient access to high-quality, cost-effective care.
    b. Be designed with input from the physician community.
    c. Ensure that physicians have an appropriate level of decision-making authority over bonus or shared-savings distributions.
    d. Not require budget neutrality within Medicare Part B.
    e. Be based on payment rates that are sufficient to cover the full cost of sustainable medical practice.
    f. Ensure reasonable implementation timeframes, with adequate support available to assist physicians with the implementation process.
    g. Make participation options available for varying practice sizes, patient mixes, specialties, and locales.
    h. Use adequate risk adjustment methodologies.
    i. Incorporate incentives large enough to merit additional investments by physicians.
    j. Provide patients with information and incentives to encourage appropriate utilization of medical care, including the use of preventive services and self-management protocols.
    k. Provide a mechanism to ensure that budget baselines are reevaluated at regular intervals and are reflective of trends in service utilization.
    l. Attribution processes should emphasize voluntary agreements between patients and physicians, minimize the use of algorithms or formulas, provide attribution information to physicians in a timely manner, and include formal mechanisms to allow physicians to verify and correct attribution data as necessary.
    m. Include ongoing evaluation processes to monitor the success of the reforms in achieving the goals of improving patient care and increasing the value of health care services.
2. Our AMA opposes bundling of payments in ways that limit medically necessary care, including institutional post-acute care, or otherwise interfere with a physician's ability to provide high quality care to patients.
3. Our AMA supports payment methodologies that redistribute Medicare payments among providers based on outcomes (including functional improvements, if appropriate), quality and risk-adjustment measures only if measures are scientifically valid, reliable, and consistent with national medical specialty society- developed clinical guidelines/standards.
4. Our AMA will continue to monitor health care delivery and physician payment reform activities and provide resources to help physicians understand and participate in these initiatives.
5. Our AMA supports the development of a public-private partnership for the purpose of validating statistical models used for risk adjustment.