AMA
AMERICAN MEDICAL ASSOCIATION

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INTEGRATED PHYSICIAN PRACTICE SECTION
Governing Council Report A
Annual 2025 Meeting

Access full text of resolutions/reports in the HOD meeting handbook.

Recommendations Key
Instructions for the delegate and alternate delegate are designated as follows:

- *Strongly support* – the delegate/alternate delegate shall support the resolution as written and actively speak in favor of the resolution
- *Support* – the delegate/alternate delegate shall support the resolution as written
- *Listen* – the delegate/alternate delegate is not instructed to take any action, however, may if they believe it is in the best interest of the Section
- *Refer* – the delegate/alternate delegate shall move to refer (the item goes to a Council) or refer for decision (item goes to the Board)
- *Amend* – the delegate/alternate delegate shall move to amend the resolution in the manner prescribed in Report A
- *Oppose* – the delegate/alternate delegate shall oppose the resolution as written
- *Strongly oppose* – the delegate/alternate delegate shall oppose the resolution as written and actively speak in opposition of the resolution

Some items may contain specific instructions not included among those listed above. In such cases, instructions to the delegate/alternate delegate are described in detail alongside the item of business.

Item #	Ref Com	Title and sponsor(s)	Proposed policy	Governing Council recommendations
1	E&B	BOT 26 – Using Person and Biological Data to Enhance Professional Wellbeing and Reduce Burnout	The Board of Trustees recommends that the following be adopted and the remainder of the report be filed. 1. With the aim of promoting physician well-being in the workplace, physician personal health information and/or biological data should be: a. Collected only if evidence supports that the specific data being collected is minimized to only that which is relevant and necessary to the development of interventions which promote physician well-being and reduce professional burnout; b. Collected only if physicians are informed whether the data is directly or indirectly identifiable; c. Collected only if physicians have the ability to opt-in or opt-out without retribution, penalty, or direct or indirect coercion; d. Collected only if physicians are able to provide informed consent prior to data acquisition and use; e. Collected only if physicians retain the option to opt-out at any time;	Delegate instructed to support, comment in HOD ORC.

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			f. Used only to ameliorate burnout-inducing working conditions. (New HOD Policy) 2. Any use of physician personal health information or biological data that is retaliatory or that perpetuates unjust biases should be avoided and prohibited. (New HOD Policy) 3. The second directive of Policy D-460.962 be rescinded having been accomplished by this report.	
2	E&B	CEJA 02 – Supporting Efforts to Strengthen Medical Staffs Through Collective Actions and/or Unionization	The Council on Ethical and Judicial Affairs recommends that the following recommendations be adopted and the remainder of the report be filed: 1. That Opinion 1.2.10 be amended by addition and deletion with a change in title as follows: Advocacy and Collective Actions by Physicians~~Political Action by Physicians~~ Like all Americans, physicians enjoy the right to advocate for change in law and policy, in the public arena, and within their institutions. Indeed, physicians have an ethical responsibility to seek change when they believe the requirements of law, ~~or~~ policy, or practice are contrary to the best interests of patients. However, advocacy actions should not put the wellbeing of patients in jeopardy. Collective action is one means by which physicians can advocate for patients, the health of communities, the profession, and their own health. Physicians have a responsibility to avoid disruption to patient care when engaging in any collective action. When considering collective actions that have the potential to be disruptive, whether aimed at changing the policies of government, the private sector, or their own institutions, there are additional considerations that should be addressed. These include avoiding harm to patients, minimizing the impact of actions on patient access to care, maintaining trust in the patient-physician relationship, fulfilling the responsibility to improve patient care, avoiding mental and physical harms to physicians, promoting physician wellbeing, upholding the values and integrity of the	Delegate instructed to listen.

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			profession, and considering alternative measures that could reasonably be expected to achieve similar results with less potential effect on patient and physician wellbeing. When considering participation ~~Physicians who participate~~ in advocacy activities, including collective actions: (a) ~~Ensure that the health of patients is not jeopardized, and that patient care is not compromised.~~ Physicians should recognize that, in pursuing their primary commitment to patients, physicians can, and at times may have an obligation to, engage in collective political action to advocate for changes in law and institutional policy aimed at promoting patient care and wellbeing. (b) ~~Avoid using disruptive means to press for reform. Strikes and other collective actions may reduce access to care, eliminate or delay needed care, and interfere with continuity of care and should not be used as a bargaining tactic. In rare circumstances, briefly limiting personal availability may be appropriate as a means of calling attention to the need for changes in patient care. Physicians should be aware that some actions may put them or their organizations at risk of violating antitrust laws or laws pertaining to medical licensure or malpractice.~~ Physicians may also engage in collective action to advocate for changes within their institutions, including changes in patient care practices, physician work conditions, health and wellbeing, and/or institutional culture that negatively affect patient care. (c) Physicians should refrain from collective action that could jeopardize the health of patients or compromise patient care. (d) Physicians may consider engaging in disruptive forms of collective action that do not compromise patient care only as a last resort, with the primary objective to improve patient care and outcomes by calling attention to and/or making needed changes in practices, protocols, incentives, expectations, structures, and/or institutional culture.	

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			(e) Disruptive actions, including strikes, that could directly compromise patient care should be avoided and should not be used solely for physician self-interest. (f) Physicians should avoid forming workplace or other alliances, such as unions, with workers colleagues and others who do not share physicians' primary and overriding commitment to patients. (g) Physicians should refrain from using undue influence or pressure colleagues punitive or coercive means to force others to participate in advocacy activities or collective actions, or to penalize others and should not punish colleagues, overtly or covertly, for deciding not to participate in such activities. 2. That Policy H-405.946(2) be rescinded as having been accomplished by this report. (Rescind AMA Policy)	
3	E&B	CEJA 05 – Protecting Physicians Who Engage in Contracts to Deliver Health Care Services	The Council on Ethical and Judicial Affairs recommends that Opinion 11.2.3, "Contracts to Deliver Health Care Services," be amended by addition and deletion as follows and the remainder of this report be filed: Prioritizing profits over patients is incompatible with physicians' ethical obligations. No part of the health care system that supports or delivers patient care should place profits over such care. Physicians have a fundamental ethical obligation to put the welfare of patients ahead of other considerations, including personal financial interests. This obligation requires ~~them to~~ that before entering into contracts to deliver health care services, physicians consider carefully the proposed contract to assure themselves that its terms and conditions ~~of contracts to deliver health care services before entering into such contracts to ensure that those contracts~~ do not create untenable conflicts of interest or compromise their ability to fulfill their ethical and professional obligations to patients. Those physicians who enter into contracts with corporate entities, such as private equity firms, management service organizations, professional services corporations, insurance companies, or pharmaceutical benefit managers, who act within their capacity as a physician, even as administrators or intermediaries, also have a duty to uphold the ethical obligations of the medical	Delegate instructed to support.

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			profession. Ongoing evolution in the health care system continues to bring changes to medicine, including changes in reimbursement mechanisms, models for health care delivery, restrictions on referral and use of services, clinical practice guidelines, and limitations on benefits packages. While these changes are intended to enhance quality, efficiency, and safety in health care, they can also put at risk physicians' ability to uphold professional ethical standards ~~of informed consent and fidelity to patients~~ and can impede physicians' freedom to exercise independent professional judgment and tailor care to meet the needs of individual patients. As physicians seek capital to support their practices or enter into various differently structured contracts to deliver health care services—with group practices, hospitals, health plans, investment firms, or other entities—they should be mindful that while ~~many~~ some arrangements have the potential to promote desired improvements in care, ~~some~~ other arrangements ~~also~~ have the potential to ~~impede~~ put patients' interests at risk and to interfere with physician autonomy. When contracting with entities, or having a representative do so on their behalf, to provide health care services, physicians should: (a) Carefully review the terms of proposed contracts, preferably with the advice of legal and ethics counsel, or have a representative do so on their behalf to assure themselves that the arrangement: (i) minimizes conflict of interest with respect to proposed reimbursement mechanisms, financial or performance incentives, restrictions on care, or other mechanisms intended to influence physicians' treatment recommendations or direct what care patients receive, in keeping with ethics guidance;	

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			(ii) does not compromise the physician's own financial well-being or ability to provide high-quality care through unrealistic expectations regarding utilization of services or terms that expose the physician to excessive financial risk; (iii) allows ensures the physician can to appropriately exercise professional judgment; (iv) includes a mechanism to address grievances and supports advocacy on behalf of individual patients; (v) is transparent and permits disclosure to patients.; (vi) enables physicians to have significant influence on, or preferably outright control of, decisions that impact practice staffing; (vii) prohibits the corporate practice of medicine. (b) Negotiate modification or removal of any terms that unduly compromise physicians' ability to uphold ethical or professional standards. When entering into contracts as employees, preferably with the advice of legal and ethics counsel, physicians should: (c) Advocate for contract provisions to specifically address and uphold physician ethics and professionalism. (d) Advocate that contract provisions affecting practice align with the professional and ethical obligations of physicians and negotiate to ensure that alignment. (e) Advocate that contracts do not require the physician to practice beyond their professional capacity and provide contractual avenues for addressing concerns related to good practice, including burnout or related issues.	

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			(f) Not enter into any contract that would require the physician to violate their professional ethical obligations. When contracted by a corporate entity involved in the delivery of health care services, physicians should: (g) Terminate any contract that requires the physician to violate their professional ethical obligations and report any known or suspected ethical violations through the appropriate oversight mechanisms.	
4	A	CMS 02 – Reconsidering the Affordable Care Act (ACA) Eligibility Firewall	The Council on Medical Service recommends that the following recommendations be adopted in lieu of Resolution 103-A-23, and that the remainder of the report be filed. 1. That it be the policy of our American Medical Association (AMA) that the Affordable Care Act (ACA) eligibility firewall not apply to individuals offered employer-sponsored coverage whose household incomes are at or below 200 percent of the federal poverty level, so they can receive federal premium tax credits and cost-sharing assistance if they opt to enroll in a marketplace health plan as an affordable alternative to their employer-based plan. (New HOD Policy) 2. That our AMA amend Policy H-165.843 by addition and deletion to read: Our AMA encourages employers to: a) promote greater individual choice and ownership of plans; b) implement plans to improve affordability of premiums and/or cost-sharing, especially expenses for employees with lower incomes and those who may qualify for Affordable Care Act marketplace plans based on affordability criteria; c) ~~help employees determine if their employer coverage offer makes them ineligible or eligible for federal marketplace subsidies~~ provide employees with user-friendly information regarding their eligibility for subsidized ACA marketplace plans based on their offer of employer-sponsored insurance; ~~b~~d) ~~enhance employee education regarding available health plan options and how to choose health plans that meet their needs~~ provide employees with information	Delegate instructed to support.

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			regarding available health plan options, including the plan's cost, network breadth, and prior authorization requirements, which will help them choose a plan that meets their needs; ~~c~~e) offer information and decision-making tools to assist employees in developing and managing their individual health care choices; ~~d~~f) support increased fairness and uniformity in the health insurance market; and ~~e~~g) promote mechanisms that encourage their employees to pre-fund future costs related to retiree health care and long-term care. (Modify HOD Policy) 3. That our AMA advocate that physician payments by health insurers participating in the ACA marketplace be sustainable, reflect the full cost of practice and the value of the care provided, include inflation-based updates, and pay no less than prevailing Medicare rates. (New HOD Policy)	
5	A	Res. 103 – Inadequate Reimbursement for Biosimilars (American Society for Gastrointestinal Endoscopy)	RESOLVED, that our American Medical Association work with stakeholders to advocate for legislation that will Amend Section 1847A(c)(3) of the Social Security Act to permanently remove manufacturer rebates from the ASP methodology for biologics. (Directive to Take Action)	Delegate instructed to listen, collaborate with the California delegation for improvements.
6	A	Res. 109 – Medicare Advantage Plans Double Standard (Indiana)	RESOLVED, that our American Medical Association seek legislation to require all payors, including Medicare Advantage plans, to use uniform payment denial appeals processes, which includes external review, for all appeals regardless of whether the physician or provider is contracted with the payor. (Directive to Take Action)	Delegate instructed to listen, review ORC and Ref Com reports.
7	A	Res. 111 – New Reimbursement System Needed for	RESOLVED, that our American Medical Association study the issue and report back the best options for achieving a new reimbursement system for rural hospital survival in our country. (Directive to Take Action)	Delegate instructed to listen.

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		Rural Hospital Survival (Mississippi)		
8	A	Res. 114 – An Assessment of Physician Support for Value-Based Payment Models and its Impact on Healthcare to Inform AMA Advocacy Efforts—A Survey (Private Practice Physicians Section)	RESOLVED, that our American Medical Association conducts a physician survey of adequate size and scope to ascertain the impact of value-based payment models on a wide spectrum of both employed and independent physician practices, exploring its specific effects on the quality of care physicians provide (i.e., help or harm quality), patient access to care (i.e., limit Medicare patients), physician professionalism (i.e., honoring patient preferences, managing conflict of interest), and adequacy of the physician workforce (i.e., availability of primary care, burnout, early retirement) to provide legislators a better understanding and inform future AMA advocacy efforts. (Directive to Take Action)	Delegate instructed to collaborate with PPPS Delegate.
9	B	Res. 208 – Binding Arbitration in Health Insurance Contracts (American Psychiatric Association)	RESOLVED, that our American Medical Association study the effects of binding arbitration in health insurance contracts with physicians. (Directive to Take Action)	Delegate instructed to support.
10	B	Res. 210 – Impact of Tariffs on Healthcare Access and Costs (American Society for Gastrointestinal Endoscopy)	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); 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);	Delegate instructed to support.

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			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); 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)	
11	B	Res. 218 – Distribution of Resident Slots Commensurate with Shortages (Medical Student Section)	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)	Delegate instructed to support.
12	B	Res. 220 – Strengthening AMA Policy on Noncompete Clauses in Ownership Transitions (New England)	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); 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); RESOLVED, that our AMA support policies that render any noncompete clause void if	Delegate instructed to listen.

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			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) 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)	
13	B	Res. 221 – Preservation of Medicaid (New England)	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); 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)	Delegate instructed to strongly support.
14	B	Res. 223 – Preservation of Medicaid (New York)	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); RESOLVED, that our AMA opposes any state or federal efforts to impose work requirements as a condition of Medicaid eligibility (New HOD Policy); RESOLVED, that our AMA opposes increasing cost-sharing requirements for Medicaid enrollees (New HOD Policy); RESOLVED, that our AMA makes preservation of federal funding and eligibility for Medicaid an urgent and top legislative advocacy priority (Directive to Take Action); RESOLVED, that our AMA strongly oppose federal and state efforts to restrict	Delegate instructed to strongly support.

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			eligibility and funding for all public health insurance programs, including Medicaid and CHIP. (New HOD Policy)	
15	B	Res. 232 – Preservation of Medicaid (Women Physicians Section)	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); 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)	Delegate instructed to strongly support.
16	C	Res. 305 – Curricular Structure Reform to Support Physician and Trainee Well-Being (Medical Student Section)	RESOLVED, that our American Medical Association promote a systems approach to student well-being and support research into the impact (beneficial or deleterious) of various educational structures and processes, including but not limited to, the use of third-party resources and distance learning, upon learner well-being and self-efficacy (New HOD Policy); RESOLVED, that our AMA discourage physician, resident/fellow, and medical student burnout prevention programs which impose inflexible requirements, mandatory assignments, or punitive measures, except where required by law (New HOD Policy); RESOLVED, that our AMA support evidence-based burnout prevention programs that: a) prioritize personal time for participants; b) facilitate voluntary participation in activities relating to personal values, leisure, hobbies, group and peer engagement, and self-care; and c) are integrated directly into medical school and residency program curricula, and; D) provide multiple options to complete any expectations or activities flexibly (New HOD Policy); RESOLVED, that our AMA support the implementation of evidence-based evaluation strategies in the ChangeMedEd Initiative for the ongoing assessment and improvement of burnout prevention programs. (New HOD Policy)	Delegate instructed to listen.

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17	D	CSAPH 02 – Addressing Social Determinants of Health Through Closed Loop Referral Systems	The Council on Science and Public Health recommends that the following be adopted, and the remainder of the report be filed. 1. Our AMA acknowledges closed loop referral systems are a mechanism to address social determinants of health (SDOH) through a community-level, system approach that connects clinicians and the patients they serve to health care services and social support services. 2. Our AMA supports the continued evaluation of closed loop referral systems in addressing SDOH and health-related social needs to identify best practices and improve health outcomes. 3. Our AMA supports continued research to streamline the workflow processes and ensure two-way communication for closed loop referrals between health care systems and community-based organizations to address SDOH and health-related social needs. 4. Our AMA supports: (a) using data to foster hospitals, health insurance, private sector, philanthropic organizations, and community- and faith-based organizations investment in addressing SDOH, (b) reducing barriers to using grants to address SDOH, and (c) promoting federal- and state- initiatives to expand funding for SDOH health-related social needs interventions. (New HOD Policy)	Delegate instructed to strongly support.
18	D	Res. 426 – Addressing Patient Safety and Environmental Stewardship of Single-Use and Reusable Medical Devices (Organized Medical Staff Section)	RESOLVED, that our American Medical Association work with interested stakeholders to develop and/or confirm a comprehensive cradle-to-grave life-cycle assessment for single-use versus reusable medical devices factoring safety relative to cost effectiveness and environmental impact (Directive to Take Action); RESOLVED, that our AMA advocate for federal regulation on medical devices that addresses patient safety as it intersects with fiscal and environmental considerations and promotes the use of a “gold standard” life-cycle assessment for single-use and reusable medical devices (Directive to Take Action).	Delegate instructed to listen.

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19	E	CSAPH 08 – Explainability of Artificial/Augmented Intelligence and Machine Learning Algorithms	The Council on Science and Public Health recommends that the following be adopted and that the remainder of the report be filed: 1. To maximize the impact and trustworthiness of augmented intelligence and machine-learning (AI/ML) tools in clinical settings, our AMA recognizes that: a. Explainable AI with safety and efficacy data should be the expected form of AI tools for clinical applications, and exceptions should be rare and require at minimum safety and efficacy data prior to their adoption or regulatory approval. b. To be considered "explainable," an AI device's explanation of how it arrived at its output must be interpretable and actionable by a trained expert. Claims that an algorithm is explainable should be adjudicated only by independent third parties, such as regulatory agencies or appropriate specialty societies, rather than by declaration from its developer. c. Explainability should not be used as a substitute for other means of establishing safety and efficacy of AI tools, such as through randomized clinical trials. d. Concerns of intellectual property (IP) infringement, when provided as rationale for not explaining how an AI device created its output, does not nullify a patient's right to transparency and autonomy in medical decision-making. While intellectual property should be afforded a certain level of protection, concerns of infringement should not outweigh the need for explainability for AI with medical applications. (New HOD Policy) 2. That our American Medical Association will collaborate with experts and interested parties to develop and disseminate a list of definitions for key concepts related to medical AI and its oversight. (Directive to Take Action) 3. That policies H-480.931, "Assessing the Intersection Between AI and Health Care," H-480.939, "Augmented Intelligence in Health Care," and H-480.940, "Augmented Intelligence in Health Care" be reaffirmed. (Reaffirm HOD Policy)	Delegate instructed to seek referral to AI Task Force.
20	G	BOT 19 – Using Personal and Biological Data to	The Board of Trustees recommends that the first directive of Policy D-460.962 be rescinded having been accomplished by this report and that the remainder of the report be filed.	Delegate instructed to support, voice appreciation for the

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		Enhance Professional Wellbeing and Reduce Burnout		update and hope to see more in the future.
21	G	CMS 03 – Regulation of Corporate Investment in the Health Care Sector	*Refer to report CMS 03 for recommendations.*	Delegate instructed to listen.
22	G	CMS 07 – Impact of Patient Non-Adherence on Quality Scores	The Council on Medical Service recommends that the following be adopted, and the remainder of the report be filed: 1. That our American Medical Association (AMA) support the removal of physician outcome scores that are unfairly tied to patient non-adherence. (New HOD Policy) 2. That our AMA support the development of models that provide guidance for physicians, medical practices, and health care teams to improve patient adherence in an individualized, continuous, and multidisciplinary way. (New HOD Policy) 3. That our AMA support additional research to understand the intricacies of non-adherence and potential models/strategies to improve adherence. (New HOD Policy) 4. That our AMA amend Policy D-450.958, "Pain Medicine," by addition and deletion, including a change in title: PAIN MEDICINE AND PATIENT ADHERENCE IN QUALITY CARE ASSESSMENT, D-450.958 Our AMA: (1) ~~continues to advocate that the Centers for Medicare & Medicaid Services (CMS) remove the pain survey questions from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS); (2)~~ continues to advocate that the Centers for Medicare & Medicaid Services ~~CMS~~ not incorporate items linked to pain scores and adherence to physician recommendations as part of	Delegate instructed to listen.

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			the Consumer Assessment of Healthcare Providers and Systems ~~CAHPS~~ Clinician and Group Surveys and the Hospital Consumer Assessment of Healthcare Providers and Systems scores in future surveys; and (2) encourages hospitals, clinics, health plans, health systems, and academic medical centers not to link physician compensation, employment retention or promotion, faculty retention or promotion, and provider network participation to patient satisfaction scores relating to the evaluation and management of pain and better adherence to physician recommendations. (Revise HOD Policy) 5. That our AMA reaffirm Policy H-450.947, which outlines the Principles for Pay-for-Performance and Guidelines for Pay-for-Performance. (Reaffirm HOD Policy) 6. That our AMA reaffirm Policy H-450.966, which provides the principles to consider while assessing quality and performance measures and the need for the AMA and state medical societies to be involved in the assessment, as well as the development and implementation, of quality measures. (Reaffirm HOD Policy) 7. That our AMA reaffirm Policy H-390.837, which encourages the Centers for Medicare & Medicaid Services (CMS) to revise the Merit-Based Incentive Payment System to a simplified quality and payment system, asks the AMA to advocate for appropriate scoring adjustments for physicians treating high risk beneficiaries in the Medicare Access and CHIP Reauthorization Act (MACRA) program, and urges CMS to continue studying whether MACRA creates a disincentive for physicians to provide care to sicker Medicare patients. (Reaffirm HOD Policy) 8. Rescind Policy D-450.950, as having been completed with this report. (Rescind HOD Policy)	
23	G	Res. 704 – Mitigating the Impact of Excessive Prior	RESOLVED, that our American Medical Association actively and urgently generate a prior authorization database collecting and analyzing data including metrics reflecting denial rates, care delays, impact on patient care, and associated cost adversely	Delegate instructed to listen.

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		Authorization Processes (American Association of Gynecologic Laparoscopists)	affecting patients and physicians across major healthcare insurers (Directive to Take Action); and be it further RESOLVED, that our AMA working with legal experts, determine whether and to what extent it may be appropriate to initiate and/or support a class action lawsuit against insurance companies based on the identified prior authorization data, and, if so appropriate, collaborate with patient advocacy groups to support potential lawsuits (Directive to Take Action); and be it further RESOLVED, that our AMA strengthen and expand the existing public awareness campaign including but not limited to social media, print media, and editorials to highlight the negative impacts of abusive and obstructive prior-authorization requirements on patient care, and educate physicians AND patients on their rights and available resources. (Directive to Take Action)	
24	G	Res. 706 – Increasing Transparency Surrounding Medicare Advantage Plans (Illinois)	RESOLVED, that our American Medical Association support policy to increase financial transparency of Medicare Advantage plans, including mandated public reporting of prior authorization practices, claim denials, marketing expenses, supplemental benefits, provider contracts, and provider networks. (New HOD Policy)	Delegate instructed to listen.

END