

DISCLAIMER

The following is a preliminary report of actions taken by the House of Delegates at its 2025 Meeting and should not be considered final. Only the Official Proceedings of the House of Delegates reflect official policy of the Association.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (A-25)

Final Report of Reference Committee B

Amar Kelkar, MD, Chair

Your Reference Committee recommends the following consent calendar for acceptance:

RECOMMENDED FOR ADOPTION

1. Board of Trustees Report 13 — The Uniform Health-Care Decisions Act
2. Board of Trustees Report 14 — A Public Health-Centered Criminal Justice System
3. Board of Trustees Report 16 — Research Correcting Political Misinformation and Disinformation on Scope of Practice
4. Board of Trustees Report 17 — Antidiscrimination Protections for LGBTQ+ Youth in Foster Care
5. Resolution 208 — Binding Arbitration in Health Insurance Contracts
6. Resolution 211 — Support for State Provider and Managed Care Organization Taxes to Sustain Federal Resolution Medicaid Matching Funding
7. Resolution 220 — Strengthening AMA Policy on Noncompete Clauses in Ownership Transitions
8. Resolution 233 — Increasing Transparency of AMA Medicare Payment Reform Strategy
9. Resolution 235 — CMS Payment Monitoring Following Government Staff Reductions
10. Resolution 239 — Ensuring Accessibility and Inclusivity of CDC Resources
11. Resolution 240 — Preserving the Specialty of Occupational and Environmental Medicine

RECOMMENDED FOR ADOPTION AS AMENDED

12. Board of Trustees Report 09 — Council on Legislation Sunset Review of 2015 House Policies
13. Board of Trustees Report 21 — Advocacy for More Stringent Regulations/Restrictions on Distribution of Cannabis
14. Resolution 201 — Inclusion of DICOM Imaging in Federal Interoperability Standards
15. Resolution 203 — Supporting SUPPORT Act modifications to enhance care of patients with chronic pain
16. Resolution 204 — Protecting the Prescriptive Authority of Plenary Licensed Physicians
17. Resolution 210 — Impact of Tariffs on Healthcare Access and Costs

- 18. Resolution 214 — United Health Care and InterQual Monopoly
- 19. Resolution 215 — Support for Changing Standards for Minors Working in Agriculture
- 20. Resolution 216 — Support for Aging-Out Foster Youth with Mental Health and Psychotropic Needs
- 21. Resolution 217 — Regulation and Oversight of the Troubled Teen Industry
- 22. Resolution 222 — Need for Separate H1B Pathway for IMG Doctors in the USA
- 23. Resolution 228 — CHIP Coverage of OTC Medications
- 24. Resolution 229 — Guaranteeing Timely Delivery and Accessibility of Federal Health Data
- 25. Resolution 234 — Protection for International Medical Graduates
- 26. Resolution 238 — Preserving Accreditation Standards on Diversity, Equity, and Inclusion
- 27. Resolution 241 — Opposition to the Decertification of Independent Universities from the Student and Exchange Visitor Program
- 28. Resolution 242 — Protecting Evidence-Based Medicine, Public Health Infrastructure and Biomedical Research from Politicized Attacks

RECOMMENDED FOR ADOPTION IN LIEU OF

- 29. *Resolution 202 — Preservation of the CDC Epilepsy Program Workforce and Infrastructure
- 30. Resolution 205 — AMA Support for Continuance of the Section 1115 - Social Security Act, Medicaid Waiver Program
- Resolution 206 — AMA Support for Renewal of Section 1115 - Social Security Act, Medicaid Waiver Demonstration Projects Supporting Food and Nutrition Services
- 31. *Resolution 207 — Abolishing Venue Shopping
- Resolution 231 — Preventing Venue Shopping in Medical Liability to Protect Physician Practices and Access to Care
- 32. *Resolution 219 — Opposing Unwarranted National Institutes of Health Research Institute Restructuring
- 33. *Resolution 221 — Preservation of Medicaid
- Resolution 223 — Preservation of Medicaid
- Resolution 232 — Preservation of Medicaid
- Resolution 236 — Preservation of Medicaid*
- 34. *Resolution 237- Urgent Advocacy to Restore J-1 Visa Processing for International Medical Graduate Physician

RECOMMENDED FOR REFERRAL

- 35. Resolution 209 — Reducing Risk of Federal Investigation or Prosecution for Prescribing Controlled Resolution Addiction Medications for Legitimate Medical Purposes
- 36. Resolution 212 — Setting Standards for Forensic Toxicology Laboratories Used in Litigation
- 37. Resolution 230 — Advocating to expand private insurance coverage of anti-obesity medications (AOM)

RECOMMENDATION FOR REAFFIRMATION IN LIEU OF

38. Resolution 213 — Emergency Department Designation Requires Physician on Site
39. Resolution 218 — Distribution of Resident Slots Commensurate with Shortages
40. Resolution 224 — Support SAVE Plan and Public Service Loan Forgiveness (PLSF) Applications
41. Resolution 225 — The Private Practice Physicians in the Community
42. Resolution 226 — Regulations for Algorithmic-Based Health Insurance Utilization Review
43. Resolution 227 — Payment Recoupment—Let Sanity Prevail

RECOMMENDED FOR ADOPTION**(1) BOARD OF TRUSTEES REPORT 13 — THE UNIFORM HEALTH-CARE DECISIONS ACT****RECOMMENDATION:**

Your Reference Committee recommends that Board of Trustees Report 13 be adopted, and the remainder of the Report be filed.

HOD ACTION: Board of Trustees Report 13 referred.

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)

Your Reference Committee heard limited testimony on Board of Trustees Report 13. Your Reference Committee heard testimony that was supportive of the preliminary Reference Committee Recommendations and that the AMA should not broadly endorse Uniform Law Commission's Uniform Health Care Decision Act because some provisions conflict with existing AMA policies in important ways. Your Reference Committee also heard testimony supporting the Board's recommendations due to concerns with the Uniform Health Care Decision Act's treatment of mental health directives. Additional testimony was provided in support of referral to ensure AMA policy adequately addressed these important issues; however, the overwhelming majority of the testimony was in support of adoption of Board of Trustees Report 13 as written. Therefore, your Reference Committee recommends that Board of Trustees Report 13 be adopted, and the remainder of the report be filed.

(2) BOARD OF TRUSTEES REPORT 14 — A PUBLIC
HEALTH-CENTERED CRIMINAL JUSTICE SYSTEM

RECOMMENDATION:

Your Reference Committee recommends that Board of
Trustees Report 14 be adopted, and the remainder of the
Report be filed.

**HOD ACTION: Board of Trustees 14 adopted and the
remainder of the Report filed.**

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-80.998, "Ending Money Bail to Decrease Burden on Lower Income Communities" (Reaffirm HOD Policy)

Your Reference Committee heard supportive testimony on Board of Trustees Report 14. Your Reference Committee heard testimony highlighting the negative public health impacts of prolonged incarceration on individuals. Your Reference Committee considered an amendment that was offered to eliminate certain types of automatic sentencing policies, such as "three strikes" types of laws. Your Reference Committee points out that, while the Report provided background about these laws, the Report ultimately did not make a specific recommendation regarding such laws. Your Reference Committee notes, however, that recommendations in the Report broadly call for our AMA to support ongoing review of sentencing and judicial discretion—two elements that accomplish the intent of the proffered amendments. Your Reference Committee also points out that "three strikes" type of laws are just one type of automatic sentencing, and the Board's recommendations provide our AMA with the ability to consider the individual and public health effects of a broader range of automatic sentencing policies. Therefore, your Reference Committee

1 recommends that Board of Trustees Report 14 be adopted, and the remainder of the
2 report be filed.

3
4 (3) BOARD OF TRUSTEES REPORT 16 — RESEARCH
5 CORRECTING POLITICAL MISINFORMATION AND
6 DISINFORMATION ON SCOPE OF PRACTICE

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8 RECOMMENDATION:

9
10 Your Reference Committee recommends that Board of
11 Trustees Report 16 be adopted, and the remainder of the
12 Report be filed.

13
14 **HOD ACTION: Board of Trustees Report 16 adopted and**
15 **the remainder of the Report filed.**

16
17 The Board of Trustees recommends the following recommendation be adopted and the
18 remainder of the report be filed:

19
20 That our American Medical Association rescind Policy D-405.968, "Research Correcting
21 Political Misinformation and Disinformation on Scope of Practice." (Rescind HOD Policy)

22
23 Your Reference Committee heard limited, but entirely supportive testimony for Board of
24 Trustees Report 16. Testimony highlighted excitement surrounding the outcomes of
25 current AMA field research being conducted in the realm of misinformation and
26 disinformation as it relates to scope of practice. Therefore, your Reference Committee
27 recommends that Board of Trustees Report 16 be adopted, and the remainder of the
28 report be filed.

29
30 (4) BOARD OF TRUSTEES REPORT 17 —
31 ANTIDISCRIMINATION PROTECTIONS FOR LGBTQ+
32 YOUTH IN FOSTER CARE

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34 RECOMMENDATION:

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36 Your Reference Committee recommends that Board of
37 Trustees Report 17 be adopted, and the remainder of the
38 Report be filed.

39
40 **HOD ACTION: Board of Trustees Report 17 referred.**

41
42 The Board therefore recommends that Resolve 2 of Resolution 224-A-24 be adopted and
43 the remainder of the report be filed:

- 44
45 1. That our AMA support efforts by the Department of Health and Human Services
46 and other appropriate stakeholders to establish a reporting mechanism for the
47 collection of anonymized and aggregated sexual orientation and gender identity
48 data in the Adoption and Foster Care Analysis and Reporting System only when
49 strong privacy protections exist. (New HOD Policy)

1 Your Reference Committee heard mostly supportive testimony for Board of Trustees
2 Report 17. Testimony highlighted the benefits of having Sexual Orientation and Gender
3 Identity (SOGI) data for foster youth, but noted that this was only true if the privacy of
4 these individuals is carefully protected. While the reporting requirements apply primarily
5 to state and Tribal entities, your Reference Committee heard some concerns about the
6 burden on smaller entities, highlighting the need for federal guidance, technical
7 assistance, and funding. Your Reference Committee heard testimony raising privacy
8 concerns and recommending that the resolution be changed to require that foster youth
9 consent to the collection of their information. However, the language of the resolution
10 includes guardrails such as requiring that data be anonymized and aggregated, and it is
11 already a common practice for foster systems to collect this information. Therefore, your
12 Reference Committee recommends that Board of Trustees Report 17 be adopted, and the
13 remainder of the report be filed.

14
15 (5) RESOLUTION 208 — BINDING ARBITRATION IN
16 HEALTH INSURANCE CONTRACTS

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18 RECOMMENDATION:

19
20 Your Reference Committee recommends that
21 Resolution 208 be adopted.

22
23 **HOD ACTION: Resolution 208 adopted.**

24
25 RESOLVED, that our American Medical Association study the effects of binding arbitration
26 in health insurance contracts with physicians. (Directive to Take Action)

27
28 Your Reference Committee heard supportive testimony for Resolution 208. Testimony
29 highlighted concerns that binding arbitration clauses limit physicians' legal recourse,
30 reduce transparency, and can disproportionately favor insurers. Given the potential
31 implications for physician practice sustainability and patient care, your Reference
32 Committee agrees that this issue warrants further investigation. Therefore, your Reference
33 Committee recommends that Resolution 208 be adopted.

(6) RESOLUTION 211 — SUPPORT FOR STATE PROVIDER
AND MANAGED CARE ORGANIZATION TAXES TO
SUSTAIN FEDERAL RESOLUTION MEDICAID
MATCHING FUNDING

RECOMMENDATION:

Your Reference Committee recommends that Resolution
211 be adopted.

HOD ACTION: Resolution 211 adopted.

RESOLVED, that our American Medical Association (AMA) 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 AMA policy H-385.925 be amended 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 AMA policy D-165.961 be amended 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 policy H-385.941 be amended 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

1 providers; and (3) urges Congress to appropriate sufficient funds to enable the CMS and
2 its carriers to carry out their statutorily required functions. (Modify Current HOD Policy)

3
4 Your Reference Committee heard mostly supportive testimony for this resolution,
5 emphasizing that provider and managed care organization (MCO) taxes are essential
6 mechanisms used by states to secure federal Medicaid matching funds. Testimony
7 consistently underscored that these financing tools help sustain access to care and
8 support physician payment rates without directly taxing individual physicians. Your
9 Reference Committee heard additional testimony that these taxes are constitutionally
10 embedded or long-standing components of Medicaid financing in many states, and that
11 their elimination could significantly reduce Medicaid coverage and funding. Your
12 Reference Committee also heard that current federal proposals threaten to restrict these
13 mechanisms, and that the term “provider tax” is often misinterpreted as applying to
14 individual physicians, even though in practice it targets institutional providers. Testimony
15 urged our AMA to clarify its position, prevent misapplication, and support states in
16 preserving these funding tools. Your Reference Committee also heard limited testimony
17 in opposition, expressing concern that the resolution reinforces a flawed and overly
18 complex Medicaid financing model. Testimony cautioned that such mechanisms could be
19 misinterpreted, contradict AMA policy supporting adequate payment, and divert attention
20 from broader reforms needed to strengthen Medicaid sustainably. Your Reference
21 Committee noted that there is no clear AMA policy addressing this specific Medicaid
22 financing mechanism and believes this resolution appropriately fills that gap. Therefore,
23 your Reference Committee recommends that Resolution 211 be adopted.

24
25 (7) RESOLUTION 220 — STRENGTHENING AMA POLICY
26 ON NONCOMPETE CLAUSES IN OWNERSHIP
27 TRANSITIONS

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29 RECOMMENDATION:

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31 Your Reference Committee recommends that Resolution
32 220 be adopted.

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34 **HOD ACTION: Resolution 220 adopted.**

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

41
42 RESOLVED, that our AMA advocate at both the state and federal levels for legislative and
43 regulatory solutions that prohibit the assignment or automatic transfer of noncompete
44 clauses in the event of ownership transitions, mergers, or acquisitions, thereby preventing
45 such clauses from being imposed on physicians without fresh contract negotiations;
46 (Directive to Take Action) and be it further

47
48 RESOLVED, that our AMA support policies that render any noncompete clause void if the
49 physician is dismissed by the employer or group, whether under the old or new ownership,
50 and support amendments to state laws to that effect; (New HOD Policy) and be it further

1 RESOLVED, that our AMA support that all physicians be provided with clear,
2 comprehensible disclosures regarding any noncompete or assignment clauses contained
3 in contracts, including detailed explanations of how such clauses would (or would not) be
4 applied in the event of a merger, acquisition, or other ownership change.(New HOD Policy)
5

6 Your Reference Committee heard testimony unanimously in support of Resolution 220.
7 Testimony agreed that non-compete clauses hinder physician mobility, compromise
8 patient care, and should be addressed through policy changes. Some testimony
9 acknowledged that there may be a small role for non-competes in protecting small, private
10 practices but additional testimony noted that since this resolution supports new contract
11 negotiations when there is a merger or sale that this would help protect small private
12 practices. Your Reference Committee heard testimony recommending that the third
13 resolved clause be amended to exclude dismissals that are “for cause;” however, the
14 majority of the testimony supported Resolution 220 as written. Additionally, your
15 Reference Committee notes that this resolution as written focused only on ownership
16 transitions where “for cause” dismissals may have a different context than what was
17 discussed in testimony. Therefore, your Reference Committee recommends that
18 Resolution 220 be adopted.
19

20 (8) RESOLUTION 233 — INCREASING TRANSPARENCY OF
21 AMA MEDICARE PAYMENT REFORM STRATEGY
22

23 RECOMMENDATION:
24

25 Your Reference Committee recommends that Resolution
26 233 be adopted.
27

28 **HOD ACTION: Resolution 233 adopted.**
29

30 RESOLVED, that our American Medical Association provide a summary of findings and
31 actionable recommendations from both internal and external advocacy consultants
32 regarding Medicare payment reform. The report must primarily focus on barriers
33 identified, gaps in the current strategy, and specific recommendations for improving and
34 accelerating advocacy efforts; (Directive to Take Action) and be it further
35

36 RESOLVED, that our AMA share with its members comprehensive reports on our
37 Medicare payment reform advocacy efforts, including consultant findings on major
38 barriers, strategy gaps, and recommendations for improvement, at both the Interim and
39 Annual Meetings beginning at I-25, and more frequently as legislative dynamics dictate.
40 (Directive to Take Action)
41

42 Your Reference Committee heard testimony overwhelmingly in support of adopting
43 Resolution 233 and in opposition to reaffirming existing policy. Your Reference Committee
44 agrees and therefore recommends that Resolution 233 be adopted.

(9) RESOLUTION 235 — CMS PAYMENT MONITORING
FOLLOWING GOVERNMENT STAFF REDUCTIONS

RECOMMENDATION:

Your Reference Committee recommends that Resolution
235 be adopted.

HOD ACTION: Resolution 235 adopted.

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)

Your Reference Committee heard testimony in strong support of Resolution 235, which directs our AMA to monitor federal staffing reductions, particularly at the Centers for Medicare and Medicaid Services (CMS), and to establish a reporting mechanism for physicians to share information about payment delays and new administrative obstacles. Your Reference Committee heard that recent restructuring at the Department of Health and Human Services (HHS) could significantly reduce CMS staffing levels, raising concerns about the agency's ability to maintain timely reimbursement and support critical functions. Your Reference Committee heard that a reporting pathway would help our AMA identify and document real-time issues that threaten physician practice sustainability and patient access to care.

Additional testimony was provided that even small CMS staffing changes can have significant consequences, including reimbursement delays and instability for independent and safety-net practices. Your Reference Committee also heard testimony that HHS has projected a 25 percent workforce reduction, reinforcing the urgency of equipping our AMA with timely data to advocate for reliable operations and public health infrastructure. Testimony noted that while physicians are paid by Medicare Administrative Contractors (intermediaries) and not directly by CMS, federal staffing reductions can still disrupt the payment process and increase administrative burdens on practices.

Your Reference Committee agrees that this resolution would strengthen our AMA's advocacy by providing timely data and aligns with our efforts to protect physicians from unnecessary administrative burdens. Therefore, your Reference Committee recommends that Resolution 235 be adopted.

(10) RESOLUTION 239 — ENSURING ACCESSIBILITY AND
INCLUSIVITY OF CDC RESOURCES

RECOMMENDATION:

Your Reference Committee recommends that Resolution
239 be adopted.

HOD ACTION: Resolution 239 adopted.

RESOLVED, that our American Medical Association encourage the Centers for Disease Control and Prevention to maintain essential medical and public health resources that remain evidence based on their website for continued accessibility to clinicians and patients. (Directive to Take Action)

Your Reference Committee heard generally positive testimony in favor of maintaining evidence-based public health information and resources on the website of the Centers for Disease Control and Prevention (CDC). Your Reference Committee also heard testimony that Resolution 229 covers the same ground as Resolution 239, and that the two resolutions could be considered together. However, additional testimony from the resolution author advocated for keeping the resolutions separate since Resolution 239 is specific to the maintenance of evidence-based resources on the CDC website. Your Reference Committee agrees. Therefore, your Reference Committee recommends that Resolution 239 be adopted.

(11) RESOLUTION 240 — PRESERVING THE SPECIALITY OF
OCCUPATIONAL AND ENVIRONMENTAL MEDICINE

RECOMMENDATION:

Your Reference Committee recommends that Resolution
240 be adopted.

HOD ACTION: Resolution 240 adopted.

RESOLVED, that our American Medical Association advocate for National Institute for Occupational Safety and Health (NIOSH) and other federal and non-federal funding mechanisms for continued graduate medical education for OEM in order to maintain and improve the health, safety and productivity of the workforce and the quality, sustainability, and safety of the environment. (Directive to Take Action)

1 Your Reference Committee heard strong testimony in support of Resolution 240.
2 Testimony focused on the critical role played by the National Institute for Occupational
3 Safety and Health (NIOSH) in the sustainability of the occupational and environment
4 medicine (OEM) specialty, the unique ability of OEM specialists to detect workplace
5 hazards and guide workers to resources such as workers' compensation, and the
6 widespread problem of workplace injuries. Testimony acknowledged existing needs within
7 OEM. Supporters of the resolution argued that shortages within OEM are harming patient
8 access to care and preventing effective preventive medicine, and as such, believe that
9 this specialty should be prioritized in terms of funding. Your Reference Committee heard
10 testimony recommending that existing AMA policy relating to graduate medical education
11 be reaffirmed in lieu of the proposed resolution, but testimony responding to this proposed
12 amendment noted that OEM residencies currently face funding cuts due to their
13 residencies being funded mainly through NIOSH. Your Reference Committee agrees.
14 Therefore, your Reference Committee recommends that Resolution 240 be adopted.

RECOMMENDED FOR ADOPTION AS AMENDED

(12) **BOARD OF TRUSTEES REPORT 09 — COUNCIL ON
LEGISLATION SUNSET REVIEW OF 2015 HOUSE
POLICIES**

RECOMMENDATION A:

Your Reference Committee recommends that the Recommendation of Board of Trustees Report 9 be amended by addition to read as follows:

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, except for Policy D-40.990, which should be retained, and the remainder of this report be filed.

RECOMMENDATION B:

Your Reference Committee recommends that the title of Policy D-40.990 be changed to read as follows:

**SUPPORT FOR PATHWAYS FOR VETERANS TO
TRANSITION TO PARAMEDICS****RECOMMENDATION C:**

Your Reference Committee recommends that the title of Policy D-260.993 be changed to read as follows:

LABORATORY REPORTING BURDENS**RECOMMENDATION D:**

Your Reference Committee recommends that Policy D-265.990 be amended by addition and deletion to read as follows:

Our AMA will make available, but not as a matter of advocacy priority, model anti-SLAPP legislation protecting ~~physicians~~ physicians' First Amendment rights in the context of proceedings relating to quality of health care.

RECOMMENDATION E:

Your Reference Committee recommends that Board of Trustees Report 9 be adopted as amended and that the remainder of the Report be filed.

**HOD ACTION: Board of Trustees 9 adopted as amended
and the remainder of the Report filed.**

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.

Your Reference Committee heard testimony that Board of Trustees Report 9 should be adopted with a few noted amendments. There was testimony recommending that Policy D-40.990 and D-260.993 be retained with a change to the title to delete the reference to a specific bill. Your Reference Committee agrees and recommends changing the title of Policy D-40.990 to "Support for Pathways for Veterans to Transition to Paramedics," and changing the title of Policy D-260.993 to "Laboratory Reporting Burdens." There was also testimony pointing out a typo in the original language of Policy D-265.990 where a question mark was included after "physicians" instead of an apostrophe. Finally, there was testimony in support of retaining Policy D-180.998, noting a recent news article that the Trump Administration intends to reconsider mental health parity and addiction equity regulations. However, your Reference Committee determined that other existing AMA policies specifically cover mental health and substance use disorder parity (see: [H-185.974](#), "Parity for Mental Health and Substance Use Disorders in Health Insurance Programs;" [H-185.916](#), "Expanding Parity Protections and Coverage of Mental Health and Substance Use Disorder Care;" [D-185.971](#), "Studying Avenues for Parity in Mental Health & Substance Use Coverage;" [H-345.975](#), "Maintaining Mental Health Services by States;" and [H-95.914](#), "Opioid Mitigation") and, since the directive in Policy D-180.998 has been achieved, it should be rescinded. Therefore, your Reference Committee recommends that the Board of Trustees Report 9 be adopted as amended, and that the remainder of the Report be filed.

(13) BOARD OF TRUSTEES REPORT 21 — ADVOCACY FOR
MORE STRINGENT REGULATIONS / RESTRICTIONS
ON DISTRIBUTION OF CANNABIS

RECOMMENDATION A:

Your Reference Committee recommends that
Recommendation 2(b) be amended by addition to read as
follows:

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 as well as
avenues for legal and financial penalties for marketing to
youth;

RECOMMENDATION B:

Your Reference Committee recommends that
Recommendation 2(c) be amended by deletion to read as
follows:

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;~~

RECOMMENDATION C:

Your Reference Committee recommends that Board of
Trustees Report 21 be adopted as amended and the
remainder of the Report be filed.

RECOMMENDATION D:

Your Reference Committee recommends that the title of
Board of Trustees Report 21 be changed to read as follows:

**ADVOCACY FOR MORE PROTECTIVE REGULATIONS
ON DISTRIBUTION OF CANNABIS**

**HOD ACTION: Board of Trustees Report 21 be adopted as
amended and the remainder of the Report filed.**

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

- 3
4 1. That our American Medical Association (AMA) will advocate that any monies paid
5 to the states, received as a result of a settlement or judgment, or other financial
6 arrangement or agreement as a result of litigation for cannabis-related harms or
7 violations of law, be used exclusively for research, education, prevention, and
8 treatment of cannabis-related harms, as well as expanding physician training
9 opportunities to provide clinical experience in the screening, diagnosis, and
10 treatment of cannabis misuse and cannabis use disorder. (New HOD Policy)
11
- 12 2. That our AMA supports legislation and/or regulation of all cannabis products that:
13
 - 14 a. prohibits cannabis use in all places that tobacco use is prohibited, including in
15 hospitals and other places in which health care is delivered;
 - 16 b. applies the same marketing and sales restrictions that are applied to tobacco
17 cigarettes, including prohibitions on television advertising, product placement
18 in television and films, and the use of celebrity spokespeople;
 - 19 c. prohibits product claims of reduced risk or effectiveness as tobacco cessation
20 tools, until such time that credible evidence is available, evaluated, and
21 supported by the FDA;
 - 22 d. requires the use of secure, child- and tamper-proof packaging and design, and
23 safety labeling on all cannabis products;
 - 24 e. establishes manufacturing and product (including e-liquids) standards for
25 identity, strength, purity, packaging, and labeling with instructions and
26 contraindications for use;
 - 27 f. requires transparency and disclosure concerning product design, contents,
28 and emissions; and
 - 29 g. prohibits the use of characterizing flavors that may enhance the appeal of such
30 products to youth. (New HOD Policy)
31
- 32 3. That our AMA encourage state medical associations to strengthen existing
33 cannabis marketing and advertising restrictions, including consideration of
34 prohibitions on marketing and advertising to children. (New HOD Policy)
35
- 36 4. That our AMA support the review of conditions that states have approved to
37 authorize cannabis for medical use and recommend the removal of those
38 conditions without scientifically valid and well-controlled clinical trials supporting
39 the use of cannabis. (New HOD Policy)
40
- 41 5. That Policy H-95.923, entitled "Taxes on Cannabis Products" be reaffirmed.
42 (Reaffirm HOD Policy)
43
- 44 6. That Policy D-95.954, entitled "Advocacy for More Stringent
45 Regulations/Restrictions on the Distribution of Cannabis," be rescinded. (Rescind
46 HOD Policy)

1 Your Reference Committee heard supportive testimony for BOT Report 21. Your
2 Reference Committee heard testimony highlighting the public health harms from cannabis
3 use. Your Committee considered a proposed amendment and agreed that removing the
4 words “restriction” and “stringent” from the title more accurately reflects the policy’s intent
5 to protect public health. The Committee also received an amendment, which it ultimately
6 supported in part, adding language regarding legal and financial penalties for marketing
7 to youth, and recognizing that enforceable mechanisms are essential to prevent youth-
8 targeted advertising. However, your Reference Committee felt that certain aspects of the
9 proposed amendment would unnecessarily narrow the scope of the policy. It was
10 determined that maintaining inclusive language covering all forms of cannabis, including
11 smoked, inhaled, and edible, would best preserve the policy’s public health focus. Your
12 Reference Committee also agreed with testimony to strike language suggesting that
13 cannabis products should be considered as tobacco cessation tools if there was “credible
14 evidence is available, evaluated, and supported by the FDA” of such cannabis products.
15 Therefore, your Reference Committee recommends that the recommendations contained
16 in Board of Trustees Report 21 be adopted as amended, and that the remainder of the
17 report be filed.

(14) RESOLUTION 201 — INCLUSION OF DICOM IMAGING IN
FEDERAL INTEROPERABILITY STANDARDS

RECOMMENDATION A:

Your Reference Committee recommends that the first
resolve of Resolution 201 be amended by addition and
deletion to read as follows:

RESOLVED, that our AMA American Medical Association
work with other interested specialty and state medical
societies to support the addition of Digital Imaging and
Communications in Medicine (DICOM) standard imaging to
the federal interoperability standards, namely the United
States Core Data for Interoperability (USCDI), to promote
standardized, interoperable image sharing across
healthcare systems; and be it further

RECOMMENDATION B:

Your Reference Committee recommends that the second
resolve of Resolution 201 be amended by addition and
deletion to read as follows:

RESOLVED, that our AMA support ~~advocate for~~ policies
and regulations requiring electronic health record (EHR)
vendors, and imaging archive system vendors, and imaging
information technology exchange service vendors to
support the secure, efficient, and interoperable exchange of
DICOM imaging data between healthcare entities.

RECOMMENDATION C:

Your Reference Committee recommends that Resolution
201 be adopted as amended.

RECOMMENDATION D:

Your Reference Committee recommends that the title of
Resolution 201 be changed to read as follows:

**INCLUSION OF DIGITAL IMAGING AND
COMMUNICATIONS IN MEDICINE (DICOM) IMAGING IN
FEDERAL INTEROPERABILITY STANDARDS**

HOD ACTION: Resolution 201 adopted as amended.

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

5
6 RESOLVED, that our AMA advocate for policies and regulations requiring EHR and
7 imaging archive system vendors to support the secure, efficient, and interoperable
8 exchange of DICOM imaging data between healthcare entities. (Directive to Take Action)

9
10 Your Reference Committee heard testimony in opposition to the preliminary report
11 recommendation and in strong support of amended language for Resolution 201.
12 Testimony provided by the authors expressed that imaging remains excluded from the
13 federal standards that govern clinical data exchange, which creates a critical gap that
14 burdens patients, delays care, and leads to unnecessary repeat imaging and radiation
15 exposure. Testimony agreed with friendly amendments to language that included
16 “specialty and state medical societies,” and spelled out Digital Imaging and
17 Communications in Medicine (DICOM) imaging in the US Core Data for Interoperability
18 (USCDI) and electronic health records (EHR). However, testimony respectfully disagreed
19 with proposed amendments to exclude imaging archive system vendors and viewed that
20 as significantly weakening the resolution. Testimony emphasized that the 21st Century
21 CURES Act has requirements in place that mandate that health data be accessible and
22 shareable amongst diverse platforms. However, additional testimony noted that due to the
23 HITECH Act, since radiologists are not considered to be patient-facing, they were granted
24 an exemption in CMS’s reporting program. This exemption has allowed DICOM imaging
25 to remain separate from USCDI up to this point in time. Your Reference Committee heard
26 that this exemption has caused significant problems for radiologists and other physicians
27 when trying to access imaging that is vital to patient care in a timely manner. To remedy
28 this issue, multiple amendments were offered. Your Reference Committee ultimately
29 accepted an amendment that received significant supportive testimony. Therefore, your
30 Reference Committee recommends that Resolution 201 be amended in lieu of adoption.

(15) RESOLUTION 203 — SUPPORTING SUPPORT ACT
MODIFICATIONS TO ENHANCE CARE OF PATIENTS
WITH CHRONIC PAIN

RECOMMENDATION A:

Your Reference Committee recommends that Resolution 203 be amended by addition and deletion to read as follows:

RESOLVED, that our ~~AMA American Medical Association~~ advocate for legislation allowing ~~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.

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 203 be adopted as amended.

RECOMMENDATION C:

Your Reference Committee recommends that the title of Resolution 203 be changed to read as follows:

**COMPOUNDED SYRINGE DELIVERY TO PHYSICIAN
PRACTICES FOR INTRATHECAL THERAPY**

HOD ACTION: Resolution 203 adopted as amended with a change of title.

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)

Your Reference Committee heard supportive testimony in favor of Resolution 203 that emphasized the need for a legislative fix to restore safe and effective access to compounded intrathecal medications. Testimony provided a detailed rationale for the resolution, citing unintended consequences of the SUPPORT Act that now require patients to personally receive syringes of controlled substances—posing safety, logistical, and compliance concerns. Testimony further highlighted [multispecialty endorsements of a fix](#) for this issue, noting that our AMA has advocated directly to the Drug Enforcement Administration (DEA) and the US Department of Justice (DOJ), who acknowledge the issue but believe only Congress can resolve it. Your Reference Committee heard testimony indicating that [a legislative fix supported by the AMA is included in the current SUPPORT Act reauthorization](#) that directly addresses these concerns. Conversely, some testimony raised concerns about unintended consequences reminiscent of white bagging practices, warning of risks to patient safety, increased inventory costs, and insurer abuse if medications were delivered outside standard distribution channels. Your Reference

1 Committee also received an amendment, that was supported by multiple testifiers, which
2 proposed removing the specific legislative reference while preserving the intent of the
3 Resolution. Therefore, your Reference Committee recommends that Resolution 203 be
4 adopted as amended.

5
6 (16) RESOLUTION 204 — PROTECTING THE PRESCRIPTIVE
7 AUTHORITY OF PLENARY LICENSED PHYSICIANS

8
9 RECOMMENDATION A:

10
11 Your Reference Committee recommends that the fifth
12 resolve of Resolution 204 be amended by addition and
13 deletion to read as follows:

14
15 RESOLVED, that our AMA encourage interprofessional
16 collaboration to clarify scope-of-practice boundaries,
17 educate interested parties ~~stakeholders~~ on the legal
18 authority of plenary licensure, and promote policies that
19 ensure timely patient access to physician-directed therapy
20 led care.

21
22 RECOMMENDATION B:

23
24 Your Reference Committee recommends that Resolution
25 204 be adopted as amended.

26
27 **HOD ACTION: Resolution 204 adopted as amended.**

28
29 RESOLVED, that our American Medical Association study the national prevalence and
30 patterns of pharmacists refusing to fill valid prescriptions from plenary licensed physicians,
31 including impact on patient outcomes and prescriber autonomy (Directive to Take Action);
32 and be it further

33
34 RESOLVED, that our AMA work with state medical boards, pharmacy boards, and
35 appropriate federal agencies to protect the authority of plenary licensed physicians to
36 prescribe all legal medications in accordance with their training and medical judgment
37 (Directive to Take Action); and be it further

38
39 RESOLVED, that our AMA reaffirm and publicize existing policy opposing unauthorized
40 medication substitution, inappropriate pharmacy inquiries, and unauthorized treatment
41 modification by pharmacists (Directive to Take Action); and be it further

42
43 RESOLVED, that our AMA support legislation or regulatory action requiring pharmacists
44 and pharmacy chains to either fill a valid prescription or immediately refer the patient to
45 an alternative dispensing pharmacy, with notification to the prescribing physician
46 (Directive to Take Action); and be it further

47
48 RESOLVED, that our AMA encourage interprofessional collaboration to clarify scope-of-
49 practice boundaries, educate stakeholders on the legal authority of plenary licensure, and

1 promote policies that ensure timely patient access to physician-directed therapy (New
2 HOD Policy).

3
4 Your Reference Committee heard unanimous supportive testimony in favor of the spirit of
5 Resolution 204. Testimony universally acknowledged that while pharmacists play an
6 important role as part of a physician-led team, they should not have the authority to
7 unilaterally withhold medication from patients after it has been prescribed by a physician.
8 An amendment was proposed to add that “scope of practice shall be defined by
9 physicians” however, it was noted that scope of practice is determined by each State
10 Board of Medical Examiners, which may include non-physician members. Another
11 amendment was offered to revise the phrase “physician-directed care” to “physician-led
12 care” to better align with existing AMA advocacy language and communication efforts.
13 Your Reference Committee also notes that AMA has existing policy on pharmacy intrusion
14 into medical practice (including but not limited to [H-35.961](#), AMA Response to Pharmacy
15 Intrusion Into Medical Practice) that further supports the sentiment in Resolution 204 and
16 negates the need for further amendments. Therefore, your Reference Committee
17 recommends that Resolution 204 be adopted as amended.

(17) RESOLUTION 210 — IMPACT OF TARIFFS ON
HEALTHCARE ACCESS AND COSTS

RECOMMENDATION A:

Your Reference Committee recommends that the second
resolve of Resolution 210 be deleted.

~~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; and be it further~~

RECOMMENDATION B:

Your Reference Committee recommends that the third
resolve of Resolution 210 be amended by addition and
deletion to read as follows:

~~RESOLVED, that our AMA support legislative efforts aimed
at mitigating the negative effects of tariffs on the healthcare
system, ensuring that patient care, medical supplies, and
pharmaceuticals remains accessible and affordable,; and
be it further~~

RECOMMENDATION C:

Your Reference Committee recommends that the fourth
resolve of Resolution 210 be deleted.

~~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.~~

RECOMMENDATION D:

Your Reference Committee recommends that Resolution
210 be adopted as amended.

HOD ACTION: Resolution 210 adopted as amended.

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

4
5 RESOLVED, that our AMA engage with relevant stakeholders, including policymakers and
6 industry leaders, to advocate for trade policies that do not adversely affect the affordability
7 and availability of medical supplies and pharmaceuticals; (Directive to Take Action) and
8 be it further

9
10 RESOLVED, that our AMA support legislative efforts aimed at mitigating the negative
11 effects of tariffs on the healthcare system, ensuring that patient care remains accessible
12 and affordable; (Directive to Take Action) and be it further

13
14 RESOLVED, that our AMA conduct a study evaluating the short- and long-term impacts
15 of U.S. tariffs on the healthcare delivery system, including effects on cost, supply chains,
16 patient outcomes, and healthcare disparities, and, given the urgency associated with the
17 issue, report its findings no later than the November 2025 interim meeting of the House of
18 Delegates. (Directive to Take Action)

19
20 Your Reference Committee heard mostly supportive testimony regarding Resolution 210.
21 Your Reference Committee heard that increased tariffs have the potential to cause health
22 care costs to rise, hurting patient access to care and practice sustainability. Other
23 testimony noted that the Centers for Medicare & Medicaid Services (CMS) will rely on
24 input and advocacy from interested parties like our AMA to keep track of the increased
25 costs of tariffed imported medical supplies. Your Reference Committee also heard
26 testimony that our AMA lacks the expertise needed to effectively advocate on trade policy
27 and that the study of short-term and long-term effects of tariffs on the health care delivery
28 system, proposed by the fourth resolved clause, is neither necessary nor feasible for our
29 AMA to conduct effectively. In alignment with this reasoning, multiple amendments were
30 offered to delete the fourth resolved clause. Amendments were also offered to the third
31 resolved clause to make it more expansive. Therefore, your Reference Committee
32 recommends that Resolution 210 be adopted as amended.

1 (18) RESOLUTION 214 — UNITED HEALTH CARE AND
2 INTERQUAL MONOPOLY
3

4 RECOMMENDATION A:
5

6 Your Reference Committee recommends that Resolution
7 214 be adopted.
8

9 RECOMMENDATION B:
10

11 Your Reference Committee recommends that the title of
12 Resolution 214 be changed to read as follows:
13

14 **MANAGED CARE UTILIZATION REVIEW SYSTEMS**
15

16 **HOD ACTION: Resolution 214 adopted with a change of**
17 **title.**
18

19 RESOLVED, that our American Medical Association oppose managed care utilization
20 review systems and tools that have anticompetitive effects, create undue influence over
21 medical necessity criteria, or negatively impact fair access to the delivery and payment of
22 medical services. (New HOD Policy)
23

24 Your Reference Committee heard unanimous support for the spirit of Resolution 214,
25 which opposes anticompetitive managed care utilization review systems that restrict fair
26 access to medical services. Your Reference Committee heard testimony emphasizing the
27 need for antitrust action and AMA advocacy to protect patient care from restrictive
28 insurance policies. One commenter raised concern with the title of the resolution and
29 suggested a title that better reflects the broader focus of the resolution beyond the entities
30 named in the original title. Your Reference Committee agrees and therefore recommends
31 that Resolution 214 be adopted as amended with a change in title.

(19) RESOLUTION 215 — SUPPORT FOR CHANGING
STANDARDS FOR MINORS WORKING IN
AGRICULTURE

RECOMMENDATION A:

Your Reference Committee recommends that Resolution 215 be amended by addition and deletion to read as follows:

RESOLVED, that our ~~AMA American Medical Association~~ strongly supports federal and state efforts to strengthen ensure that child labor protections by implementing effective mechanisms, including increasing employer penalties uniformly apply to children working in agriculture, including raising the, maintaining a minimum age of employment, enforcing work hour restrictions, and extending workplace health and safety standards, such as protections against exposures to hazardous substances and unsafe equipment, to all minors, including those working in agriculture.

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 215 be adopted as amended.

RECOMMENDATION C:

Your Reference Committee recommends that the title of Resolution 215 be changed to read as follows:

**STRENGTHENING CHILD LABOR PROTECTIONS FOR
WORKING MINORS**

**HOD ACTION: Resolution 215 adopted as amended with a
change of title.**

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)

Your Reference Committee heard testimony in favor of Resolution 215. Testimony was unanimously in support of the resolution and spoke to the importance of child labor protections. Your Reference Committee heard testimony that children who work in the agricultural sector face particular danger, and are often less protected than minors who work in other sectors, due to an existing legal framework that applies fewer protections to children in the agricultural sector compared to other sectors. Testimony also noted that some states are actively rolling back labor protections for minors. Your Reference Committee also heard that children from low-income, migrant, and Latine communities are

1 disproportionately exploited under existing labor laws. A clarifying amendment was offered
2 by the author of the original resolution. Therefore, your Reference Committee
3 recommends that Resolution 215 be adopted as amended with a change in title.

4
5 (20) RESOLUTION 216 — SUPPORT FOR AGING-OUT
6 FOSTER YOUTH WITH MENTAL HEALTH AND
7 PSYCHOTROPIC NEEDS

8
9 RECOMMENDATION A:

10
11 Your Reference Committee recommends that Resolution
12 216 be amended by addition and deletion to read as follows:

13
14 RESOLVED, that our ~~AMA American Medical Association~~
15 support federal and state initiatives aimed at increasing
16 funding and enhancing accessibility to services designed to
17 help youths as they transition out of foster care; especially
18 for youths requiring comprehensive mental health support,
19 and, when clinically indicated, and access to psychotropic
20 medications—or other treatment recommended by their
21 physician as part of an overall treatment plan.

22
23 RECOMMENDATION B:

24
25 Your Reference Committee recommends that Resolution
26 216 be adopted as amended.

27
28 RECOMMENDATION C:

29
30 Your Reference Committee recommends that the title of
31 Resolution 216 be changed to read as follows:

32
33 **SUPPORT FOR AGING-OUT FOSTER YOUTH WITH**
34 **MENTAL HEALTH NEEDS**

35
36 **HOD ACTION: Resolution 216 adopted as amended with a**
37 **change of title.**

38
39 RESOLVED, that our American Medical Association support federal and state initiatives
40 aimed at increasing funding and enhancing accessibility to services designed to help
41 youths as they transition out of foster care; especially for youths requiring mental health
42 support and access to psychotropic medications. (New HOD Policy)

43
44 Your Reference Committee heard testimony in favor of Resolution 216. Testimony noted
45 that youth aging out of foster care face special challenges and are at heightened risk for
46 mental health problems and substance use disorders. Additional testimony noted that
47 special programs (such as the Transition Housing Program and the John H Chafee
48 Program for Successful Transition to Adulthood) provide valuable supports and services
49 to youth transitioning from foster care, but that funding for many of these programs has
50 remained flat despite increasing demand. Two amendments were offered that would

broaden the scope of the initiatives supported by the resolution to include support for transition age youth who require access to any kind of medication or treatment recommended by their physician. Additional testimony was received that supported the amended language but noted that the title no longer matched the resolved clauses and as such a new title was needed. Therefore, your Reference Committee recommends that Resolution 216 be adopted as amended with a change in title.

(21) RESOLUTION 217 — REGULATION AND OVERSIGHT
OF THE TROUBLED TEEN INDUSTRY

RECOMMENDATION A:

Your Reference Committee recommends that proposed new item 3 of Policy H-60.896 be amended by addition and deletion to read as follows:

Our AMA **a)** opposes the use of any non-evidence-based therapies, and any abusive measures, in Youth Residential and Other Treatment Programs. **b)** and supports that only appropriately qualified and certified child and adolescent medical and mental health professionals provide clinical services to participants, and **c)** supports oversight and review by licensed physicians, mental health professionals, and any other appropriate healthcare professionals.

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 217 be adopted as amended.

HOD ACTION: Resolution 217 adopted as amended.

RESOLVED, that our 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

- 1 only appropriately qualified and certified child and adolescent medical and mental
 2 health professionals provide services to participants, and support oversight and
 3 review by licensed physicians, mental health professionals, and any other
 4 appropriate healthcare professionals
 5
 6 4. Our AMA supports efforts to improve information sharing between states on
 7 promising practices for preventing and addressing maltreatment in residential
 8 facilities. (Modify Current HOD Policy)
 9

10 Your Reference Committee heard testimony in strong support of Resolution 217, which
 11 calls for greater oversight and regulation of the adolescent therapeutic service industry to
 12 address the issue of unregulated youth programs that often employ punitive rather than
 13 therapeutic interventions. On balance, the testimony underscored strong support for
 14 regulating youth programs, preventing abusive practices, and ensuring evidence-based
 15 care. While some commenters suggested amendments to refine the resolution's
 16 language, all contributors agree on the urgency of reform. Finally, your Reference
 17 Committee heard testimony recommending removing the phrase "Troubled Teen Industry"
 18 in the title of this resolution. However, your Reference Committee notes that because this
 19 resolution is amending existing policy, H-60.896 "Youth Residential Treatment Program
 20 Regulation", the resolution title itself will not be reflected in Policy Finder, and therefore
 21 such an amendment is not necessary. Additional testimony was offered proposing
 22 grammatical changes to your Reference Committee's proposed amendment. Therefore,
 23 your Reference Committee recommends that Resolution 217 be adopted as amended.
 24

25 (22) RESOLUTION 222 — NEED FOR SEPARATE H1B
 26 PATHWAY FOR IMG DOCTORS IN THE USA
 27

28 RECOMMENDATION A:
 29

30 Your Reference Committee recommends that Resolution
 31 222 be amended by addition and deletion to read as follows:
 32

33 RESOLVED, that our ~~AMA American Medical Association~~
 34 ~~advocate for~~ support the continuance of premium
 35 processing and other mechanisms that an expedited H-1B
 36 visa applications and renewals process for International
 37 Medical Graduate physicians. (Directive to Take Action)
 38

39 RECOMMENDATION B:
 40

41 Your Reference Committee recommends that Resolution
 42 222 be adopted as amended.

1 RECOMMENDATION C:

2
3 Your Reference Committee recommends that the title of
4 Resolution 222 be changed to read as follows:

5
6 **EXPEDITED H-1B PATHWAYS FOR INTERNATIONAL**
7 **MEDICAL GRADUATE PHYSICIANS IN THE USA**

8
9 **HOD ACTION: Resolution 222 adopted as amended with a**
10 **change of title.**

11
12 RESOLVED, that our American Medical Association advocate for an expedited H-1B visa
13 application and renewal process for International Medical Graduate physicians. (Directive
14 to Take Action)

15
16 Your Reference Committee heard consistent support for our International Medical
17 Graduates (IMG) colleagues across all the testimony received. Your Reference
18 Committee heard that international medical graduates play an irreplaceable role in our
19 healthcare system. Testimony further noted the difficulty that some IMGs have
20 experienced within the immigration system, including concerns about being able to start
21 residencies on time, and highlighted the importance of having an immigration system that
22 is quick and efficient so that our IMG physicians can continue to stay employed and care
23 for their patients. Testimony also stated that H-1B visas can be arduous to obtain, and
24 that help is needed to ensure timely delivery of visas to our IMGs. However, your
25 Reference Committee also heard that U.S. Citizenship and Immigration Services (USCIS)
26 already has a premium processing option. Testimony stated that USCIS guarantees a
27 response (approval, denial, or a Request for Evidence) within 15 days of receiving the
28 petition. Testimony noted that premium processing is already available for H-1B holders
29 and applicants. Moreover, testimony highlighted that it would be a more effective advocacy
30 strategy to support the continuance of premium processing than to ask for an expedited
31 applicant and renewal process since premium processing is already an expedited system
32 that is in use by USCIS. Finally, your Reference Committee heard testimony
33 recommending that the resolution be amended to call for an increase to the H-1B visa cap,
34 but notes that this is beyond the scope of the resolution. Therefore, your Reference
35 Committee recommends that Resolution 222 be adopted as amended.

(23) RESOLUTION 228 — CHIP COVERAGE OF OTC
MEDICATIONS

RECOMMENDATION A:

Your Reference Committee recommends that the first
resolve of Resolution 228 be amended by addition and
deletion to read as follows:

RESOLVED, that our ~~American Medical Association
(AMA) advocate support for~~ expanding coverage of
~~for~~ 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; and be it further

RECOMMENDATION B:

Your Reference Committee recommends that the second
resolve of Resolution 228 be amended by addition and
deletion to read as follows:

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

RECOMMENDATION C:

Your Reference Committee recommends that the third
resolve of Resolution 228 be amended by addition to read
as follows:

RESOLVED, that our AMA oppose copayment or other cost
sharing requirements for over-the-counter medications for
patients enrolled in CHIP.

RECOMMENDATION D:

Your Reference Committee recommends that Resolution
228 be adopted as amended.

HOD ACTION: Resolution 228 adopted as amended.

RESOLVED, that our American Medical Association (AMA) 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

1 by expanding medication classes covered under CHIP; (Directive to Take Action) and be
2 it further

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

6
7 RESOLVED, that our AMA oppose copayment requirements for over-the-counter
8 medications for patients enrolled in CHIP. (New HOD Policy)

9
10 Your Reference Committee heard testimony in strong support of Resolution 228.
11 Testimony stated that since its inception, the Children's Health Insurance Program (CHIP)
12 has helped reduce the number of uninsured children. However, testimony also highlighted
13 that many individuals still face barriers to care due to inconsistent coverage of over-the-
14 counter (OTC) medications. Testimony noted the importance of expanded OTC coverage
15 under CHIP to improve children's health outcomes and ease financial burdens on low-
16 income families. Testimony stated that limited OTC access negatively impacts care, with
17 even small costs creating obstacles. Your Reference Committee heard that variations in
18 state-level CHIP coverage, such as limited access in South Dakota, Texas, and
19 Wisconsin, further exacerbate these issues. Additional testimony supported OTC access
20 without age or quantity restrictions, citing precedent that a 12-month supply of
21 contraceptives improves access, reduces unintended pregnancies, and promotes
22 equitable, cost-effective care. Testimony also proffered technical amendments directed at
23 avoiding potential unnecessary barriers to timely coverage while focusing on opposing
24 limitations on OTC medications and clarifying opposition to copayments and any other
25 cost-sharing requirements. Your Reference Committee appreciated testimony that raised
26 the issue of CHIP's block grant financing structure and the danger that the additional cost
27 of covering OTC medications might result in states exhausting their CHIP allotments.
28 However, the Reference Committee would note that the appropriation language that
29 Congress has adopted for CHIP for fiscal years 2024 through 2028 does not limit the
30 amount that is appropriated for state CHIP allotments (see section 2104(a)(27) of the
31 Social Security Act ([42 U.S.C. 1397dd\(a\)\(27\)](#))) to a specific dollar amount (as was the case
32 in prior fiscal years), allowing for state allotments to grow as program expenditures
33 increase and reducing the danger of states outspending their allotments. Similarly, your
34 Reference Committee appreciated testimony raising concerns that a policy allowing for
35 coverage of OTC medications under CHIP could open the door to abusive practices, but
36 feels that the policy established by Resolution 228 is sufficiently flexible to allow our AMA
37 to oppose proposals to expand CHIP coverage of OTC medications that would invite such
38 practices. Therefore, your Reference Committee recommends that Resolution 228 be
39 adopted as amended.

(24) RESOLUTION 229 — GUARANTEEING TIMELY
DELIVERY AND ACCESSIBILITY OF FEDERAL HEALTH
DATA

RECOMMENDATION A:

Your Reference Committee recommends that the first
resolve of Resolution 229 be amended by addition and
deletion to read as follows:

RESOLVED, that our ~~American Medical Association (AMA)~~
advocate for the immediate reinstatement of dissemination
of critical public health information by 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 puts the American public at increased risk of exposes
~~all patients who are receiving care to less than optimal
health~~ outcomes; and be it further

RECOMMENDATION B:

Your Reference Committee recommends that the second
resolve of Resolution 229 be amended by addition and
deletion to read as follows:

RESOLVED, that our AMA ~~promote~~ support 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.~~

RECOMMENDATION C:

Your Reference Committee recommends that Resolution
229 be adopted as amended.

HOD ACTION: Resolution 229 adopted as amended.

RESOLVED, that our American Medical Association (AMA) 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)

1 Your Reference Committee heard generally positive testimony in favor of reinstating the
2 dissemination of critical health data by public health agencies responsible for informing
3 the public and health care professionals of emergent threats to public health. Testimony
4 highlighted that recent actions by the current Administration have curtailed the ability of
5 agencies like the National Institutes of Health (NIH) and the Centers for Disease Control
6 and Prevention (CDC) to collect and disseminate essential information. An amendment
7 was offered to frame the language in more affirmative terms, and another proposed the
8 addition of the word “immediate” to underscore the urgency of this issue, both of which
9 your Reference Committee supported. Therefore, your Reference Committee
10 recommends that Resolution 229 be adopted as amended.

11
12 (25) RESOLUTION 234 — PROTECTION FOR
13 INTERNATIONAL MEDICAL GRADUATES

14
15 RECOMMENDATION A:

16
17 Your Reference Committee recommends that AMA policies
18 D-160.921 and H-255.988 be reaffirmed in lieu of the first
19 resolve of Resolution 234.

20
21 RECOMMENDATION B:

22
23 Your Reference Committee recommends that the second
24 resolve of Resolution 234 be amended by addition and
25 deletion to read as follows:

26
27 RESOLVED, that our AMA ~~work with support~~ relevant
28 ~~stakeholders interested parties to develop in developing~~ a
29 confidential mechanism through which IMG physicians can
30 report workplace immigration related interviews;
31 ~~enforcement actions, or audits,~~ in order to identify and
32 address potential instances of unfair treatment or targeting
33 of international medical graduate IMG physicians.

34
35 RECOMMENDATION C:

36
37 Your Reference Committee recommends that Resolution
38 234 be adopted as amended and that AMA policies D-
39 160.921 and H-255.988 be reaffirmed.

40
41 **HOD ACTION: Resolution 234 adopted as amended and**
42 **AMA policies D-160.921 and H-255.988 reaffirmed.**

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

7
8 RESOLVED, that our AMA work with relevant stakeholders to develop a confidential
9 mechanism through which IMG physicians can report workplace immigration related
10 interviews, enforcement actions, or audits, in order to identify and address potential
11 instances of unfair treatment or targeting of IMG physicians. (Directive to Take Action)

12
13 Your Reference Committee heard mixed testimony on Resolution 234. Testimony
14 unanimously supported the need to help ensure that medical facilities remain safe for all
15 patients and noted that our AMA should support our international medical graduate (IMG)
16 colleagues and protect them from being treated unfairly or being targeted. However, some
17 testimony highlighted that existing AMA policy already covers the asks in the first resolve
18 noting that our AMA policy already states that healthcare facilities should be designated
19 as sensitive areas and, among other things, opposes the presence of immigration and
20 customs enforcement at healthcare facilities. Additional testimony noted that US
21 Immigration and Customs Enforcement (ICE) has the authority to arrest undocumented
22 immigrants and highlighted that workplaces cannot stop immigration enforcement actions
23 or legitimate audits that follow proper legal procedures. However, a minor amendment
24 was made, and accepted by your Reference Committee, noting that all physicians should
25 be able to report unfair workplace immigration issues, even if it is on behalf of their IMG
26 colleagues. Your Reference Committee received amendments in alignment with these
27 legal limitations. Therefore, your Reference Committee recommends that Resolution 234
28 be adopted as amended and that existing AMA policies D-160.921 and H-255.988 be
29 reaffirmed.

30
31 [Presence and Enforcement Actions of Immigration and Customs](#)
32 [Enforcement \(ICE\) in Healthcare D-160.921](#)
33

34 Our AMA: (1) advocates for and supports legislative efforts to designate
35 healthcare facilities as sensitive locations by law; (2) will work with
36 appropriate stakeholders to educate medical providers on the rights of
37 undocumented patients while receiving medical care, and the designation
38 of healthcare facilities as sensitive locations where U.S. Immigration and
39 Customs Enforcement (ICE) enforcement actions should not occur; (3)
40 encourages healthcare facilities to clearly demonstrate and promote their
41 status as sensitive locations; and (4) opposes the presence of ICE
42 enforcement at healthcare facilities.

43
44 [AMA Principles on International Medical Graduates H-255.988](#)
45

- 46 1. Our American Medical Association supports current U.S. visa
47 and immigration requirements applicable to foreign national physicians

- 1 who are graduates of medical schools other than those in the United
- 2 States and Canada.
- 3 2. Our AMA supports current regulations governing the issuance of
- 4 exchange visitor visas to foreign national IMGs, including the
- 5 requirements for successful completion of the USMLE.
- 6 3. Our AMA reaffirms its policy that the U.S. and Canada medical schools
- 7 be accredited by a nongovernmental accrediting body.
- 8 4. Our AMA supports cooperation in the collection and analysis of
- 9 information on medical schools in nations other than the U.S. and
- 10 Canada.
- 11 5. Our AMA supports continued cooperation with the ECFMG and other
- 12 appropriate organizations to disseminate information to prospective
- 13 and current students in foreign medical schools. An AMA member, who
- 14 is an IMG, should be appointed regularly as one of the AMA's
- 15 representatives to the ECFMG Board of Trustees.
- 16 6. Our AMA supports working with the Accreditation Council for Graduate
- 17 Medical Education (ACGME) and the Federation of State Medical
- 18 Boards (FSMB) to assure that institutions offering accredited
- 19 residencies, residency program directors, and U.S. licensing authorities
- 20 do not deviate from established standards when evaluating graduates
- 21 of foreign medical schools.
- 22 7. In cooperation with the ACGME and the FSMB, our AMA supports only
- 23 those modifications in established graduate medical education or
- 24 licensing standards designed to enhance the quality of medical
- 25 education and patient care.
- 26 8. Our AMA continues to support the activities of the ECFMG related to
- 27 verification of education credentials and testing of IMGs.
- 28 9. Our AMA supports that special consideration be given to the limited
- 29 number of IMGs who are refugees from foreign governments that
- 30 refuse to provide pertinent information usually required to establish
- 31 eligibility for residency training or licensure.
- 32 10. Our AMA supports that accreditation standards enhance the quality of
- 33 patient care and medical education and not be used for purposes of
- 34 regulating physician manpower.
- 35 11. Our AMA representatives to the ACGME, residency review committees
- 36 and to the ECFMG should support AMA policy opposing discrimination.
- 37 Medical school admissions officers and directors of residency programs
- 38 should select applicants on the basis of merit, without considering
- 39 status as an IMG or an ethnic name as a negative factor.
- 40 12. Our AMA supports the requirement that all medical school graduates
- 41 complete at least one year of graduate medical education in an
- 42 accredited U.S. program in order to qualify for full and unrestricted
- 43 licensure. State medical licensing boards are encouraged to allow an
- 44 alternate set of criteria for granting licensure in lieu of this requirement:
- 45 a. completion of medical school and residency training outside the
- 46 U.S.;
- 47 b. extensive U.S. medical practice; and
- 48 c. evidence of good standing within the local medical community.
- 49 13. Our AMA supports publicizing existing policy concerning the granting
- 50 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. 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.
15. Our AMA supports studying the feasibility of conducting peer-to-peer membership recruitment efforts aimed at IMGs who are not AMA members.
16. Our AMA membership outreach to IMGs to include
 - a. using its existing publications to highlight policies and activities of interest to IMGs, stressing the common concerns of all physicians;
 - b. publicizing its many relevant resources to all physicians, especially to nonmember IMGs;
 - c. identifying and publicizing AMA resources to respond to inquiries from IMGs; and
 - d. 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.
17. 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.
18. 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.
19. 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.
20. 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.
21. Our AMA supports U.S. medical schools offering admission with advanced standing, within the capabilities determined by each

1 institution, to international medical students who satisfy the
2 requirements of the institution for matriculation.

3 22. Our AMA supports the Federation of State Medical Boards, its member
4 boards, and the ECFMG in their willingness to adjust their
5 administrative procedures in processing IMG applications so that
6 original documents do not have to be recertified in home countries
7 when physicians apply for licenses in a second state.

8 23. Our AMA supports continued efforts to protect the rights and privileges
9 of all physicians duly licensed in the U.S. regardless of ethnic or
10 educational background and opposes any legislative efforts to
11 discriminate against duly licensed physicians on the basis of ethnic or
12 educational background.

13 24. Our AMA supports continued study of challenges and issues pertinent
14 to IMGs as they affect our country's health care system and our
15 physician workforce.

16 25. Our AMA supports advocacy to Congress to fund studies through
17 appropriate agencies, such as the Department of Health and Human
18 Services, to examine issues and experiences of IMGs and make
19 recommendations for improvements.

(26) RESOLUTION 238 — PRESERVING ACCREDITATION
STANDARDS ON DIVERSITY, EQUITY, AND INCLUSION

RECOMMENDATION A:

Your Reference Committee recommends that the first
resolve of Resolution 238 be amended by addition and
deletion to read as follows:

RESOLVED, that our ~~American Medical Association (AMA)~~
oppose any federal actions or executive orders that threaten
the ability of accreditation bodies, including the
Accreditation Council for Graduate Medical Education
(ACGME), the Commission on Osteopathic College
Accreditation (COCA), and the Liaison Committee on
Medical Education (LCME), to enforce appropriate
accreditation diversity, equity, and inclusion standards; and
be it further

RECOMMENDATION B:

Your Reference Committee recommends that the second
resolve of Resolution 238 be amended by addition and
deletion to read as follows:

RESOLVED, that our AMA support ~~advocate to relevant
federal agencies and officials emphasizing the value of~~
ACGME, COCA, and LCME in advocating for their
accreditation standards focused on diversity, equity, and
inclusion for the betterment of patient care and public health;
and be it further

RECOMMENDATION C:

Your Reference Committee recommends that the third
resolve of Resolution 238 be amended by addition and
deletion to read as follows:

RESOLVED, that, consistent with applicable laws, our AMA
support ~~work collaboratively with~~ allopathic and osteopathic
medical education accreditation bodies ~~to restore and in~~
strengthening accreditation standards focused on diversity,
equity, and inclusion.

RECOMMENDATION D:

Your Reference Committee recommends that Resolution
238 be adopted as amended.

1 RECOMMENDATION E:

2
3 Your Reference Committee recommends that the title of
4 Resolution 238 be changed to read as follows:

5
6 **PRESERVING ACCREDITATION STANDARDS ON**
7 **INCLUSIVE EXCELLENCE**

8
9 **HOD ACTION: Resolution 238 adopted as amended without**
10 **a change of title.**

11
12 RESOLVED, that our American Medical Association (AMA) oppose any federal actions or
13 executive orders that threaten the ability of accreditation bodies, including the
14 Accreditation Council for Graduate Medical Education (ACGME) , the Commission on
15 Osteopathic College Accreditation (COCA), and the Liaison Committee on Medical
16 Education (LCME), to enforce appropriate diversity, equity, and inclusion standards; and
17 be it further

18
19 RESOLVED, that our AMA advocate to relevant federal agencies and officials
20 emphasizing the value of ACGME, COCA, and LCME accreditation standards focused on
21 diversity, equity, and inclusion for the betterment of patient care and public health; and be
22 it further

23
24 RESOLVED, that, consistent with applicable laws, our AMA work collaboratively with
25 allopathic and osteopathic medical education accreditation bodies to restore and
26 strengthen accreditation standards focused on diversity, equity, and inclusion.

27
28 Your Reference Committee heard mixed testimony on Resolution 238. Your Reference
29 Committee heard that the Executive Orders have placed pressure on physician
30 accreditation bodies including Accreditation Council for Graduate Medical Education
31 (ACGME), the Commission on Osteopathic College Accreditation (COCA), and the Liaison
32 Committee on Medical Education (LCME) surrounding their diversity equity and inclusion
33 standards. Testimony noted that this pressure from the federal government resulted in
34 these accreditation bodies changing or suspending their standards surrounding diversity,
35 equity, and inclusion. Further testimony highlighted concerns that without these standards
36 institutions would become less inclusive, and as a result our physician and patient
37 population would suffer. However, your Reference Committee also heard that our AMA
38 has strong working relationships with all the physician accreditation bodies including
39 AGCME, COCA, and LCME. Testimony noted that, out of respect for maintaining these
40 relationships, our AMA does and should continue to allow these accreditation bodies to
41 take the lead in advocating for their accreditation standards. Testimony stated that our
42 AMA will continue to aid these organizations in their advocacy work as requested and
43 appropriate. Your Reference Committee heard about the importance of having a holistic
44 and collegial working environment with our accreditation colleagues while still noting the
45 importance of having standards that promote inclusion. Amendments were offered to help
46 reflect these working relations, keep our policy focused on what our AMA supports, and
47 adopt needed language updates to align with currently used terminology in this space.
48 Your Reference Committee accepted these amendments. Therefore, your Reference
49 Committee recommends that Resolution 238 be adopted as amended.

(27) RESOLUTION 241 — OPPOSITION TO THE
DECERTIFICATION OF INDEPENDENT UNIVERSITIES
FROM THE STUDENT AND EXCHANGE VISITOR
PROGRAM

RECOMMENDATION A:

Your Reference Committee recommends that existing AMA
policies H-255.988 and D-255.911 be reaffirmed.

RECOMMENDATION B:

Your Reference Committee recommends that the first
resolve of Resolution 241 be deleted.

~~RESOLVED, that our American Medical Association
publicly advocate against the targeted use of Student and
Exchange Visitor Program decertification against
independent universities; and be it further~~

RECOMMENDATION C:

Your Reference Committee recommends that Resolution
241 be adopted as amended.

RECOMMENDATION D:

Your Reference Committee recommends that the title of
Resolution 241 be changed to read as follows:

**PRESERVATION OF IMMIGRATION PATHWAYS FOR
INTERNATIONAL MEDICAL STUDENTS**

**HOD ACTION: Resolution 241 adopted with a change of
title and AMA policies H-255.988 and D-255.911 reaffirmed.**

RESOLVED, that our American Medical Association publicly advocate against the
targeted use of Student and Exchange Visitor Program decertification against
independent universities; and be it further

RESOLVED, that our AMA advocate for the preservation of pathways that allow
international students to pursue medical education in the United States, recognizing their
vital contribution to addressing future physician shortages and diversity in healthcare.

Your Reference Committee heard mixed testimony on Resolution 241. Your Reference
Committee heard about the important role that our international medical students play
within the educational system and within healthcare in the United States. Testimony noted
the ongoing actions that the Administration is taking that are impacting student visas within
the Student and Exchange Visitor Program (SEVP) and that certain universities are being
targeted and impacted by these actions. However, your Reference Committee also heard

1 that the SEVP does not apply to J-1 visas, which is the visa type most commonly utilized
2 by international medical students, and instead only applies to F-1 and M-1 visas.
3 Testimony noted that since the main visa type that our international medical students use
4 is not impacted by the SEVP that our AMA should instead allow key parties including
5 impacted universities who have strong standing in this space, to take the lead advocacy
6 role in this space. Further testimony noted that our AMA should focus its engagement on
7 a space where we can have a meaningful impact, and where our work will be most felt by
8 our physicians. An amendment that reflected this sentiment was offered which your
9 Reference Committee accepted. Your Reference Committee also notes that our AMA has
10 existing policy in this space that complements this resolution. Therefore, your Reference
11 Committee recommends that Resolution 241 be adopted as amended and that existing
12 AMA policies H-255.988 and D-255.911 be reaffirmed.

13
14 [AMA Principles on International Medical Graduates H-255.988](#)
15

- 16 1. Our American Medical Association supports current U.S. visa and
17 immigration requirements applicable to foreign national physicians who
18 are graduates of medical schools other than those in the United States
19 and Canada.
- 20 2. Our AMA supports current regulations governing the issuance of
21 exchange visitor visas to foreign national IMGs, including the
22 requirements for successful completion of the USMLE.
- 23 3. Our AMA reaffirms its policy that the U.S. and Canada medical schools
24 be accredited by a nongovernmental accrediting body.
- 25 4. Our AMA supports cooperation in the collection and analysis of
26 information on medical schools in nations other than the U.S. and
27 Canada.
- 28 5. Our AMA supports continued cooperation with the ECFMG and other
29 appropriate organizations to disseminate information to prospective
30 and current students in foreign medical schools. An AMA member, who
31 is an IMG, should be appointed regularly as one of the AMA's
32 representatives to the ECFMG Board of Trustees.
- 33 6. Our AMA supports working with the Accreditation Council for Graduate
34 Medical Education (ACGME) and the Federation of State Medical
35 Boards (FSMB) to assure that institutions offering accredited
36 residencies, residency program directors, and U.S. licensing authorities
37 do not deviate from established standards when evaluating graduates
38 of foreign medical schools.
- 39 7. In cooperation with the ACGME and the FSMB, our AMA supports only
40 those modifications in established graduate medical education or
41 licensing standards designed to enhance the quality of medical
42 education and patient care.
- 43 8. Our AMA continues to support the activities of the ECFMG related to
44 verification of education credentials and testing of IMGs.
- 45 9. Our AMA supports that special consideration be given to the limited
46 number of IMGs who are refugees from foreign governments that
47 refuse to provide pertinent information usually required to establish
48 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:
 - a. completion of medical school and residency training outside the U.S.;
 - b. extensive U.S. medical practice; and
 - c. 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. 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.
15. Our AMA supports studying the feasibility of conducting peer-to-peer membership recruitment efforts aimed at IMGs who are not AMA members.
16. Our AMA membership outreach to IMGs to include
 - a. using its existing publications to highlight policies and activities of interest to IMGs, stressing the common concerns of all physicians;
 - b. publicizing its many relevant resources to all physicians, especially to nonmember IMGs;
 - c. identifying and publicizing AMA resources to respond to inquiries from IMGs; and
 - d. 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.

17. 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.
18. 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.
19. 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.
20. 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.
21. 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.
22. 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.
23. 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.
24. 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.
25. 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.

[Visa Complications for IMGs in GME D-255.991](#)

1. Our American Medical Association will
 - a. 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.
 - b. 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.

- c. 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.
2. 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.

(28) RESOLUTION 242 — PROTECTING EVIDENCE-BASED
MEDICINE, PUBLIC HEALTH INFRASTRUCTURE AND
BIOMEDICAL RESEARCH FROM POLITICIZED
ATTACKS

RECOMMENDATION A:

Your Reference Committee recommends that the first
resolve of Resolution 242 be amended by addition and
deletion to read as follows:

RESOLVED, that our AMA ~~American Medical Association~~
affirm that protecting science, clinical integrity, and the
patient-physician relationship ~~in the face of political
interference~~ is central to the organization's mission ~~and a
defining challenge of this moment in history~~; and be it
further

RECOMMENDATION B:

Your Reference Committee recommends that the second
resolve of Resolution 242 be amended by addition and
deletion to read as follows:

RESOLVED, that our AMA assertively and publicly lead the
House of Medicine in collective, sustained ~~opposition to~~
advocacy for federal and state policies, proposals, and
actions that ~~undermine~~ safeguard public health
infrastructure, advance biomedical research, improve
vaccine confidence, ~~or~~ and maintain the integrity of
evidence-based medicine and decision-making processes;
and be it further

RECOMMENDATION C:

Your Reference Committee recommends that the third
resolve of Resolution 242 be amended by addition and
deletion to read as follows:

RESOLVED, that our AMA report back at the 2025~~6~~ Interim
Meeting of the AMA House of Delegates on the actions
taken to implement this policy.

RECOMMENDATION D:

Your Reference Committee recommends that Resolution
242 be adopted as amended.

1 RECOMMENDATION E:
2

3 Your Reference Committee recommends that the title of
4 Resolution 242 be changed to read as follows:
5

6 **PROTECTING EVIDENCE-BASED MEDICINE, PUBLIC**
7 **HEALTH INFRASTRUCTURE AND BIOMEDICAL**
8 **RESEARCH**
9

10 **HOD ACTION: Resolution 242 adopted as amended with a**
11 **change of title.**
12

13 RESOLVED, that our American Medical Association affirm that protecting science, clinical
14 integrity, and the patient-physician relationship in the face of political interference is central
15 to the organization's mission and a defining challenge of this moment in history (New HOD
16 Policy); and be it further
17

18 RESOLVED, that our AMA assertively and publicly lead the House of Medicine in
19 collective, sustained opposition to federal and state policies, proposals, and actions that
20 undermine public health infrastructure, biomedical research, vaccine confidence, or
21 evidence-based medicine and decision-making (Directive to Take Action); and be it further
22

23 RESOLVED, that our AMA report back at the 2026 Interim Meeting of the AMA House of
24 Delegates on the actions taken to implement this policy.
25

26 Your Reference Committee heard strong and extensive testimony in support of Resolution
27 242. As an initial matter, the authors of the resolution noted that they intended the third
28 resolve of the resolution requested a report back at the 2025 Interim Meeting of our AMA
29 House of Delegates rather than the 2026 Interim Meeting. Further testimony supported
30 this change. More substantively, your Reference Committee heard repeated expressions
31 of support for the spirit and substance of the resolution, with commenters specifically
32 voicing support for resolution language calling on our AMA to act "assertively" and
33 "publicly" to protect science, clinical integrity, public health infrastructure, biomedical
34 research, vaccine confidence, and evidence-based medicine and decision-making
35 processes. Amendments were proposed that would phrase the resolution in the positive,
36 on the grounds that such a change would make the policy more flexible. An amendment
37 was proposed to strike the reference to the current moment being a "defining moment in
38 history," on the grounds that our policy should not be limited to a specific moment in time.
39 Your Reference Committee appreciates both the strong sentiments expressed by the
40 House of Delegates and multiple proposed amendments that were thoughtfully crafted to
41 preserve these sentiments while strengthening the final policy. Therefore, your Reference
42 Committee recommends that Resolution 242 be adopted as amended.

RECOMMENDED FOR ADOPTION IN LIEU OF

(29) RESOLUTION 202 — PRESERVATION OF THE CDC
EPILEPSY PROGRAM WORKFORCE AND
INFRASTRUCTURE

RECOMMENDATION A:

Your Reference Committee recommends that Alternate
Resolution 202 be adopted in lieu of Resolution 202.

RESOLVED, That our AMA support the adequate funding of
the Department of Health and Human Services (HHS) to
ensure the preservation of its workforce and evidence-
based public health initiatives; and be it further

RESOLVED, That our AMA support efforts by HHS and
Congress to prioritize sustained funding and staffing for
programs that promote ongoing public health and clinical
care advancement.

RECOMMENDATION B:

Your Reference Committee that the title of Alternate
Resolution 202 be changed to read as follows:

**PRESERVATION OF THE DEPARTMENT OF HEALTH
AND HUMAN SERVICES WORKFORCE AND
INFRASTRUCTURE**

**HOD ACTION: Alternate Resolution 202 adopted in lieu of
Resolution 202 with a change of title.**

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)

Your Reference Committee heard limited, but supportive testimony for Resolution 202 and
the Centers for Disease Control and Prevention (CDC) Epilepsy Program, emphasizing
the importance of continued support since this program improves clinical care. However,
your Reference Committee also heard testimony that supported broadening the policy to
include the entirety of the Department of Health and Human Services funding and
workforce. This testimony highlighted that by broadening this policy our AMA's advocacy
would be strengthened because it would allow our AMA to advocate not only for the CDC

1 Epilepsy Program but also the many other valuable programs housed within HHS.
2 Moreover, testimony noted that by broadening this policy we would not be prioritizing one
3 program over others. Therefore, your Reference Committee recommends that Alternate
4 Resolution 202 be adopted in lieu of Resolution 202.

5
6 (30) RESOLUTION 205 — AMA SUPPORT FOR
7 CONTINUANCE OF THE SECTION 1115 - SOCIAL
8 SECURITY ACT, MEDICAID WAIVER PROGRAM

9
10 RESOLUTION 206 — AMA SUPPORT FOR RENEWAL OF
11 SECTION 1115 - SOCIAL SECURITY ACT, MEDICAID
12 WAIVER DEMONSTRATION PROJECTS SUPPORTING
13 FOOD AND NUTRITION SERVICES

14
15 RECOMMENDATION A:

16
17 Your Reference Committee recommends that Alternate
18 Resolution 205 be adopted in lieu of Resolutions 205 and
19 206.

20
21 RESOLVED, That our AMA advocate for the approval or
22 renewal of Section 1115 Medicaid waivers that will improve
23 and preserve the Medicaid program as a critical safety net;
24 and be it further

25
26 RESOLVED, That our AMA advocates for continued and
27 sustained federal funding for Designated State Health
28 Programs (DSHP) in Medicaid Section 1115 waivers; and
29 be it further

30
31 RESOLVED, That our AMA supports the use of Medicaid
32 Section 1115 waivers to address health-related social
33 needs through evidence-based and medically appropriate
34 interventions; and be it further

35
36 RESOLVED, That our AMA advocate for the inclusion,
37 renewal, and expansion of food and nutritional services in
38 Medicaid Section 1115 waivers, as a strategy to reduce food
39 insecurity and improve health outcomes among Medicaid
40 beneficiaries.

41
42 RECOMMENDATION B:

43
44 Your Reference Committee recommends that the title of
45 Alternate Resolution 205 be changed to read as follows:

46
47 **SUPPORT FOR CONTINUANCE OF SECTION 1115**
48 **MEDICAID WAIVERS AND DEMONSTRATION**
49 **PROJECTS**

**HOD ACTION: Alternate Resolution 205 adopted in lieu of
Resolutions 205 and 206 with a change of title.**

Resolution 205 — AMA Support For Continuance Of The Section 1115 - Social Security Act, Medicaid

RESOLVED, that our AMA 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).

Resolution 206 — AMA Support For Renewal Of Section 1115 - Social Security Act, Medicaid Waiver Demonstration Projects Supporting Food And Nutrition Services

RESOLVED, that our AMA that our AMA 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)

Your Reference Committee heard extensive testimony on Resolutions 205 and 206, both of which relate to Section 1115 Medicaid waivers. All testimony was supportive of the resolutions and the Section 1115 Medicaid waiver program, although multiple commenters noted that our AMA does not always support policies implemented by states through Section 1115 waivers. Testimony noted that our AMA has advocated against certain proposed waivers in the past when they were not in the best interest of public health(see, e.g., AMA's [2020](#) and [2018](#) letters opposing specific state waivers). An amendment was offered to consolidate the resolutions, clarify that our AMA only supports those Medicaid waivers that improve and preserve the Medicaid program, and remove any references in support of specific types of waivers, such as waivers that support Designated State Health Programs or food and nutrition services. However, while significant testimony supported the language to clarify that our AMA does not automatically support all Section 1115 Medicaid waivers, there was substantial testimony in favor of keeping the language that specifically supports certain types of waivers given their critical importance and the current threats to their approval and renewal. Therefore, your Reference Committee recommends that Alternate Resolution 205 be adopted in lieu of Resolutions 205 and 206.

(31) RESOLUTION 207 — ABOLISHING VENUE SHOPPING

RESOLUTION 231 — PREVENTING VENUE SHOPPING
IN MEDICAL LIABILITY TO PROTECT PHYSICIAN
PRACTICES AND RESOLUTION ACCESS TO CARE

RECOMMENDATION:

Your Reference Committee recommends that Alternate
Resolution 207 be adopted in lieu of Resolutions 207 and
231.

RESOLVED, That our AMA oppose venue shopping in
medical professional liability actions; and be it further

RESOLVED, That our AMA study avenues to most
effectively combat venue shopping in state and federal
medical professional liability actions with report back at A-
26.

**HOD ACTION: Alternate Resolution 207 adopted in lieu of
Resolutions 207 and 231.**

Resolution 207 — Abolishing Venue Shopping

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)

**Resolution 231 — Preventing Venue Shopping In Medical Liability To Protect
Physician Practices And Resolution Access To Care**

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)

Your Reference Committee heard testimony recognizing that venue shopping can be a
significant problem in some medical liability cases. Multiple amendments were offered on

1 behalf of the combined Resolutions 207 and 231 and it was widely supported that
2 Resolutions 207 and 231 be considered together. Your Reference Committee also heard
3 testimony noting that venue shopping is an extremely complicated issue involving varying
4 state and federal rules, statutes, cases, and Constitutional issues. Testimony also
5 highlighted that having our AMA advocate for specific venue requirements may have
6 unintended consequences for physicians who are defending allegations of medical
7 liability. However, significant testimony was offered highlighting the problems that can
8 arise for physicians when venue shopping is utilized in medical liability cases. An alternate
9 resolution was offered by the authors of the two resolutions which the Reference
10 Committee largely accepted. Though your Reference Committee considered testimony to
11 the effect that it would be preferable to have the study on this topic performed before
12 taking a stance on this issue, especially given the complexity of the issues surrounding
13 venue shopping, overwhelming testimony was received in support of action being taken
14 on venue shopping immediately. Therefore, your Reference Committee recommends that
15 Alternate Resolution 207 be adopted in lieu of Resolutions 207 and 231.

16
17 (32) RESOLUTION 219 — OPPOSING UNWARRANTED
18 NATIONAL INSTITUTES OF HEALTH RESEARCH
19 INSTITUTE RESTRUCTURING

20
21 RECOMMENDATION:

22
23 Your Reference Committee recommends that Alternate
24 Resolution 219 be adopted in lieu of Resolution 219.

25
26 RESOLVED, that our AMA advocate for an independent
27 NIH reorganization advisory commission composed of
28 interested parties, including physicians, scientists,
29 researchers, academics, and patient advocacy
30 organizations, to ensure that any proposed restructuring of
31 the NIH is guided by medical, scientific, and public health
32 expertise and serves the best interests of patients and the
33 scientific community; and be it further

34
35 RESOLVED, that our AMA advocates against
36 reorganization or consolidation of the NIH when such
37 action:

- 38 1. Lacks transparency or is implemented without
39 meaningful input from the biomedical research
40 and physician communities; and
41 2. Results in a reduction of funding that jeopardizes
42 ongoing or long-term research through
43 premature cancellation of grants, contracts, or
44 programs essential to public health, biomedical
45 innovation, or patient care; and be it further

46
47 RESOLVED, that our AMA support study of the short- and
48 long-term impacts of federal biomedical research funding
49 reductions, including medical innovation, the healthcare

1 workforce, medical education, public health and local
2 economies and communities.

3
4 RESOLVED, that our AMA publicly oppose the reduction
5 of research funding and funding opportunities from the NIH.
6

7 **HOD ACTION: Alternate Resolution 219 adopted in lieu of**
8 **Resolution 219.**
9

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

14
15 Your Reference Committee heard testimony in strong support of amended language for
16 Resolution 219. The authors of this resolution supported the proposed amendments and
17 emphasized the timeliness and importance of our AMA addressing this issue. Testimony
18 noted that, since the original drafting of the resolution, there have been multiple proposals
19 to restructure the National Institutes of Health (NIH) by consolidating institutes in a manner
20 that would slash funding and devastate highly specialized research efforts and long-term
21 health projects in numerous fields. Additionally, these proposals have excluded input from
22 physicians, researchers, and patient advocacy groups. Testimony emphasized that the
23 restructuring and reorganization of NIH disproportionately and adversely affects funding
24 for pediatric, maternal health, as well as infectious diseases. Limited testimony found it
25 was not timely to convene a committee and supported referral. Therefore, Your Reference
26 Committee recommends adoption of alternate Resolution 219.

(33) RESOLUTION 221 — PRESERVATION OF MEDICAID

RESOLUTION 223 — PRESERVATION OF MEDICAID

RESOLUTION 232 — PRESERVATION OF MEDICAID

RESOLUTION 236 — PRESERVATION OF MEDICAID

RECOMMENDATION:

Your Reference Committee recommends that Alternate Resolution 221 be adopted in lieu of Resolutions 221, 223, 232, and 236.

RESOLVED, that our AMA elevate Medicaid to an urgent and top legislative advocacy priority alongside Medicare payment reform, specifically advocating for maintaining and expanding Medicaid coverage, access, federal funding, and eligibility, and request report back on the Board of Trustees' actions at I-25.

RESOLVED, that our AMA strongly opposes federal and state efforts to restrict eligibility, coverage, access, and funding for Medicaid and the Children's Health Insurance Program (CHIP).

HOD ACTION: Alternate Resolution 221 adopted in lieu of Resolutions 221, 223, 232, and 236.

Resolution 221 — Preservation Of Medicaid

RESOLVED, that our American Medical Association will 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 Taken 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)

Resolution 223 — Preservation Of Medicaid

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

1 RESOLVED, that our AMA opposes increasing cost-sharing requirements for Medicaid
2 enrollees; (New HOD Policy) and be it further
3

4 RESOLVED, that our AMA makes preservation of federal funding and eligibility for
5 Medicaid an urgent and top legislative advocacy priority;(Directive to Take Action) and be
6 it further
7

8 RESOLVED, that our AMA strongly oppose federal and state efforts to restrict eligibility
9 and funding for all public health insurance programs, including Medicaid and CHIP. (New
10 HOD Policy)
11

12 13 **Resolution 232 — Preservation Of Medicaid** 14

15 RESOLVED, that our American Medical Association will make preservation of federal
16 funding and eligibility for Medicaid an urgent and top legislative advocacy priority, effective
17 immediately at the conclusion of the Annual 2025 House of Delegates Meeting; (Directive
18 to Take Action) and be it further
19

20 RESOLVED, our AMA strongly opposes federal and state efforts to restrict eligibility and
21 funding for all public health insurance programs, including Medicaid and CHIP. (New HOD
22 Policy)
23

24 **Resolution 236 – Preservation of Medicaid** 25

26 RESOLVED, that our American Medical Association will make preservation of federal
27 funding and eligibility for all public health insurance programs, including Medicaid and
28 CHIP, an urgent and top legislative advocacy priority, effective immediately at the
29 conclusion of the Annual 2025 House of Delegates Meeting; and be it further
30

31 RESOLVED, that our AMA strongly opposes federal and state efforts to restrict eligibility
32 and funding for public health insurance programs, including Medicaid and CHIP. (New
33 HOD Policy)
34

35 Your Reference Committee heard substantial testimony on Resolutions 221, 223, 232,
36 and 236 which all relate to the preservation of the Medicaid program. The testimony for all
37 four resolutions was largely the same, with many testifiers providing identical testimony
38 for more than one resolution. As a result, many commenters noted that the resolutions
39 should be consolidated into a single resolution, and no testimony opposed consolidation.
40 An amendment to consolidate the resolutions was offered and received support from
41 multiple commenters. Much of the testimony favored making Medicaid advocacy a top
42 legislative advocacy priority of our AMA. Your Reference Committee believes this would
43 be consistent with our AMA's existing efforts in advocating for the preservation of
44 Medicaid, including two recent letters to the [Energy and Commerce Committee](#) of the
45 House of Representatives and the [leadership of the House of Representatives](#) expressing
46 our AMA's concern with the Medicaid proposals included in the reconciliation legislation
47 that Congress is currently considering. Further testimony noted that our AMA Center for
48 Health Equity's guide [Advancing Health Equity: A Guide to Narrative, Language, and](#)
49 [Concepts](#) discourages the use of the term "vulnerable" when referencing the Medicaid

population. Therefore, your Reference Committee recommends that Alternate Resolution 221 be adopted in lieu of Resolutions 221, 223, 232, and 236.

(34) **RESOLUTION 237 — URGENT ADVOCACY TO
RESTORE J-1 VISA PROCESSING FOR
INTERNATIONAL MEDICAL GRADUATE PHYSICIANS**

RECOMMENDATION A:

Your Reference Committee recommends that Alternate Resolution 237 be adopted in lieu of Resolution 237.

RESOLVED, that our AMA advocate in alignment with Educational Commission for Foreign Medical Graduates (ECFMG) to preserve the timely scheduling of J-1 visa appointments affecting International Medical Graduates and monitor the impact of visa appointment suspensions on patient care and physician workforce stability.

RECOMMENDATION B:

Your Reference Committee recommends that the title of Alternate Resolution 237 be changed to read as follows:

**PRESERVATION OF J-1 VISA PROCESSING FOR
INTERNATIONAL MEDICAL GRADUATE PHYSICIANS**

HOD ACTION: Resolution 237 adopted.

RESOLVED, that our American Medical Association:

1. Publicly advocate to resume the scheduling of new J-1 visa appointments affecting International Medical Graduates;
2. Issue urgent advocacy communications to Congress, the Department of Homeland Security, the Department of State, and other relevant agencies, calling for the immediate resumption of J-1 visa processing for International Medical Graduates;
3. Collaborate with key parties, including program directors, Designated Institutional Officers, medical schools, and healthcare organizations to monitor the impact of visa appointment suspensions on patient care and physician workforce stability;
4. Work proactively and transparently to reverse policies harmful to IMGs and mitigate future disruptions, emphasizing the essential contributions of International Medical Graduates to healthcare delivery in the United States.

Mixed testimony was received for Resolution 237. Your Reference Committee heard about the current pause on the J-1 visa interview appointment process, a necessary step in the process of being granted a J-1 visa. Testimony highlighted that due to this pause, J-1 physicians are worried about not being able to start their residencies in July on time, and future residency cycles. Further testimony noted the extremely important role that international medical graduate physicians (IMGs) play in medical education in the United States healthcare system overall and stated that by not being able to access these visa

1 appointments, their future as physicians in the United States would be in jeopardy.
2 However, your Reference Committee also heard that our AMA strives to maintain broad
3 policies that can be responsive both to the immediate needs that arise within the
4 immigration space as well as address the issues long term and that as a result, our current
5 AMA policies already speak to the importance of maintaining a well-functioning and timely
6 visa application process including working “with the ECFMG to minimize delays in the visa
7 process for International Medical Graduates applying for visas to enter the US for
8 postgraduate medical training and/or medical practice.” Testimony also highlighted that,
9 our AMA acknowledges that the Educational Commission for Foreign Medical Graduates
10 (ECFMG) is the universal sponsor for J-1 physicians in the United States. Our AMA
11 consistently works to support ECFMG as the recognized leader in this space. Testimony
12 stated that, due to the deference that our AMA provides to ECFMG, our AMA has a good
13 working relationship with ECFMG and supports ECFMG as requested and appropriate.
14 Therefore, your Reference Committee recommends that Alternate Resolution 237 be
15 adopted in lieu of Resolution 237.

RECOMMENDED FOR REFERRAL

(35) RESOLUTION 209 — REDUCING RISK OF FEDERAL INVESTIGATION OR PROSECUTION FOR PRESCRIBING CONTROLLED RESOLUTION ADDICTION MEDICATIONS FOR LEGITIMATE MEDICAL PURPOSES

RECOMMENDATION A:

Your Reference Committee recommends that item 1 of Resolution 209 be amended by addition and deletion to read as follows:

(1) advance the adoption of a conjunctive ~~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

RECOMMENDATION B:

Your Reference Committee recommends that item 2 of Resolution 209 be referred.

RECOMMENDATION C:

Your Reference Committee recommends that Resolution 209 be adopted as amended.

RECOMMENDATION D:

Your Reference Committee recommends that the title of Resolution 209 be changed to read as follows:

REDUCING RISK OF FEDERAL INVESTIGATION OR PROSECUTION FOR PRESCRIBING CONTROLLED SUBSTANCES FOR LEGITIMATE MEDICAL PURPOSES

HOD ACTION: Clause 1 of Resolution 209 adopted as amended with a change of title and clause 2 of Resolution 209 referred.

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

1 "legitimate medical purpose" means "for the purpose of preventing, treating, or managing
2 a patient's health-related condition." (New HOD Policy)
3

4 Your Reference Committee heard supportive testimony for Resolution 209, which seeks
5 to protect physicians prescribing controlled substances for opioid use disorder (OUD) by
6 clarifying the interpretation of the Controlled Substances Act (CSA). While your Reference
7 Committee heard strong support for Resolution 209's goal of preventing undue legal risks
8 for physicians, some commenters were concerned about the definition of "legitimate
9 medical purpose" proposed by the resolution and urged further study of that issue. Your
10 Reference Committee agrees. Your Reference Committee included an editorial
11 amendment to change the word "conjunction" to "conjunctive" in clause one of Resolution
12 209. Therefore, your Reference Committee recommends that clause one of Resolution
13 209 be adopted as amended with a change of title and clause two of Resolution 209 be
14 referred.
15

16 (36) RESOLUTION 212 — SETTING STANDARDS FOR
17 FORENSIC TOXICOLOGY LABORATORIES USED IN
18 LITIGATION
19

20 RECOMMENDATION:
21

22 Your Reference Committee recommends that Resolution
23 212 be referred.
24

25 **HOD ACTION: Resolution 212 referred.**
26

27 RESOLVED, that our American Medical Association pursue legislative or regulatory
28 changes to require:
29

- 30 1. Forensic toxicology laboratories that analyze drugs in bodily fluids to follow the
31 same protocols and obtain equivalent certifications as their clinical chemistry
32 counterparts based in hospitals; and
33
- 34 2. CLIA – exempt forensic toxicology laboratories to obtain relevant accreditations
35 and certifications such as CAP Forensic Drug Testing accreditation program (CAP
36 FDT, formerly FUDT or Forensic Urine Drug Testing Accreditation Program]) the
37 American Board of Forensic Toxicology Laboratory Accreditation Program (ABFT
38 LAP), the American Society of Crime Laboratory Directors Laboratory
39 Accreditation Board (ASCLD/LAB) or other related certification program (as their
40 clinical chemistry counterparts in hospitals are required) which are publicly
41 displayed; and
42
- 43 3. forensic toxicology laboratories to follow relevant state codes and regulations
44 addressing testing of breath, blood, and urine for alcohol, other drugs, and
45 intoxicating compounds; and
46
- 47 4. a Laboratory Director and/or Certifying Scientist who reviews all protocols and
48 laboratory manuals and signs off on each result electronically to be a licensed
49 physician (with proper and current board certification) or a scientist with an
50 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)

Your Reference Committee heard minimal testimony for Resolution 212. An amendment was provided to change the title as well as provide new, clarifying language to the resolves. Your Reference Committee also heard testimony which recommended referral as the subject of the Resolution presents scientific, legal, and factual questions that warrant further review before an appropriate recommendation can be made. The authors supported referral of the amended language upon hearing this testimony. Your Reference Committee would encourage the referral of this item to consider the amended language as the report is being drafted. Therefore, Your Reference Committee recommends that Resolution 212 be referred.

(37) RESOLUTION 230 — ADVOCATING TO EXPAND
PRIVATE INSURANCE COVERAGE OF ANTI-OBESITY
MEDICATIONS (AOM)

RECOMMENDATION:

Your Reference Committee recommends that Resolution 230 be referred.

HOD ACTION: Subclause h of Resolution 230 adopted; subclauses e and g referred; subclause f adopted as amended to read as follows:

f. 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 "stop therapy".

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 is 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. Eliminate coverage exclusions for the pharmacologic treatment of obesity.

- 1 f. Reduce the prior authorization burden for the coverage of anti-obesity
2 medications, to include not requiring a new prior authorization for every
3 dose change or requiring “step therapy”.
4 g. Support and cover chronic treatment with anti-obesity medications to
5 maintain weight loss.
6 h. Allow a patient’s physician to prescribe anti-obesity medication and have it
7 covered by insurance, without a requirement that patients must receive the
8 prescription only from contracted disease management companies.
9
10 2. Our AMA will support and provide resources to state delegations in their efforts to
11 advocate for the reduction of bias against patients that suffer from obesity for the
12 actions listed. (Modify Current HOD Policy)

13
14 Your Reference Committee heard strong mixed testimony on Resolution 230. Testimony
15 in support of adoption raised the fact that there are now several very effective FDA-
16 approved medications to treat obesity. However, in terms of insurance coverage, the
17 outlook is much bleaker. Testimony stressed that obesity is a disease and warrants
18 coverage, but despite this recognition, patients continue to fight overt discrimination from
19 insurance providers and policy makers. Testimony was provided that supported adoption
20 with an amendment to strike “step-therapy” from the language to recognize the cost
21 implications to health plans and the unintended consequences of the drugs becoming cost
22 prohibitive for plans to maintain as part of covered benefits. Testimony was also provided
23 in support of referral to analyze the economic component of this issue before creating
24 policy that would mandate coverage of the drugs despite the knowledge that they are an
25 exorbitant cost on the health system. Testimony recommended taking advantage of the
26 recently released Institute for Clinical and Effective Economic Research (ICER) report
27 examining strategies to ensure affordable access for obesity medications as well as their
28 existing evidence-based analysis of GLP-1s and their return on investment. Testimony in
29 support of referral also expressed that the problem is not with the GLP-1's but rather with
30 the pharmacy industry and the pharmacy benefit managers (PBMs). Therefore, your
31 Reference Committee recommends that Resolution 230 be referred.

RECOMMENDATION FOR REAFFIRMATION IN LIEU OF

(38) RESOLUTION 213 — EMERGENCY DEPARTMENT
DESIGNATION REQUIRES PHYSICIAN ON SITE

RECOMMENDATION:

Your Reference Committee recommends that AMA policies D-130.958, D-35.976, H-103.929, H-160.949, and H-160.947 be reaffirmed in lieu of Resolution 213.

HOD ACTION: AMA policies D-130.958, D-35.976, H-103.929, H-160.949, and H-160.947 reaffirmed in lieu of Resolution 213.

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)

Your Reference Committee heard testimony both in support of reaffirming existing policy in lieu of Resolution 213 and in favor of adopting the resolution. Those in favor of adopting the resolution explained that the resolution differs from existing policy because it calls for transparency in how emergency departments present themselves to the public, asking for model state legislation reserving the term “emergency department” to those with 24-7 onsite presence of a physician. Overall, those supporting reaffirmation acknowledged the importance of the issue raised in Resolution 213 but noted that this issue has been thoroughly considered and addressed by the [House of Delegates](#), resulting in recently adopted AMA policy that directly aligns with the resolution. Testimony highlighted Policy D-130.958 specifically which affirms that our AMA “supports that all Emergency Departments be staffed 24-7 by a qualified physician.” While Resolution 213 calls for the development of model legislation, testimony highlighted that the American College of Emergency Physicians (ACEP) already offers [model state legislation](#) that can be utilized by state medical associations, making further AMA action in this area potentially duplicative. Therefore, your Reference Committee recommends that Policies D-130.958, D-35.976, H-103.929, H-160.949, and H-160.947 be reaffirmed in lieu of Resolution 213.

[Staffing Ratios in the Emergency Department D-130.958](#)

1. Our American Medical Association will seek federal legislation or regulation prohibiting staffing ratios that do not allow for proper physician supervision of non-physician practitioners in the Emergency Department.
2. Our AMA supports that all Emergency Departments be staffed 24-7 by a qualified physician.

[Promoting Supervision of Emergency Care Services in Emergency Departments by Physicians D-35.976](#)

Our American Medical Association will advocate for the establishment and enforcement of legislation and/or regulations that ensure only physicians supervise the provision of emergency care services in an emergency department.

[On-Site Physician Requirements for Emergency Departments H-130.929](#)

1. Our American Medical Association recognizes that the preferred model of emergency care is the on-site presence of a physician in the emergency department (ED) whose primary duty is to provide care in that ED, and support state and federal legislation or regulation requiring that a hospital with an ED must have a physician on-site and on duty who is primarily responsible for the emergency department at all times the emergency department is open.
2. Our AMA, in the pursuit of any legislation or regulation requiring the on-site presence of a physician who is primarily responsible for care in the emergency department (ED), supports state medical associations in developing appropriate rural exceptions to such a requirement if, based on the needs of their states, the association chooses to pursue certain alternative supervision models for care provided in EDs in remote rural areas that cannot meet such a requirement due to workforce limitations, ensuring that exceptions only apply where needed. These exceptions shall preserve 24/7 physician supervision of the ED and provide for the availability of a physician to provide on-site care.

[Practicing Medicine by Non-Physicians H-160.949](#)

1. Our American Medical Association urges all people, including physicians and patients, to consider the consequences of any health care plan that places any patient care at risk by substitution of a non-physician in the diagnosis, treatment, education, direction and medical procedures where clear-cut documentation of assured quality has not been carried out, and where such alters the traditional pattern of practice in which the physician directs and supervises the care given;
2. Our AMA continues to work with constituent societies to educate the public regarding the differences in the scopes of practice and education of physicians and non-physician health care workers.
3. Our AMA continues to actively oppose legislation allowing non-physician groups to engage in the practice of medicine without physician (MD, DO) training or appropriate physician (MD, DO) supervision.
4. Our AMA continues to encourage state medical societies to oppose state legislation allowing non-physician groups to engage in the practice of medicine without physician (MD, DO) training or appropriate physician (MD, DO) supervision.

5. Our AMA, through legislative and regulatory efforts, vigorously support and advocate for the requirement of appropriate physician supervision of non-physician clinical staff in all areas of medicine.
6. Our AMA opposes special licensing pathways for “assistant physicians” (i.e., those who are not currently enrolled in an Accreditation Council for Graduate Medical Education training program, or have not completed at least one year of accredited graduate medical education in the U.S).

Physician Assistants and Nurse Practitioners H-160.947

Our American Medical Association will develop a plan to assist the state and local medical societies in identifying and lobbying against laws that allow advanced practice nurses to provide medical care without the supervision of a physician.

The suggested Guidelines for Physician/Physician Assistant Practice are adopted to read as follows (these guidelines shall be used in their entirety):

1. The physician is responsible for managing the health care of patients in all settings.
2. Health care services delivered by physicians and physician assistants must be within the scope of each practitioner's authorized practice, as defined by state law.
3. The physician is ultimately responsible for coordinating and managing the care of patients and, with the appropriate input of the physician assistant, ensuring the quality of health care provided to patients.
4. The physician is responsible for the supervision of the physician assistant in all settings.
5. The role of the physician assistant in the delivery of care should be defined through mutually agreed upon guidelines that are developed by the physician and the physician assistant and based on the physician's delegatory style.
6. The physician must be available for consultation with the physician assistant at all times, either in person or through telecommunication systems or other means.
7. The extent of the involvement by the physician assistant in the assessment and implementation of treatment will depend on the complexity and acuity of the patient's condition and the training, experience, and preparation of the physician assistant, as adjudged by the physician.
8. Patients should be made clearly aware at all times whether they are being cared for by a physician or a physician assistant.
9. The physician and physician assistant together should review all delegated patient services on a regular basis, as well as the mutually agreed upon guidelines for practice.
10. The physician is responsible for clarifying and familiarizing the physician assistant with their supervising methods and style of delegating patient care.

(39) RESOLUTION 218 — DISTRIBUTION OF RESIDENT SLOTS COMMENSURATE WITH SHORTAGES

RECOMMENDATION:

Your Reference Committee recommends that AMA policies H-200.954 and H-200.955 be reaffirmed in lieu of Resolution 218.

HOD ACTION: AMA policies H-200.954 and H-200.955 reaffirmed in lieu of Resolution 218.

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)

Your Reference Committee heard mixed testimony on Resolution 218. Testimony acknowledged existing shortages in several specialties, including general internal medicine, family medicine, preventive medicine, pediatrics, obstetrics and gynecology, and psychiatry. Supporters of the resolution argued that these shortages are harming patient access to care and noted that these specialties should be prioritized in the distribution of residency slots. Amendments were offered to include additional specialties and some of their unique needs. However, your Reference Committee also heard that our AMA is an umbrella organization representing all specialties, and that physician shortages are projected across the board—estimated at approximately 86,000 by 2036—not just in the fields identified in the resolution. Testimony further emphasized that current AMA policy supports a flexible, needs-based approach to residency slot allocation. Specifically, Policy H-200.955, clause 6, states: “Any increase in the number of funded GME positions, overall or in a given specialty, and in the number of US medical students should be based on a demonstrated regional or national need.” This policy approach helps avoid repeating the challenges created by the 1996 cap on Medicare-funded residency slots, which has constrained growth and limited the ability to meet evolving community needs. Testimony also noted that, in alignment with this policy, our AMA has supported multiple federal bills that seek to expand residency slots both broadly and in targeted areas of shortage. Therefore, your Reference Committee recommends that existing AMA policies H-200.954 and H-200.955 be reaffirmed in lieu of Resolution 218.

[US Physician Shortage H-200.954](#)

1. Our American Medical Association explicitly recognizes the existing shortage of physicians in many specialties and areas of the US.
2. Our AMA supports efforts to quantify the geographic maldistribution and physician shortage in many specialties.
3. Our AMA supports current programs to alleviate the shortages in many specialties and the maldistribution of physicians in the US.
4. Our AMA encourages medical schools and residency programs to consider developing admissions policies and practices and targeted

- educational efforts aimed at attracting physicians to practice in underserved areas and to provide care to underserved populations.
5. Our AMA encourages medical schools and residency programs to continue to provide courses, clerkships, and longitudinal experiences in rural and other underserved areas as a means to support educational program objectives and to influence choice of graduates' practice locations.
 6. Our AMA encourages medical schools to include criteria and processes in admission of medical students that are predictive of graduates' eventual practice in underserved areas and with underserved populations.
 7. Our AMA will continue to advocate for funding from public and private payers for educational programs that provide experiences for medical students in rural and other underserved areas.
 8. Our AMA will continue to advocate for funding from all payers (public and private sector) to increase the number of graduate medical education positions in specialties leading to first certification.
 9. Our AMA will work with other groups to explore additional innovative strategies for funding graduate medical education positions, including positions tied to geographic or specialty need.
 10. Our AMA continues to work with the Association of American Medical Colleges (AAMC) and other relevant groups to monitor the outcomes of the National Resident Matching Program; and
 11. Our AMA continues to work with the AAMC and other relevant groups to develop strategies to address the current and potential shortages in clinical training sites for medical students.
 12. Our AMA will:
 - a. promote greater awareness and implementation of the Project ECHO (Extension for Community Healthcare Outcomes) and Child Psychiatry Access Project models among academic health centers and community-based primary care physicians;
 - b. work with stakeholders to identify and mitigate barriers to broader implementation of these models in the United States; and
 - c. monitor whether health care payers offer additional payment or incentive payments for physicians who engage in clinical practice improvement activities as a result of their participation in programs such as Project ECHO and the Child Psychiatry Access Project; and if confirmed, promote awareness of these benefits among physicians.
 13. Our AMA will work to augment the impact of initiatives to address rural physician workforce shortages.
 14. Our AMA supports opportunities to incentivize physicians to select specialties and practice settings which involve delivery of health services to populations experiencing a shortage of providers, such as women, LGBTQ+ patients, children, elder adults, and patients with disabilities, including populations of such patients who do not live in underserved geographic areas.

[Revisions to AMA Policy on the Physician Workforce H-200.955](#)

It is our American Medical Association policy that:

1. Any workforce planning efforts, done by our AMA or others, should utilize data on all aspects of the health care system, including projected demographics of both providers and patients, the number and roles of other health professionals in providing care, and practice environment changes. Planning should have as a goal appropriate physician numbers, specialty mix, and geographic distribution.
2. Our AMA encourages and collaborates in the collection of the data needed for workforce planning and in the conduct of national and regional research on physician supply and distribution. The AMA will independently and in collaboration with state and specialty societies, national medical organizations, and other public and private sector groups, compile and disseminate the results of the research.
3. The medical profession must be integrally involved in any workforce planning efforts sponsored by federal or state governments, or by the private sector.
4. In order to enhance access to care, our AMA collaborates with the public and private sectors to ensure an adequate supply of physicians in all specialties and to develop strategies to mitigate the current geographic maldistribution of physicians.
5. There is a need to enhance underrepresented minority representation in medical schools and in the physician workforce, as a means to ultimately improve access to care for minority and underserved groups.
6. There should be no decrease in the number of funded graduate medical education (GME) positions. Any increase in the number of funded GME positions, overall or in a given specialty, and in the number of US medical students should be based on a demonstrated regional or national need.
7. Our AMA will collect and disseminate information on market demands and workforce needs, so as to assist medical students and resident physicians in selecting a specialty and choosing a career.
8. Our AMA will encourage the Health Resources & Service Administration to collaborate with specialty societies to determine specific changes that would improve the agency's physician workforce projections process, to potentially include more detailed projection inputs, with the goal of producing more accurate and detailed projections including specialty and subspecialty workforces.
9. Our AMA will consider physician retraining during all its deliberations on physician workforce planning.

(40) RESOLUTION 224 — SUPPORT SAVE PLAN AND
PUBLIC SERVICE LOAN FORGIVENESS (PSLF)
APPLICATIONS

RECOMMENDATION:

Your Reference Committee recommends that AMA policies
H-305.925 and D-305.984 be reaffirmed in lieu of
Resolution 224.

**HOD ACTION: AMA policies H-305.925 and D-305.984
reaffirmed in lieu of Resolution 224.**

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 (AMA)
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)

Your Reference Committee heard mixed testimony for Resolution 224. Your Reference
Committee heard that medical education is expensive and so student loans are a vital part
of ensuring that a wide range of individuals can become physicians. The testimony stated
how important it was to have a sustainable and fair way to pay for medical school and
highlighted the positive aspects of the SAVE Plan. However, further testimony noted that
the SAVE Plan was unlikely to be implemented and instead would very likely be rescinded
by the current Administration if the courts do not find it illegal first. Further testimony noted
the strong policy that our AMA already has in this space. Current policy already includes
asks such as advocating for an affordable student loan structure, advocating for a capped
interest rate of five percent in student loans, advocating for lower interest rates on student
loans, advocating for equal or less expensive loans, and ensuring favorable terms in the
Higher Education Act. Your Reference Committee heard that this strong policy that our
AMA already possesses allowed our AMA to respond to [requests for information](#) regarding
the Public Service Loan Forgiveness Program, provide comments to the Administration
when the SAVE Plan was being created, [support](#) legislation such as the REDI Act which
would allow borrowers to qualify for interest-free deferment on their student loans while
serving in a residency program, maintain valuable [resources](#) for medical student
borrowers, and [comment](#) on the latest proposed changes to the PSLF, Income-Driven
Repayment Plans, and student loan caps in the Continuing Resolution (CR). Therefore,
your Reference Committee recommends that existing AMA policies H-305.925 and D-
305.984 be reaffirmed in lieu of Resolution 224.

[Principles of and Actions to Address Medical Education Costs and Student Debt H-305.925](#)

The costs of medical education should never be a barrier to the pursuit of a career in medicine nor to the decision to practice in a given specialty. To help address this issue, our American Medical Association (AMA) will:

1. Collaborate with members of the Federation and the medical education community, and with other interested organizations, to address the cost of medical education and medical student debt through public- and private-sector advocacy.
2. Vigorously advocate for and support expansion of and adequate funding for federal scholarship and loan repayment programs--such as those from the National Health Service Corps, Indian Health Service, Armed Forces, and Department of Veterans Affairs, and for comparable programs from states and the private sector--to promote practice in underserved areas, the military, and academic medicine or clinical research.
3. Encourage the expansion of National Institutes of Health programs that provide loan repayment in exchange for a commitment to conduct targeted research.
4. Advocate for increased funding for the National Health Service Corps Loan Repayment Program to assure adequate funding of primary care within the National Health Service Corps, as well as to permit:
 - a. inclusion of all medical specialties in need, and
 - b. service in clinical settings that care for the underserved but are not necessarily located in health professions shortage areas.
5. Encourage the National Health Service Corps to have repayment policies that are consistent with other federal loan forgiveness programs, thereby decreasing the amount of loans in default and increasing the number of physicians practicing in underserved areas.
6. Work to reinstate the economic hardship deferment qualification criterion known as the "20/220 pathway," and support alternate mechanisms that better address the financial needs of trainees with educational debt.
7. Advocate for federal legislation to support the creation of student loan savings accounts that allow for pre-tax dollars to be used to pay for student loans.
8. Work with other concerned organizations to advocate for legislation and regulation that would result in favorable terms and conditions for borrowing and for loan repayment, and would permit 100% tax deductibility of interest on student loans and elimination of taxes on aid from service-based programs.
9. Encourage the creation of private-sector financial aid programs with favorable interest rates or service obligations (such as community- or institution-based loan repayment programs or state medical society loan programs).
10. Support stable funding for medical education programs to limit excessive tuition increases, and collect and disseminate information on

- 1 medical school programs that cap medical education debt, including the
2 types of debt management education that are provided.
- 3 11. Work with state medical societies to advocate for the creation of either
4 tuition caps or, if caps are not feasible, pre-defined tuition increases, so
5 that medical students will be aware of their tuition and fee costs for the
6 total period of their enrollment.
- 7 12. Encourage medical schools to:
- 8 a. study the costs and benefits associated with non-traditional
9 instructional formats (such as online and distance learning, and
10 combined baccalaureate/MD or DO programs) to determine if cost
11 savings to medical schools and to medical students could be
12 realized without jeopardizing the quality of medical education;
- 13 b. engage in fundraising activities to increase the availability of
14 scholarship support, with the support of the Federation, medical
15 schools, and state and specialty medical societies, and develop or
16 enhance financial aid opportunities for medical students, such as
17 self-managed, low-interest loan programs;
- 18 c. cooperate with postsecondary institutions to establish collaborative
19 debt counseling for entering first-year medical students;
- 20 d. allow for flexible scheduling for medical students who encounter
21 financial difficulties that can be remedied only by employment, and
22 consider creating opportunities for paid employment for medical
23 students;
- 24 e. counsel individual medical student borrowers on the status of their
25 indebtedness and payment schedules prior to their graduation;
- 26 f. inform students of all government loan opportunities and disclose
27 the reasons that preferred lenders were chosen;
- 28 g. ensure that all medical student fees are earmarked for specific and
29 well-defined purposes, and avoid charging any overly broad and ill-
30 defined fees, such as but not limited to professional fees;
- 31 h. use their collective purchasing power to obtain discounts for their
32 students on necessary medical equipment, textbooks, and other
33 educational supplies;
- 34 i. work to ensure stable funding, to eliminate the need for increases
35 in tuition and fees to compensate for unanticipated decreases in
36 other sources of revenue; mid-year and retroactive tuition increases
37 should be opposed.
- 38 13. Support and encourage state medical societies to support further
39 expansion of state loan repayment programs, particularly those that
40 encompass physicians in non-primary care specialties.
- 41 14. Take an active advocacy role during reauthorization of the Higher
42 Education Act and similar legislation, to achieve the following goals:
- 43 a. Eliminating the single holder rule.
- 44 b. Making the availability of loan deferment more flexible, including
45 broadening the definition of economic hardship and expanding the
46 period for loan deferment to include the entire length of residency
47 and fellowship training.
- 48 c. Retaining the option of loan forbearance for residents ineligible for
49 loan deferment.

- d. Including, explicitly, dependent care expenses in the definition of the “cost of attendance”.
 - e. Including room and board expenses in the definition of tax-exempt scholarship income.
 - f. Continuing the federal Direct Loan Consolidation program, including the ability to “lock in” a fixed interest rate, and giving consideration to grace periods in renewals of federal loan programs.
 - g. Adding the ability to refinance Federal Consolidation Loans.
 - h. Eliminating the cap on the student loan interest deduction.
 - i. Increasing the income limits for taking the interest deduction.
 - j. Making permanent the education tax incentives that our AMA successfully lobbied for as part of Economic Growth and Tax Relief Reconciliation Act of 2001.
 - k. Ensuring that loan repayment programs do not place greater burdens upon married couples than for similarly situated couples who are cohabitating.
 - l. Increasing efforts to collect overdue debts from the present medical student loan programs in a manner that would not interfere with the provision of future loan funds to medical students.
15. Continue to work with state and county medical societies to advocate for adequate levels of medical school funding and to oppose legislative or regulatory provisions that would result in significant or unplanned tuition increases.
 16. Continue to study medical education financing, so as to identify long-term strategies to mitigate the debt burden of medical students, and monitor the short-and long-term impact of the economic environment on the availability of institutional and external sources of financial aid for medical students, as well as on choice of specialty and practice location.
 17. Collect and disseminate information on successful strategies used by medical schools to cap or reduce tuition.
 18. Continue to monitor the availability of and encourage medical schools and residency/fellowship programs to:
 - a. provide financial aid opportunities and financial planning/debt management counseling to medical students and resident/fellow physicians;
 - b. work with key stakeholders to develop and disseminate standardized information on these topics for use by medical students, resident/fellow physicians, and young physicians; and
 - c. share innovative approaches with the medical education community.
 19. Seek federal legislation or rule changes that would stop Medicare and Medicaid decertification of physicians due to unpaid student loan debt. Our AMA believes that it is improper for physicians not to repay their educational loans, but assistance should be available to those physicians who are experiencing hardship in meeting their obligations.
 20. Related to the Public Service Loan Forgiveness (PSLF) Program, our AMA supports increased medical student and physician participation in the program, and will:

- a. Advocate that all resident/fellow physicians have access to PSLF during their training years.
 - b. Advocate against a monetary cap on PSLF and other federal loan forgiveness programs.
 - c. Work with the United States Department of Education to ensure that any cap on loan forgiveness under PSLF be at least equal to the principal amount borrowed.
 - d. Ask the United States Department of Education to include all terms of PSLF in the contractual obligations of the Master Promissory Note.
 - e. Encourage the Accreditation Council for Graduate Medical Education (ACGME) to require residency/fellowship programs to include within the terms, conditions, and benefits of program appointment information on the employer's PSLF program qualifying status.
 - f. Advocate that the profit status of a physician's training institution not be a factor for PSLF eligibility,
 - g. Encourage medical school financial advisors to counsel wise borrowing by medical students, in the event that the PSLF program is eliminated or severely curtailed.
 - h. Encourage medical school financial advisors to increase medical student engagement in service-based loan repayment options, and other federal and military programs, as an attractive alternative to the PSLF in terms of financial prospects as well as providing the opportunity to provide care in medically underserved areas.
 - i. Strongly advocate that the terms of the PSLF that existed at the time of the agreement remain unchanged for any program participant in the event of any future restrictive changes.
 - j. Monitor the denial rates for physician applicants to the PSLF.
 - k. Undertake expanded federal advocacy, in the event denial rates for physician applicants are unexpectedly high, to encourage release of information on the basis for the high denial rates, increased transparency and streamlining of program requirements, consistent and accurate communication between loan servicers and borrowers, and clear expectations regarding oversight and accountability of the loan servicers responsible for the program.
 - l. Work with the United States Department of Education to ensure that applicants to the PSLF and its supplemental extensions, such as Temporary Expanded Public Service Loan Forgiveness (TEPSLF), are provided with the necessary information to successfully complete the program(s) in a timely manner.
 - m. Work with the United States Department of Education to ensure that individuals who would otherwise qualify for PSLF and its supplemental extensions, such as TEPSLF, are not disqualified from the program(s).
21. Advocate for continued funding of programs including Income-Driven Repayment plans for the benefit of reducing medical student load burden.
 22. Strongly advocate for the passage of legislation to allow medical students, residents and fellows who have education loans to qualify for

1 interest-free deferment on their student loans while serving in a medical
2 internship, residency, or fellowship program, as well as permitting the
3 conversion of currently unsubsidized Stafford and Graduate Plus loans
4 to interest free status for the duration of undergraduate and graduate
5 medical education.

- 6 23. Continue to monitor opportunities to reduce additional expense burden
7 upon medical students including reduced-cost or free programs for
8 residency applications, virtual or hybrid interviews, and other cost-
9 reduction initiatives aimed at reducing non-educational debt.
- 10 24. Encourage medical students, residents, fellows and physicians in
11 practice to take advantage of available loan forgiveness programs and
12 grants and scholarships that have been historically underutilized, as
13 well as financial information and resources available through the
14 Association of American Medical Colleges and American Association
15 of Colleges of Osteopathic Medicine, as required by the Liaison
16 Committee on Medical Education and Commission on Osteopathic
17 College Accreditation, and resources available at the federal, state and
18 local levels.
- 19 25. Support federal efforts to forgive debt incurred during medical school
20 and other higher education by physicians and medical students,
21 including educational and cost of attendance debt.
- 22 26. Support that residency and fellowship application services grant fee
23 assistance to applicants who previously received fee assistance from
24 medical school application services or are determined to have financial
25 need through another formal mechanism.

26 [Reduction in Student Loan Interest Rates D-305.984](#)

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- 28
- 29 1. Our American Medical Association will actively lobby for legislation
30 aimed at establishing an affordable student loan structure with a
31 variable interest rate capped at no more than 5.0%.
- 32 2. Our AMA will work in collaboration with other health profession
33 organizations to advocate for a reduction of the fixed interest rate of the
34 Stafford student loan program and the Graduate PLUS loan program.
- 35 3. Our AMA will consider the total cost of loans including loan origination
36 fees and benefits of federal loans such as tax deductibility or loan
37 forgiveness when advocating for a reduction in student loan interest
38 rates.
- 39 4. Our AMA will advocate for policies which lead to equal or less
40 expensive loans (in terms of loan benefits, origination fees, and interest
41 rates) for Grad-PLUS loans as this would change the status quo of high-
42 borrowers paying higher interest rates and fees in addition to having a
43 higher overall loan burden.

(41) RESOLUTION 225 — THE PRIVATE PRACTICE
PHYSICIANS IN THE COMMUNITY

RECOMMENDATION:

Your Reference Committee recommends that AMA policies H-330.932, D-385.945, H-385.900, and H-390.849 be reaffirmed in lieu of Resolution 225.

HOD ACTION: AMA policies H-330.932, D-385.945, H-385.900, and H-390.849 reaffirmed in lieu of Resolution 225.

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)

Your Reference Committee heard mixed testimony on Resolution 225. Those in support of adoption emphasized the urgency of addressing ongoing physician payment cuts—particularly amid rising practice costs and inflation—and called for stronger, more visible advocacy from our AMA. In contrast, supporters of reaffirmation highlighted the extensive work already underway, noting our AMA's robust policy portfolio and its designation of Medicare Physician Payment Reform as a top advocacy priority. Testimony highlighted that our AMA has consistently submitted [comments](#) on the Medicare Physician Fee Schedule, sent letters, and engaged in direct lobbying with key legislators on this issue. While some testimony noted that the resolution's novelty lies in its call for a cost-of-living adjustment, your Reference Committee found that this is already addressed under existing AMA Policy H-330.932, clause 5, which states: "Our AMA supports a mandatory annual 'cost-of-living' or COLA increase in Medicaid, Medicare, and other appropriate health care reimbursement programs." Therefore, your Reference Committee recommends that Policies H-330.932, D-385.945, H-385.900, and H-390.849 be reaffirmed in lieu of Resolution 225.

[Cuts in Medicare and Medicaid Reimbursement H-330.932](#)

1. Our American Medical Association continues to oppose payment cuts in the Medicare and Medicaid budgets that may reduce patient access to care and undermine the quality of care provided to patients.
2. Our AMA supports the concept that the Medicare and Medicaid budgets need to expand adequately to adjust for factors such as cost of living, the growing size of the Medicare population, and the cost of new technology.

3. Our AMA aggressively encourages CMS to affirm the patient's and the physician's constitutional right to privately contract for medical services.
4. If the reimbursement is not improved, our AMA declares the Medicare reimbursement unworkable and intolerable, and seek immediate legislation to allow the physician to balance bill the patient according to their usual and customary fee.
5. Our AMA supports a mandatory annual "cost-of-living" or COLA increase in Medicaid, Medicare, and other appropriate health care reimbursement programs, in addition to other needed payment increases.

[Advocacy and Action for a Sustainable Medical Care System D-385.945](#)

1. Our American Medical Association will declare Medicare physician payment reform as an urgent advocacy and legislative priority for our AMA.
2. Our AMA will prioritize significant increases in funding for federal and state advocacy budgets specifically allocated to achieve Medicare physician payment reform to ensure that physician payments are updated annually at least equal to the annual percentage increase in the Medicare Economic Index.
3. Our AMA Board of Trustees will report back to the House of Delegates at each annual and interim meeting on the progress of our AMA in achieving Medicare payment reform until predictable, sustainable, fair physician payment is achieved.

[Payment for Pre-Certified/Preauthorized Procedures H-385.900](#)

1. Our American Medical Association supports the position that the practice of retrospective denial of payment or payment recoupment for care which has been pre-certified by an insurer should be prohibited under federal statute, except when materially false or fraudulent information has knowingly been given to the insurer by the physician, hospital or ancillary service provider to obtain pre-certification.
2. Our AMA will continue to advocate for legislation, regulation, or other appropriate means to ensure that all health plans including those regulated by ERISA, pay for services that are pre-authorized, or pre-certified by such health plan, including services that are deemed pre-authorized or pre-certified because the physician participates in a "Gold Card" program operated by that health plan.
3. Our AMA encourages legal action against health plans that engage in inappropriate post-service payment denials and payment recoupment.

[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.

(42) RESOLUTION 226 — REGULATIONS FOR
ALGORITHMIC-BASED HEALTH INSURANCE
UTILIZATION REVIEW

RECOMMENDATION A:

Your Reference Committee recommends that AMA policy H-480.931 be reaffirmed in lieu of the first resolve of Resolution 226.

RECOMMENDATION B:

Your Reference Committee recommends that the second resolve of Resolution 226 be adopted.

HOD ACTION: AMA policy H-480.931 reaffirmed in lieu of the first resolve of Resolution 226 and the second resolve of Resolution 226 adopted.

RESOLVED, that our American Medical Association shall 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)

Your Reference Committee heard mixed testimony on Resolution 226. Testimony in support of adoption emphasized growing concerns about the use of artificial intelligence (AI) in insurance utilization review, particularly regarding its lack of transparency, potential for bias, and the risk of harm to patient care. Several testifiers shared personal experiences in which AI-driven denials of prescription renewals or prior authorization requests led to patient harm and distress. However, your Reference Committee also heard testimony that the key asks of this resolution are already addressed by existing AMA policy, and that our AMA is actively advocating on this issue at both the state and federal levels. Supporters of reaffirmation highlighted Policy H-480.931, adopted at I-24, which reflects current AMA positions and was vetted by subject matter experts, relevant Councils, and the Board of Trustees. An amendment was offered to Policy D-480.956, but as that policy was not included in the original resolution, the amendment was deemed not germane at this time. Therefore, your Reference Committee recommends that existing AMA policy H-480.931 be reaffirmed in lieu of the first resolve of Resolution 226 and that the second resolve of Resolution 226 be adopted.

Assessing the Intersection Between AI and Health Care H-480.931

1. General Governance

- a. Health care AI must be designed, developed, and deployed in a manner which is ethical, equitable, responsible, accurate, transparent, and evidence-based.
- b. Use of AI in health care delivery requires clear national governance policies to regulate its adoption and utilization, ensuring patient safety, and mitigating inequities. Development of national governance policies should include interdepartmental and interagency collaboration.
- c. Compliance with national governance policies is necessary to develop AI in an ethical and responsible manner to ensure patient safety, quality, and continued access to care. Voluntary agreements or voluntary compliance is not sufficient.
- d. AI systems should be developed and evaluated with a specific focus on mitigating bias and promoting health equity, ensuring that the deployment of these technologies does not exacerbate existing disparities in health care access, treatment, or outcomes.
- e. Health care AI requires a risk-based approach where the level of scrutiny, validation, and oversight should be proportionate to the overall potential of disparate harm and consequences the AI system might introduce [See also Augmented Intelligence in Health Care H-480.939 at (1)]
- f. AI risk management should minimize potential negative impacts of health care AI systems while providing opportunities to maximize positive impacts.
- g. Clinical decisions influenced by AI must be made with specified qualified human intervention points during the decision-making process. A qualified human is defined as a licensed physician with the necessary qualifications and training to independently provide the same medical service without the aid of AI. As the potential for patient harm increases, the point in time when a physician should utilize their clinical judgment to interpret or act on an AI recommendation should occur earlier in the care plan. With few exceptions, there generally should be a qualified human in the loop when it comes to medical decision making capable of intervening or overriding the output of an AI model.
- h. Health care practices and institutions should not utilize AI systems or technologies that introduce overall or disparate risk that is beyond their capabilities to mitigate. Implementation and utilization of AI should avoid exacerbating clinician burden and should be designed and deployed in harmony with the clinical workflow and, in institutional settings, consistent with AMA Policy H-225.940 - Augmented Intelligence and Organized Medical Staff.
- i. Medical specialty societies, clinical experts, and informaticists are best positioned and should identify the most appropriate uses of AI-enabled technologies relevant to their clinical expertise and set the standards for AI use in their specific domain. [See Augmented Intelligence in Health Care H-480.940 at (2)]

2. When to Disclose: Transparency in Use of Augmented Intelligence-Enabled Systems and Technologies That Impact Medical Decision Making at the Point of Care
 - a. Decisions regarding transparency and disclosure of the use of AI should be based upon a risk- and impact-based approach that considers the unique circumstance of AI and its use case. The need for transparency and disclosure is greater where the performance of an AI-enabled technology has a greater risk of causing harm to a patient.
 - i. AI disclosure should align and meet ethical standards or norms.
 - ii. Transparency requirements should be designed to meet the needs of the end users. Documentation and disclosure should enhance patient and physician knowledge without increasing administrative burden.
 - iii. When AI is used in a manner which impacts access to care or impacts medical decision making at the point of care, that use of AI should be disclosed and documented to both physicians and/or patients in a culturally and linguistically appropriate manner. The opportunity for a patient or their caregiver to request additional review from a licensed clinician should be made available upon request.
 - iv. When AI is used in a manner which directly impacts patient care, access to care, medical decision making, or the medical record, that use of AI should be documented in the medical record.
 - b. AI tools or systems cannot augment, create, or otherwise generate records, communications, or other content on behalf of a physician without that physician's consent and final review.
 - c. When AI or other algorithmic-based systems or programs are utilized in ways that impact patient access to care, such as by payors to make claims determinations or set coverage limitations, use of those systems or programs must be disclosed to impacted parties.
 - d. The use of AI-enabled technologies by hospitals, health systems, physician practices, or other entities, where patients engage directly with AI, should be clearly disclosed to patients at the beginning of the encounter or interaction with the AI-enabled technology. Where patient-facing content is generated by AI, the use of AI in generating that content should be disclosed or otherwise noted within the content.
3. What to Disclose: Required Disclosures by Health Care Augmented Intelligence-Enabled Systems and Technologies
 - a. When AI-enabled systems and technologies are utilized in health care, the following information should be disclosed by the AI developer to allow the purchaser and/or user (physician) to appropriately evaluate the system or technology prior to purchase or utilization:
 - i. Regulatory approval status.

- 1 ii. Applicable consensus standards and clinical guidelines
- 2 utilized in design, development, deployment, and continued
- 3 use of the technology.
- 4 iii. Clear description of problem formulation and intended use
- 5 accompanied by clear and detailed instructions for use.
- 6 iv. Intended population and intended practice setting.
- 7 v. Clear description of any limitations or risks for use, including
- 8 possible disparate impact.
- 9 vi. Description of how impacted populations were engaged
- 10 during the AI lifecycle.
- 11 vii. Detailed information regarding data used to train the model:
- 12 1. Data provenance.
- 13 2. Data size and completeness.
- 14 3. Data timeframes.
- 15 4. Data diversity.
- 16 5. Data labeling accuracy.
- 17 viii. Validation Data/Information and evidence of:
- 18 1. Clinical expert validation in intended population and
- 19 practice setting and intended clinical outcomes.
- 20 2. Constraint to evidence-based outcomes and
- 21 mitigation of “hallucination”/“confabulation” or other
- 22 output error.
- 23 3. Algorithmic validation.
- 24 4. External validation processes for ongoing evaluation
- 25 of the model performance, e.g., accounting for AI
- 26 model drift and degradation.
- 27 5. Comprehensiveness of data and steps taken to
- 28 mitigate biased outcomes.
- 29 6. Other relevant performance characteristics,
- 30 including but not limited to performance
- 31 characteristics at peer institutions/similar practice
- 32 settings.
- 33 7. Post-market surveillance activities aimed at
- 34 ensuring continued safety, performance, and equity.
- 35 ix. Data Use Policy:
- 36 1. Privacy.
- 37 2. Security.
- 38 3. Special considerations for protected populations or
- 39 groups put at increased risk.
- 40 x. Information regarding maintenance of the algorithm,
- 41 including any use of active patient data for ongoing training.
- 42 xi. Disclosures regarding the composition of design and
- 43 development team, including diversity and conflicts of
- 44 interest, and points of physician involvement and review.
- 45 b. Purchasers and/or users (physicians) should carefully consider
- 46 whether or not to engage with AI-enabled health care technologies
- 47 if this information is not disclosed by the developer. As the risk of
- 48 AI being incorrect increases risks to patients (such as with clinical
- 49 applications of AI that impact medical decision making), disclosure

- 1 of this information becomes increasingly important. [See also
2 Augmented Intelligence in Health Care H-480.939]
- 3 4. Generative Augmented Intelligence
- 4 a. Generative AI should: (a) only be used where appropriate policies
5 are in place within the practice or other health care organization to
6 govern its use and help mitigate associated risks; and (b) follow
7 applicable state and federal laws and regulations (e.g., HIPAA-
8 compliant Business Associate Agreement).
- 9 b. Appropriate governance policies should be developed by health
10 care organizations and account for and mitigate risks of:
- 11 i. Incorrect or falsified responses; lack of ability to readily
12 verify the accuracy of responses or the sources used to
13 generate the response.
- 14 ii. Training data set limitations that could result in responses
15 that are out of date or otherwise incomplete or inaccurate
16 for all patients or specific populations.
- 17 iii. Lack of regulatory or clinical oversight to ensure
18 performance of the tool.
- 19 iv. Bias, discrimination, promotion of stereotypes, and
20 disparate impacts on access or outcomes.
- 21 v. Data privacy.
- 22 vi. Cybersecurity.
- 23 vii. Physician liability associated with the use of generative AI
24 tools.
- 25 c. Health care organizations should work with their AI and other health
26 information technology (health IT) system developers to implement
27 rigorous data validation and verification protocols to ensure that
28 only accurate, comprehensive, and bias managed datasets inform
29 generative AI models, thereby safeguarding equitable patient care
30 and medical outcomes. [See Augmented Intelligence in Health
31 Care H-480.940 at (3)(d)]
- 32 d. Use of generative AI should incorporate physician and staff
33 education about the appropriate use, risks, and benefits of
34 engaging with generative AI. Additionally, physicians and
35 healthcare organizations should engage with generative AI tools
36 only when adequate information regarding the product is provided
37 to physicians and other users by the developers of those tools.
- 38 e. Clinicians should be aware of the risks of patients engaging with
39 generative AI products that produce inaccurate or harmful medical
40 information (g., patients asking chatbots about symptoms) and
41 should be prepared to counsel patients on the limitations of AI-
42 driven medical advice.
- 43 5. Physician Liability for Use of Augmented Intelligence-Enabled
44 Technologies
- 45 a. Current AMA policy states that liability and incentives should be
46 aligned so that the individual(s) or entity(ies) best positioned to
47 know the AI system risks and best positioned to avert or mitigate
48 harm do so through design, development, validation, and
49 implementation. [See Augmented Intelligence in Health Care H-
50 480.939]

- i. 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.
 - ii. 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.
 - iii. 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.
 - b. When physicians do not know or have reason to know that there are concerns about the quality and safety of an AI-enabled technology, they should not be held liable for the performance of the technology in question.
 - c. Liability protections for physicians using AI-enabled technologies should align with both current and future AMA medical liability reform policies.
6. Data Privacy and Augmented Intelligence
 - a. Entity Responsibility:
 - i. Entities, e.g., AI developers, should make information available about the intended use of generative AI in health care and identify the purpose of its use. Individuals should know how their data will be used or reused, and the potential risks and benefits.
 - ii. Individuals should have the right to opt-out, update, or request deletion of their data from generative AI tools. These rights should encompass AI training data and disclosure to other users of the tool.
 - iii. Generative AI tools should not reverse engineer, reconstruct, or reidentify an individual's originally identifiable data or use identifiable data for nonpermitted uses, e.g., when data are permitted to conduct quality and safety evaluations. Preventive measures should include both legal frameworks and data model protections, e.g., secure enclaves, federated learning, and differential privacy.
 - b. User Education:
 - i. Users should be provided with training specifically on generative AI. Education should address:
 1. Legal, ethical, and equity considerations.
 2. Risks such as data breaches and re-identification.
 3. Potential pitfalls of inputting sensitive and personal data.
 4. The importance of transparency with patients regarding the use of generative AI and their data.

[See H-480.940, Augmented Intelligence in Health Care, at (4) and (5)]

1 7. Augmented Intelligence Cybersecurity

- 2 a. AI systems must have strong protections against input manipulation
- 3 and malicious attacks.
- 4 b. Entities developing or deploying health care AI should regularly
- 5 monitor for anomalies or performance deviations, comparing AI
- 6 outputs against known and normal behavior.
- 7 c. Independent of an entity's legal responsibility to notify a health care
- 8 provider or organization of a data breach, that entity should also act
- 9 diligently in identifying and notifying the individuals themselves of
- 10 breaches that impact their personal information.
- 11 d. Users should be provided education on AI cybersecurity
- 12 fundamentals, including specific cybersecurity risks that AI systems
- 13 can face, evolving tactics of AI cyber attackers, and the user's role
- 14 in mitigating threats and reporting suspicious AI behavior or
- 15 outputs.

16 8. Mitigating Misinformation in AI-Enabled Technologies

- 17 a. AI developers should ensure transparency and accountability by
- 18 disclosing how their models are trained and the sources of their
- 19 training data. Clear disclosures are necessary to build trust in the
- 20 accuracy and reliability of the information produced by AI systems.
- 21 b. Algorithms should be developed to detect and flag potentially false
- 22 and misleading content before it is widely disseminated.
- 23 c. Developers of AI should have mechanisms in place to allow for
- 24 reporting of mis- and disinformation generated or propagated by AI-
- 25 enabled systems.
- 26 d. Developers of AI systems should be guided by policies that
- 27 emphasize rigorous validation and accountability for the content
- 28 their tools generate, and, consistent with AMA Policy H-480.939(7),
- 29 are in the best position to manage issues of liability arising directly
- 30 from system failure or misdiagnosis and must accept this liability
- 31 with measures such as maintaining appropriate medical liability
- 32 insurance and in their agreements with users.
- 33 e. Academic publications and journals should establish clear
- 34 guidelines to regulate the use of AI in manuscript submissions.
- 35 These guidelines should include requiring the disclosure that AI was
- 36 used in research methods and data collection, requiring the
- 37 exclusion of AI systems as authors, and should outline the
- 38 responsibility of the authors to validate the veracity of any
- 39 referenced content generated by AI.
- 40 f. Education programs are needed to enhance digital literacy, helping
- 41 individuals critically assess the information they encounter online,
- 42 particularly in the medical field where mis- and disinformation can
- 43 have severe consequences.

44 9. Payor Use of Augmented Intelligence and Automated Decision-Making

45 Systems

- 46 a. Use of automated decision-making systems that determine
- 47 coverage limits, make claim determinations, and engage in benefit
- 48 design should be publicly reported, based on easily accessible
- 49 evidence-based clinical guidelines (as opposed to proprietary payor

1 criteria), and disclosed to both patients and their physician in a way
2 that is easy to understand.

- 3 b. Payors should only use automated decision-making systems to
4 improve or enhance efficiencies in coverage and payment
5 automation, facilitate administrative simplification, and reduce
6 workflow burdens. Automated decision-making systems should
7 never create or exacerbate overall or disparate access barriers to
8 needed benefits by increasing denials, coverage limitations, or
9 limiting benefit offerings. Use of automated decision-making
10 systems should not replace the individualized assessment of a
11 patient's specific medical and social circumstances and payors' use
12 of such systems should allow for flexibility to override automated
13 decisions. Payors should always make determinations based on
14 particular patient care needs and not base decisions on algorithms
15 developed on "similar" or "like" patients.
- 16 c. Payors using automated decision-making systems should disclose
17 information about any algorithm training and reference data,
18 including where data were sourced and attributes about individuals
19 contained within the training data set (e.g., age, race, gender).
20 Payors should provide clear evidence that their systems do not
21 discriminate, increase inequities, and that protections are in place
22 to mitigate bias.
- 23 d. Payors using automated decision-making systems should identify
24 and cite peer-reviewed studies assessing the system's accuracy
25 measured against the outcomes of patients and the validity of the
26 system's predictions.
- 27 e. Any automated decision-making system recommendation that
28 indicates limitations or denials of care, at both the initial review and
29 appeal levels, should be automatically referred for review to a
30 physician (a) possessing a current and valid non-restricted license
31 to practice medicine in the state in which the proposed services
32 would be provided if authorized and (b) be of the same specialty as
33 the physician who typically manages the medical condition or
34 disease or provides the health care service involved in the request
35 prior to issuance of any final determination. Prior to issuing an
36 adverse determination, the treating physician must have the
37 opportunity to discuss the medical necessity of the care directly with
38 the physician who will be responsible for determining if the care is
39 authorized.
- 40 f. Individuals impacted by a payor's automated decision-making
41 system, including patients and their physicians, must have access
42 to all relevant information (including the coverage criteria, results
43 that led to the coverage determination, and clinical guidelines
44 used).
- 45 g. Payors using automated decision-making systems should be
46 required to engage in regular system audits to ensure use of the
47 system is not increasing overall or disparate claims denials or
48 coverage limitations, or otherwise decreasing access to care.
49 Payors using automated decision-making systems should make
50 statistics regarding systems' approval, denial, and appeal rates

1 available on their website (or another publicly available website) in
2 a readily accessible format with patient population demographics to
3 report and contextualize equity implications of automated
4 decisions. Insurance regulators should consider requiring reporting
5 of payor use of automated decision-making systems so that they
6 can be monitored for negative and disparate impacts on access to
7 care. Payor use of automated decision-making systems must
8 conform to all relevant state and federal laws.

9
10 (43) RESOLUTION 227 — PAYMENT RECOUPMENT—LET
11 SANITY PREVAIL

12
13 RECOMMENDATION:

14
15 Your Reference Committee recommends that AMA policies
16 H-70.926, H-335.981, H-385.900, D-385.944, D-385.965,
17 D-320.991, H-335.963, H-190.969, and H-185.999 be
18 reaffirmed in lieu of Resolution 227.

19
20 **HOD ACTION: AMA policies H-70.926, H-335.981, H-**
21 **385.900, D-385.944, D-385.965, D-320.991, H-335.963, H-**
22 **190.969, and H-185.999 reaffirmed in lieu of Resolution 227.**

23
24 RESOLVED, that our American Medical Association advocates for legislation and
25 regulations compliant with the Supreme Court holding in *Rutledge v. PCMA* (Directive to
26 Take Action); and be it further

27
28 RESOLVED, that our AMA advocates for legislation and regulations that stipulate that if
29 payment recovery or recoupment is due to coordination of benefit failure, the payer seeks
30 recovery from the patient and/or the correct insurance company or primary payer
31 responsible for the claim (Directive to Take Action); and be it further

32
33 RESOLVED, that our AMA advocates for legislation and that whenever a health plan
34 seeks recoupment or payment recovery for overpayment or wrong payment from a
35 physician, a detailed and comprehensive explanation for the payment
36 recoupment/recovery must be provided (Directive to Take Action); and be it further

37
38 RESOLVED, that our AMA advocates for legislation and regulation that if the reason for
39 claim recovery or recoupment is not due to physician error, the health plan may not seek
40 recovery from the physician and that health plans must seek resolution from the patient
41 on whose behalf the insurance company paid the claim and who has a contract with the
42 insurance company or the third party responsible for the payment involved in claim
43 recovery or recoupment (Directive to Take Action); and be it further

44
45 RESOLVED, that our AMA report back at the 2026 Annual Meeting on the progress of the
46 implementation of this resolution (Directive to Take Action).

47
48 Your Reference Committee heard mixed testimony on Resolution 227. Testimony
49 reflected broad support for the resolution's intent to protect physicians from unjust
50 recoupment practices, particularly in cases where the physician is not at fault. There was

1 strong emphasis in the testimony regarding the need for greater transparency, fairness,
2 and for shifting the administrative and financial burden away from physicians. Your
3 Reference Committee also heard that our AMA already maintains comprehensive policy
4 addressing these concerns. Further testimony noted that our AMA has developed
5 [resources](#) to help physicians secure accurate claims payments, navigate the overpayment
6 recovery process, appeal incorrect payments, and understand state-specific insurance
7 recoupment laws. In addition, our AMA has provided extensive [guidance](#) on the
8 implications of the Supreme Court's decision in *Rutledge v. PCMA*. Our AMA is also in the
9 process of updating our ERISA preemption issue brief to more broadly address
10 preemption of state laws applying directly to ERISA plans, including but not limited to
11 recoupment, and how laws might best be structured to survive ERISA preemption.
12 Therefore, your Reference Committee recommends that existing AMA policies H-70.926,
13 H-335.981, H-385.900, D-385.944, D-385.965, D-320.991, H-335.963, H-190.969, and H-
14 185.999 be reaffirmed in lieu of Resolution 227.

15
16 [Reasonable Time Limitations on Post-Payment Audits and Recoupments](#)
17 [by Third Party Payers H-70.926](#)

18
19 Our AMA policy is that post-payment audits, post-payment downcodes and
20 other similar requests for recoupment by third party payers be made within
21 one year of the date the claim is submitted or within the same amount of
22 time permitted for submission of the claim, whichever is less.

23
24 [Medical Office Screens H-335.981](#)

25
26 It is the policy of the AMA to take the following actions:

- 27
28 1. seek specific clarification from CMS on the process, procedures, and
29 criteria of physician office postpayment review and recoupment;
30 2. lobby for full due process protection for carrier postpayment review and
31 recoupment situation;
32 3. oppose the concept and application of extrapolation;
33 4. oppose arbitrary, erratic, or inappropriate components of postpayment
34 review and recoupment; and
35 5. seek appropriate relief to achieve equitable treatment of physicians in
36 office postpayment review and recoupment situations.

37
38 [Payment for Pre-Certified/Preauthorized Procedures H-385.900](#)

- 39
40 1. Our American Medical Association supports the position that the
41 practice of retrospective denial of payment or payment recoupment for
42 care which has been pre-certified by an insurer should be prohibited
43 under federal statute, except when materially false or fraudulent
44 information has knowingly been given to the insurer by the physician,
45 hospital or ancillary service provider to obtain pre-certification.
46 2. Our AMA will continue to advocate for legislation, regulation, or other
47 appropriate means to ensure that all health plans including those
48 regulated by ERISA, pay for services that are pre-authorized, or pre-
49 certified by such health plan, including services that are deemed pre-

1 authorized or pre-certified because the physician participates in a "Gold
2 Card" program operated by that health plan.

- 3 3. Our AMA encourages legal action against health plans that engage in
4 inappropriate post-service payment denials and payment recoupment.
5

6 [ERISA Preemption of State Laws Regulating Pharmacy Benefit Managers](#)
7 [D-385.944](#)
8

9 Our American Medical Association will study, and create resources for
10 states, on the implication of Rutledge, Attorney General Of Arkansas v.
11 Pharmaceutical Care Management Association, and any other relevant
12 legal decisions from the last several years, in reference to potentially
13 allowing more successful challenges to the actions of healthcare plans
14 protected by the Employee Retirement Income Security Act of 1974
15 (ERISA) when the quality of care or healthcare outcomes are questioned.
16

17 [Insurance Companies Use of Contractors to Recover Payments D-385.965](#)
18

- 19 1. Our AMA will seek legislation to limit insurance companies, their
20 agents, or any contractors from requesting payment back on paid
21 claims to no more than 90 days after payment is made.
22

23 (a) Such legislation would require insurance companies, their agents,
24 or any contractors to have a defined and acceptable process for
25 physicians to dispute these maneuvers to get payment back on
26 claims already processed, verified, and paid.

27 (b) Such legislation would ban insurance companies, their agents or
28 contractors from using re-pricers and re-reviewers and to adhere to
29 their own pricing and reviewing guidelines as agreed upon in their
30 contracts with physicians.
31

- 32 2. Our AMA will pursue legislation to regulate self-insured plans in this
33 regard and apply the same rules to Medicare and other federal plans.
34

35 [Creating a Fair and Balanced Medicare and Medicaid RAC Program D-](#)
36 [320.991](#)
37

- 38 1. Our AMA will continue to monitor Medicare and Medicaid Recovery
39 Audit Contractor (RAC) practices and recovery statistics and continue
40 to encourage the Centers for Medicare and Medicaid Services (CMS)
41 to adopt new regulations which will impose penalties against RACs for
42 abusive practices.

43 2. Our AMA will continue to encourage CMS to adopt new regulations
44 which require physician review of all medical necessity cases in post-
45 payment audits, as medical necessity is quintessentially a physician
46 determination and judgment.

- 47 3. Our AMA will encourage CMS to discontinue the denial of payments or
48 imposition of negative action during an audit due to the absence of
49 specific words in the chief complaint when the note provides adequate
50 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.

[Member Education on Medicare Recovery Audit Contractors H-335.963](#)

Our AMA: (1) will educate our membership about the effect of the program's safeguard contractor activity and Recovery Audit Contractor (RAC) audits on individual physician practices, expansion of the RAC program, and assistance that may be available through our AMA; and (2) will actively support the legislation currently before Congress to require an immediate moratorium on the expansion of the RAC program, and will seek the introduction of subsequent legislation that would limit or exclude physician billings from the authority of RAC audits altogether.

[Delay in Payments Due to Disputes in Coordination of Benefits H-190.969](#)

1. Our American Medical Association urges state and federal agencies to exercise their authority over health plans to ensure that beneficiaries' claims are promptly paid and that state and federal legislation that guarantees the timely resolution of disputes in coordination of benefits between health plans is actively enforced.
2. Our AMA includes the "birthday rule" as a last resort only after parents/guardians have been allowed a choice of insurer and have failed to choose, and the "employer first rule" in any and all future AMA model legislation and model medical service agreements that contain coordination of benefits information and/or guidance on timely payment of health insurances claims.
3. Our AMA urges state medical associations to advocate for the inclusion of the "employer first rule", and "birthday rule" as a last resort only after parents/guardians have been allowed a choice of insurer and have failed to choose, in state insurance statutes as mechanisms for alleviating disputes in coordination of benefits.
4. Our AMA includes questions on payment timeliness in its Socioeconomic Monitoring System survey to collect information on the extent of the problem at the national level and to track the success of state legislation on payment delays.
5. Our AMA continues to encourage state medical associations to utilize the prompt payment provisions contained in the AMA Model Managed Care Medical Services Agreement and in AMA model state legislation.
6. Our AMA, through its Advocacy Resource Center, continues to coordinate and implement the timely payment campaign, including the promotion of the payment delay survey instrument, to assess and communicate the scope of payment delays as well as ensure prompt payment of health insurance claims and interest accrual on late payments by all health plans, including those regulated by ERISA.
7. Our AMA urges private sector health care accreditation organizations to
 - a. develop and utilize standards that incorporate summary statistics on claims processing performance, including claim payment timeliness, and
 - b. require accredited health plans to provide this information to patients, physicians, and other purchasers of health care services.

[Multiple Coverage in Voluntary Health Insurance H-185.999](#)

1. Over-insurance can arise when an individual is insured under two or more policies of health insurance. When the reimbursement from this multiple coverage exceeds the expenses against which the individual has insured himself, a profit may result. Over-insurance thus encourages wasteful use of the public's health care dollar.
2. A solution to this problem can be accomplished by the use of contract language and the application of coordination of benefits provisions which operate to enable persons covered under two or more group programs to be fully reimbursed for their expenses of insured services

- 1 without receiving more in total benefits than the amount of such
- 2 expenses.
- 3 3. Therefore, the AMA encourages the health insurance companies and
- 4 prepayment plans to adopt policy provisions and mechanisms based
- 5 upon the preceding principles which would control the adverse effects
- 6 of over-insurance.

- 1 This concludes the report of Reference Committee B. I would like to thank Man-Kit Leung,
- 2 MD, Ryan Hall, MD, Matthew D. Gold, MD, Sara Coffey, DO, Caleb C. Atkins, MD,
- 3 Deborah Fletcher, MD, and all those who testified before the Committee.

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