DISCLAIMER

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

If you wish to propose an amendment to an item of business, click here: A25 HOD Amendment

*Your Reference Committee recommendation has changed from the preliminary report.

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.

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.

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

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

RECOMMENDATION:

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

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

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

Your Reference Committee heard limited, but entirely supportive testimony for Board of Trustees Report 16. Testimony highlighted excitement surrounding the outcomes of current AMA field research being conducted in the realm of misinformation and disinformation as it relates to scope of practice. Therefore, your Reference Committee

recommends that Board of Trustees Report 16 be adopted, and the remainder of the report be filed.

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

RECOMMENDATION:

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

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

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

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

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

RECOMMENDATION:

Your Reference Committee recommends that Resolution 208 be adopted.

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

Your Reference Committee heard supportive testimony for Resolution 208. Testimony highlighted concerns that binding arbitration clauses limit physicians' legal recourse, reduce transparency, and can disproportionately favor insurers. Given the potential

implications for physician practice sustainability and patient care, your Reference Committee agrees that this issue warrants further investigation. Therefore, your Reference 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.

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

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

(7) RESOLUTION 220 — STRENGTHENING AMA POLICY ON NONCOMPETE CLAUSES IN OWNERSHIP TRANSITIONS

RECOMMENDATION:

Your Reference Committee recommends that Resolution 220 be adopted.

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

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

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

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

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

(8) *RESOLUTION 233 — INCREASING TRANSPARENCY OF AMA MEDICARE PAYMENT REFORM STRATEGY

RECOMMENDATION:

Your Reference Committee recommends that Resolution 233 be adopted.

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

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

Your Reference Committee heard testimony overwhelmingly in support of adopting Resolution 233 and in opposition to reaffirming existing policy. Your Reference Committee 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.

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.

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.

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)

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

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

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

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

2. That our AMA supports legislation and/or regulation of all cannabis products that:

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

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

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

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

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

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

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

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

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

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 Committee also received an amendment, that was supported by multiple testifiers, which proposed removing the specific legislative reference while preserving the intent of the

Resolution. Therefore, your Reference Committee recommends that Resolution 203 be adopted as amended.

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

RECOMMENDATION A:

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

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

RECOMMENDATION B:

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

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

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

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

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

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

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

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

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

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

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

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

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

RECOMMENDATION A:

Your Reference Committee recommends that Resolution 214 be adopted.

RECOMMENDATION B:

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

MANAGED CARE UTILIZATION REVIEW SYSTEMS

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

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

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

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

RECOMMENDATION A:

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

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

RECOMMENDATION B:

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

RECOMMENDATION C:

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

SUPPORT FOR AGING-OUT FOSTER YOUTH WITH MENTAL HEALTH NEEDS

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

Your Reference Committee heard testimony in favor of Resolution 216. Testimony noted that youth aging out of foster care face special challenges and are at heightened risk for mental health problems and substance use disorders. Additional testimony noted that special programs (such as the Transition Housing Program and the John H Chafee Program for Successful Transition to Adulthood) provide valuable supports and services to youth transitioning from foster care, but that funding for many of these programs has 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.

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 only appropriately qualified and certified child and adolescent medical and mental health professionals provide services to participants, and support oversight and review by licensed physicians, mental health professionals, and any other appropriate healthcare professionals

4. Our AMA supports efforts to improve information sharing between states on promising practices for preventing and addressing maltreatment in residential facilities. (Modify Current HOD Policy)

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

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

RECOMMENDATION A:

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

RESOLVED, that our AMA ~~American Medical Association advocate for~~ support the continuance of premium processing and other mechanisms that ~~an expedited~~ H-1B visa application**s** and renewal**s** ~~process~~ for International Medical Graduate physicians. (Directive to Take Action)

RECOMMENDATION B:

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

RECOMMENDATION C:

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

EXPEDITED H-1B PATHWAYS FOR INTERNATIONAL MEDICAL GRADUATE PHYSICIANS IN THE USA

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

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

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

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

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

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

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)

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

(25) *RESOLUTION 234 — PROTECTION FOR INTERNATIONAL MEDICAL GRADUATES

RECOMMENDATION A:

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

RECOMMENDATION B:

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

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

RECOMMENDATION C:

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

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

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

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

Presence and Enforcement Actions of Immigration and Customs Enforcement (ICE) in Healthcare D-160.921

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

AMA Principles on International Medical Graduates H-255.988

1. Our American Medical Association supports current U.S. visa and immigration requirements applicable to foreign national physicians who are graduates of medical schools other than those in the United States and Canada.

2. Our AMA supports current regulations governing the issuance of exchange visitor visas to foreign national IMGs, including the requirements for successful completion of the USMLE.
3. Our AMA reaffirms its policy that the U.S. and Canada medical schools be accredited by a nongovernmental accrediting body.
4. Our AMA supports cooperation in the collection and analysis of information on medical schools in nations other than the U.S. and Canada.
5. Our AMA supports continued cooperation with the ECFMG and other appropriate organizations to disseminate information to prospective and current students in foreign medical schools. An AMA member, who is an IMG, should be appointed regularly as one of the AMA's representatives to the ECFMG Board of Trustees.
6. Our AMA supports working with the Accreditation Council for Graduate Medical Education (ACGME) and the Federation of State Medical Boards (FSMB) to assure that institutions offering accredited residencies, residency program directors, and U.S. licensing authorities do not deviate from established standards when evaluating graduates of foreign medical schools.
7. In cooperation with the ACGME and the FSMB, our AMA supports only those modifications in established graduate medical education or licensing standards designed to enhance the quality of medical education and patient care.
8. Our AMA continues to support the activities of the ECFMG related to verification of education credentials and testing of IMGs.
9. Our AMA supports that special consideration be given to the limited number of IMGs who are refugees from foreign governments that refuse to provide pertinent information usually required to establish eligibility for residency training or licensure.
10. Our AMA supports that accreditation standards enhance the quality of patient care and medical education and not be used for purposes of regulating physician manpower.
11. Our AMA representatives to the ACGME, residency review committees and to the ECFMG should support AMA policy opposing discrimination. Medical school admissions officers and directors of residency programs should select applicants on the basis of merit, without considering status as an IMG or an ethnic name as a negative factor.
12. Our AMA supports the requirement that all medical school graduates complete at least one year of graduate medical education in an accredited U.S. program in order to qualify for full and unrestricted licensure. State medical licensing boards are encouraged to allow an alternate set of criteria for granting licensure in lieu of this requirement:
    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.

(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~~ support the Accreditation Council for Graduate Medical Education (ACGME), the Commission on Osteopathic College Accreditation (COCA), and the Liaison Committee on Medical Education (LCME), ~~to~~ in enforc~~e~~ing appropriate inclusive excellence ~~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 creating a culture of inclusive excellence ~~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 inclusive excellence ~~diversity, equity, and inclusion~~.

RECOMMENDATION D:

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

RECOMMENDATION E:

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

PRESERVING ACCREDITATION STANDARDS ON INCLUSIVE EXCELLENCE

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 diversity, equity, and inclusion standards; and be it further

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

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

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

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 that the SEVP does not apply to J-1 visas, which is the visa type most commonly utilized by international medical students, and instead only applies to F-1 and M-1 visas. Testimony noted that since the main visa type that our international medical students use

is not impacted by the SEVP that our AMA should instead allow key parties including impacted universities who have strong standing in this space, to take the lead advocacy role in this space. Further testimony noted that our AMA should focus its engagement on a space where we can have a meaningful impact, and where our work will be most felt by our physicians. An amendment that reflected this sentiment was offered which your Reference Committee accepted. Your Reference Committee also notes that our AMA has existing policy in this space that complements this resolution. Therefore, your Reference Committee recommends that Resolution 241 be adopted as amended and that existing AMA policies H-255.988 and D-255.911 be reaffirmed.

AMA Principles on International Medical Graduates H-255.988

1. Our American Medical Association supports current U.S. visa and immigration requirements applicable to foreign national physicians who are graduates of medical schools other than those in the United States and Canada.
2. Our AMA supports current regulations governing the issuance of exchange visitor visas to foreign national IMGs, including the requirements for successful completion of the USMLE.
3. Our AMA reaffirms its policy that the U.S. and Canada medical schools be accredited by a nongovernmental accrediting body.
4. Our AMA supports cooperation in the collection and analysis of information on medical schools in nations other than the U.S. and Canada.
5. Our AMA supports continued cooperation with the ECFMG and other appropriate organizations to disseminate information to prospective and current students in foreign medical schools. An AMA member, who is an IMG, should be appointed regularly as one of the AMA's representatives to the ECFMG Board of Trustees.
6. Our AMA supports working with the Accreditation Council for Graduate Medical Education (ACGME) and the Federation of State Medical Boards (FSMB) to assure that institutions offering accredited residencies, residency program directors, and U.S. licensing authorities do not deviate from established standards when evaluating graduates of foreign medical schools.
7. In cooperation with the ACGME and the FSMB, our AMA supports only those modifications in established graduate medical education or licensing standards designed to enhance the quality of medical education and patient care.
8. Our AMA continues to support the activities of the ECFMG related to verification of education credentials and testing of IMGs.
9. Our AMA supports that special consideration be given to the limited number of IMGs who are refugees from foreign governments that refuse to provide pertinent information usually required to establish eligibility for residency training or licensure.
10. Our AMA supports that accreditation standards enhance the quality of patient care and medical education and not be used for purposes of regulating physician manpower.
11. Our AMA representatives to the ACGME, residency review committees and to the ECFMG should support AMA policy opposing discrimination.

Medical school admissions officers and directors of residency programs should select applicants on the basis of merit, without considering status as an IMG or an ethnic name as a negative factor.

12. Our AMA supports the requirement that all medical school graduates complete at least one year of graduate medical education in an accredited U.S. program in order to qualify for full and unrestricted licensure. State medical licensing boards are encouraged to allow an alternate set of criteria for granting licensure in lieu of this requirement:
    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 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.

RECOMMENDATION E:

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

PROTECTING EVIDENCE-BASED MEDICINE, PUBLIC HEALTH INFRASTRUCTURE AND BIOMEDICAL RESEARCH

RESOLVED, that our 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 (New HOD Policy); and be it further

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

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

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

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 Epilepsy Program but also the many other valuable programs housed within HHS. Moreover, testimony noted that by broadening this policy we would not be prioritizing one

program over others. Therefore, your Reference Committee recommends that Alternate Resolution 202 be adopted in lieu of Resolution 202.

(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

RECOMMENDATION A:

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

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

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

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

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

RECOMMENDATION B:

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

SUPPORT FOR CONTINUANCE OF SECTION 1115 MEDICAID WAIVERS AND DEMONSTRATION PROJECTS

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.

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 behalf of the combined Resolutions 207 and 231 and it was widely supported that Resolutions 207 and 231 be considered together. Your Reference Committee also heard testimony noting that venue shopping is an extremely complicated issue involving varying

state and federal rules, statutes, cases, and Constitutional issues. Testimony also highlighted that having our AMA advocate for specific venue requirements may have unintended consequences for physicians who are defending allegations of medical liability. However, significant testimony was offered highlighting the problems that can arise for physicians when venue shopping is utilized in medical liability cases. An alternate resolution was offered by the authors of the two resolutions which the Reference Committee largely accepted. Though your Reference Committee considered testimony to the effect that it would be preferable to have the study on this topic performed before taking a stance on this issue, especially given the complexity of the issues surrounding venue shopping, overwhelming testimony was received in support of action being taken on venue shopping immediately. Therefore, your Reference Committee recommends that Alternate Resolution 207 be adopted in lieu of Resolutions 207 and 231.

(32) *RESOLUTION 219 — OPPOSING UNWARRANTED NATIONAL INSTITUTES OF HEALTH RESEARCH INSTITUTE RESTRUCTURING

RECOMMENDATION:

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

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

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

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

RESOLVED, that our AMA support study of the short- and long-term impacts of federal biomedical research funding reductions, including medical innovation, the healthcare workforce, medical education, public health and local economies and communities.

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

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

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

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

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

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

Resolution 232 — Preservation Of Medicaid

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

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

Resolution 236 – Preservation of Medicaid

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

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

Your Reference Committee heard substantial testimony on Resolutions 221, 223, 232, and 236 which all relate to the preservation of the Medicaid program. The testimony for all four resolutions was largely the same, with many testifiers providing identical testimony for more than one resolution. As a result, many commenters noted that the resolutions should be consolidated into a single resolution, and no testimony opposed consolidation. An amendment to consolidate the resolutions was offered and received support from multiple commenters. Much of the testimony favored making Medicaid advocacy a top legislative advocacy priority of our AMA. Your Reference Committee believes this would be consistent with our AMA's existing efforts in advocating for the preservation of Medicaid, including two recent letters to the Energy and Commerce Committee of the House of Representatives and the leadership of the House of Representatives expressing our AMA's concern with the Medicaid proposals included in the reconciliation legislation that Congress is currently considering. Further testimony noted that our AMA Center for Health Equity's guide Advancing Health Equity: A Guide to Narrative, Language, and 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

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 appointments, their future as physicians in the United Sates would be in jeopardy. However, your Reference Committee also heard that our AMA strives to maintain broad policies that can be responsive both to the immediate needs that arise within the immigration space as well as address the issues long term and that as a result, our current AMA policies already speak to the importance of maintaining a well-functioning and timely

visa application process including working “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.” Testimony also highlighted that, our AMA acknowledges that the Educational Commission for Foreign Medical Graduates (ECFMG) is the universal sponsor for J-1 physicians in the United States. Our AMA consistently works to support ECFMG as the recognized leader in this space. Testimony stated that, due to the deference that our AMA provides to ECFMG, our AMA has a good working relationship with ECFMG and supports ECFMG as requested and appropriate. Therefore, your Reference Committee recommends that Alternate Resolution 237 be 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

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

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

(36) *RESOLUTION 212 — SETTING STANDARDS FOR FORENSIC TOXICOLOGY LABORATORIES USED IN LITIGATION

RECOMMENDATION:

Your Reference Committee recommends that Resolution 212 be referred.

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

1. Forensic toxicology laboratories that analyze drugs in bodily fluids to follow the same protocols and obtain equivalent certifications as their clinical chemistry counterparts based in hospitals; and

2. CLIA – exempt forensic toxicology laboratories to obtain relevant accreditations and certifications such as CAP Forensic Drug Testing accreditation program (CAP FDT, formerly FUDT or Forensic Urine Drug Testing Accreditation Program]) the American Board of Forensic Toxicology Laboratory Accreditation Program (ABFT LAP), the American Society of Crime Laboratory Directors Laboratory Accreditation Board (ASCLD/LAB) or other related certification program (as their clinical chemistry counterparts in hospitals are required) which are publicly displayed; and

3. forensic toxicology laboratories to follow relevant state codes and regulations addressing testing of breath, blood, and urine for alcohol, other drugs, and intoxicating compounds; and

4. a Laboratory Director and/or Certifying Scientist who reviews all protocols and laboratory manuals and signs off on each result electronically to be a licensed physician (with proper and current board certification) or a scientist with an appropriate advanced graduate degree and certification; and

5. that results of laboratory proficiency testing and Quality Control Programs be available to the court and its litigants for review to assist in verifying forensic laboratory results. (Directive to Take Action)

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.

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.
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 "step therapy".
g. Support and cover chronic treatment with anti-obesity medications to maintain weight loss.
h. Allow a patient's physician to prescribe anti-obesity medication and have it covered by insurance, without a requirement that patients must receive the prescription only from contracted disease management companies.

2. Our AMA will support and provide resources to state delegations in their efforts to advocate for the reduction of bias against patients that suffer from obesity for the actions listed. (Modify Current HOD Policy)

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

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.

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 agencys 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.

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 medical school programs that cap medical education debt, including the types of debt management education that are provided.
11. Work with state medical societies to advocate for the creation of either tuition caps or, if caps are not feasible, pre-defined tuition increases, so that medical students will be aware of their tuition and fee costs for the total period of their enrollment.
12. Encourage medical schools to:

a. study the costs and benefits associated with non-traditional instructional formats (such as online and distance learning, and combined baccalaureate/MD or DO programs) to determine if cost savings to medical schools and to medical students could be realized without jeopardizing the quality of medical education;
b. engage in fundraising activities to increase the availability of scholarship support, with the support of the Federation, medical schools, and state and specialty medical societies, and develop or enhance financial aid opportunities for medical students, such as self-managed, low-interest loan programs;
c. cooperate with postsecondary institutions to establish collaborative debt counseling for entering first-year medical students;
d. allow for flexible scheduling for medical students who encounter financial difficulties that can be remedied only by employment, and consider creating opportunities for paid employment for medical students;
e. counsel individual medical student borrowers on the status of their indebtedness and payment schedules prior to their graduation;
f. inform students of all government loan opportunities and disclose the reasons that preferred lenders were chosen;
g. ensure that all medical student fees are earmarked for specific and well-defined purposes, and avoid charging any overly broad and ill-defined fees, such as but not limited to professional fees;
h. use their collective purchasing power to obtain discounts for their students on necessary medical equipment, textbooks, and other educational supplies;
i. work to ensure stable funding, to eliminate the need for increases in tuition and fees to compensate for unanticipated decreases in other sources of revenue; mid-year and retroactive tuition increases should be opposed.

13. Support and encourage state medical societies to support further expansion of state loan repayment programs, particularly those that encompass physicians in non-primary care specialties.
14. Take an active advocacy role during reauthorization of the Higher Education Act and similar legislation, to achieve the following goals:
    a. Eliminating the single holder rule.
    b. Making the availability of loan deferment more flexible, including broadening the definition of economic hardship and expanding the period for loan deferment to include the entire length of residency and fellowship training.
    c. Retaining the option of loan forbearance for residents ineligible for 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 interest-free deferment on their student loans while serving in a medical internship, residency, or fellowship program, as well as permitting the conversion of currently unsubsidized Stafford and Graduate Plus loans to interest free status for the duration of undergraduate and graduate medical education.
23. Continue to monitor opportunities to reduce additional expense burden upon medical students including reduced-cost or free programs for

residency applications, virtual or hybrid interviews, and other cost-reduction initiatives aimed at reducing non-educational debt.

24. Encourage medical students, residents, fellows and physicians in practice to take advantage of available loan forgiveness programs and grants and scholarships that have been historically underutilized, as well as financial information and resources available through the Association of American Medical Colleges and American Association of Colleges of Osteopathic Medicine, as required by the Liaison Committee on Medical Education and Commission on Osteopathic College Accreditation, and resources available at the federal, state and local levels.
25. Support federal efforts to forgive debt incurred during medical school and other higher education by physicians and medical students, including educational and cost of attendance debt.
26. Support that residency and fellowship application services grant fee assistance to applicants who previously received fee assistance from medical school application services or are determined to have financial need through another formal mechanism.

Reduction in Student Loan Interest Rates D-305.984

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

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.

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 introduc [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.
    ii. Applicable consensus standards and clinical guidelines utilized in design, development, deployment, and continued use of the technology.
    iii. Clear description of problem formulation and intended use accompanied by clear and detailed instructions for use.
    iv. Intended population and intended practice setting.

v. Clear description of any limitations or risks for use, including possible disparate impact.
vi. Description of how impacted populations were engaged during the AI lifecycle.
vii. Detailed information regarding data used to train the model:
    1. Data provenance.
    2. Data size and completeness.
    3. Data timeframes.
    4. Data diversity.
    5. Data labeling accuracy.
viii. Validation Data/Information and evidence of:
    1. Clinical expert validation in intended population and practice setting and intended clinical outcomes.
    2. Constraint to evidence-based outcomes and mitigation of “hallucination”/“confabulation” or other output error.
    3. Algorithmic validation.
    4. External validation processes for ongoing evaluation of the model performance, e.g., accounting for AI model drift and degradation.
    5. Comprehensiveness of data and steps taken to mitigate biased outcomes.
    6. Other relevant performance characteristics, including but not limited to performance characteristics at peer institutions/similar practice settings.
    7. Post-market surveillance activities aimed at ensuring continued safety, performance, and equity.
ix. Data Use Policy:
    1. Privacy.
    2. Security.
    3. Special considerations for protected populations or groups put at increased risk.
x. Information regarding maintenance of the algorithm, including any use of active patient data for ongoing training.
xi. Disclosures regarding the composition of design and development team, including diversity and conflicts of interest, and points of physician involvement and review.

b. Purchasers and/or users (physicians) should carefully consider whether or not to engage with AI-enabled health care technologies if this information is not disclosed by the developer. As the risk of AI being incorrect increases risks to patients (such as with clinical applications of AI that impact medical decision making), disclosure of this information becomes increasingly important. [See also Augmented Intelligence in Health Care H-480.939]

4. Generative Augmented Intelligence

a. Generative AI should: (a) only be used where appropriate policies are in place within the practice or other health care organization to govern its use and help mitigate associated risks; and (b) follow

applicable state and federal laws and regulations (e.g., HIPAA-compliant Business Associate Agreement).

b. Appropriate governance policies should be developed by health care organizations and account for and mitigate risks of:
    i. Incorrect or falsified responses; lack of ability to readily verify the accuracy of responses or the sources used to generate the response.
    ii. Training data set limitations that could result in responses that are out of date or otherwise incomplete or inaccurate for all patients or specific populations.
    iii. Lack of regulatory or clinical oversight to ensure performance of the tool.
    iv. Bias, discrimination, promotion of stereotypes, and disparate impacts on access or outcomes.
    v. Data privacy.
    vi. Cybersecurity.
    vii. Physician liability associated with the use of generative AI tools.

c. Health care organizations should work with their AI and other health information technology (health IT) system developers to implement rigorous data validation and verification protocols to ensure that only accurate, comprehensive, and bias managed datasets inform generative AI models, thereby safeguarding equitable patient care and medical outcomes. [See Augmented Intelligence in Health Care H-480.940 at (3)(d)]

d. Use of generative AI should incorporate physician and staff education about the appropriate use, risks, and benefits of engaging with generative AI. Additionally, physicians and healthcare organizations should engage with generative AI tools only when adequate information regarding the product is provided to physicians and other users by the developers of those tools.

e. Clinicians should be aware of the risks of patients engaging with generative AI products that produce inaccurate or harmful medical information (g., patients asking chatbots about symptoms) and should be prepared to counsel patients on the limitations of AI-driven medical advice.

5. Physician Liability for Use of Augmented Intelligence-Enabled Technologies

a. Current AMA policy states that liability and incentives should be aligned so that the individual(s) or entity(ies) best positioned to know the AI system risks and best positioned to avert or mitigate harm do so through design, development, validation, and implementation. [See Augmented Intelligence in Health Care H-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)]

7. Augmented Intelligence Cybersecurity

a. AI systems must have strong protections against input manipulation and malicious attacks.

b. Entities developing or deploying health care AI should regularly monitor for anomalies or performance deviations, comparing AI outputs against known and normal behavior.

c. Independent of an entity's legal responsibility to notify a health care provider or organization of a data breach, that entity should also act diligently in identifying and notifying the individuals themselves of breaches that impact their personal information.
d. Users should be provided education on AI cybersecurity fundamentals, including specific cybersecurity risks that AI systems can face, evolving tactics of AI cyber attackers, and the user's role in mitigating threats and reporting suspicious AI behavior or outputs.

8. Mitigating Misinformation in AI-Enabled Technologies
   a. AI developers should ensure transparency and accountability by disclosing how their models are trained and the sources of their training dat Clear disclosures are necessary to build trust in the accuracy and reliability of the information produced by AI systems.
   b. Algorithms should be developed to detect and flag potentially false and misleading content before it is widely disseminated.
   c. Developers of AI should have mechanisms in place to allow for reporting of mis- and disinformation generated or propagated by AI-enabled systems.
   d. Developers of AI systems should be guided by policies that emphasize rigorous validation and accountability for the content their tools generate, and, consistent with AMA Policy H-480.939(7), 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.
   e. Academic publications and journals should establish clear guidelines to regulate the use of AI in manuscript submissions. These guidelines should include requiring the disclosure that AI was used in research methods and data collection, requiring the exclusion of AI systems as authors, and should outline the responsibility of the authors to validate the veracity of any referenced content generated by AI.
   f. Education programs are needed to enhance digital literacy, helping individuals critically assess the information they encounter online, particularly in the medical field where mis- and disinformation can have severe consequences.
9. Payor Use of Augmented Intelligence and Automated Decision-Making Systems
   a. Use of automated decision-making systems that determine coverage limits, make claim determinations, and engage in benefit design should be publicly reported, based on easily accessible evidence-based clinical guidelines (as opposed to proprietary payor criteria), and disclosed to both patients and their physician in a way that is easy to understand.
   b. Payors should only use automated decision-making systems to improve or enhance efficiencies in coverage and payment automation, facilitate administrative simplification, and reduce workflow burdens. Automated decision-making systems should never create or exacerbate overall or disparate access barriers to

needed benefits by increasing denials, coverage limitations, or limiting benefit offerings. Use of automated decision-making systems should not replace the individualized assessment of a patient's specific medical and social circumstances and payors' use of such systems should allow for flexibility to override automated decisions. Payors should always make determinations based on particular patient care needs and not base decisions on algorithms developed on "similar" or "like" patients.

c. Payors using automated decision-making systems should disclose information about any algorithm training and reference data, including where data were sourced and attributes about individuals contained within the training data set (e.g., age, race, gender). Payors should provide clear evidence that their systems do not discriminate, increase inequities, and that protections are in place to mitigate bias.

d. Payors using automated decision-making systems should identify and cite peer-reviewed studies assessing the system's accuracy measured against the outcomes of patients and the validity of the system's predictions.

e. Any automated decision-making system recommendation that indicates limitations or denials of care, at both the initial review and appeal levels, should be automatically referred for review to a physician (a) possessing a current and valid non-restricted license to practice medicine in the state in which the proposed services would be provided if authorized and (b) be of the same specialty as the physician who typically manages the medical condition or disease or provides the health care service involved in the request prior to issuance of any final determination. Prior to issuing an adverse determination, the treating physician must have the opportunity to discuss the medical necessity of the care directly with the physician who will be responsible for determining if the care is authorized.

f. Individuals impacted by a payor's automated decision-making system, including patients and their physicians, must have access to all relevant information (including the coverage criteria, results that led to the coverage determination, and clinical guidelines used).

g. Payors using automated decision-making systems should be required to engage in regular system audits to ensure use of the system is not increasing overall or disparate claims denials or coverage limitations, or otherwise decreasing access to care. Payors using automated decision-making systems should make statistics regarding systems' approval, denial, and appeal rates available on their website (or another publicly available website) in a readily accessible format with patient population demographics to report and contextualize equity implications of automated decisions. Insurance regulators should consider requiring reporting of payor use of automated decision-making systems so that they can be monitored for negative and disparate impacts on access to

care. Payor use of automated decision-making systems must conform to all relevant state and federal laws.

(43) RESOLUTION 227 — PAYMENT RECOUPMENT—LET SANITY PREVAIL

RECOMMENDATION:

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

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

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

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

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

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

Your Reference Committee heard mixed testimony on Resolution 227. Testimony reflected broad support for the resolution's intent to protect physicians from unjust recoupment practices, particularly in cases where the physician is not at fault. There was strong emphasis in the testimony regarding the need for greater transparency, fairness, and for shifting the administrative and financial burden away from physicians. Your Reference Committee also heard that our AMA already maintains comprehensive policy addressing these concerns. Further testimony noted that our AMA has developed resources to help physicians secure accurate claims payments, navigate the overpayment recovery process, appeal incorrect payments, and understand state-specific insurance recoupment laws. In addition, our AMA has provided extensive guidance on the implications of the Supreme Court's decision in *Rutledge v. PCMA*. Our AMA is also in the process of updating our ERISA preemption issue brief to more broadly address preemption of state laws applying directly to ERISA plans, including but not limited to

recoupment, and how laws might best be structured to survive ERISA preemption. Therefore, your Reference Committee recommends that existing AMA policies H-70.926, H-335.981, H-385.900, D-385.944, D-385.965, D-320.991, H-335.963, H-190.969, and H-185.999 be reaffirmed in lieu of Resolution 227.

Reasonable Time Limitations on Post-Payment Audits and Recoupments by Third Party Payers H-70.926

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

Medical Office Screens H-335.981

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

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

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.

ERISA Preemption of State Laws Regulating Pharmacy Benefit Managers D-385.944

Our American Medical Association will study, and create resources for states, on the implication of Rutledge, Attorney General Of Arkansas v. Pharmaceutical Care Management Association, and any other relevant

legal decisions from the last several years, in reference to potentially allowing more successful challenges to the actions of healthcare plans protected by the Employee Retirement Income Security Act of 1974 (ERISA) when the quality of care or healthcare outcomes are questioned.

Insurance Companies Use of Contractors to Recover Payments D-385.965

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

    (a) Such legislation would require insurance companies, their agents, or any contractors to have a defined and acceptable process for physicians to dispute these maneuvers to get payment back on claims already processed, verified, and paid.
    (b) Such legislation would ban insurance companies, their agents or contractors from using re-pricers and re-reviewers and to adhere to their own pricing and reviewing guidelines as agreed upon in their contracts with physicians.

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

Creating a Fair and Balanced Medicare and Medicaid RAC Program D-320.991

1. Our AMA will continue to monitor Medicare and Medicaid Recovery Audit Contractor (RAC) practices and recovery statistics and continue to encourage the Centers for Medicare and Medicaid Services (CMS) to adopt new regulations which will impose penalties against RACs for abusive practices.
2. Our AMA will continue to encourage CMS to adopt new regulations which require physician review of all medical necessity cases in post-payment audits, as medical necessity is quintessentially a physician determination and judgment.
3. Our AMA will encourage CMS to discontinue the denial of payments or imposition of negative action during an audit due to the absence of specific words in the chief complaint when the note provides adequate documentation of the reason for the visit and services rendered.
4. Our AMA will assist states by providing recommendations regarding state implementation of Medicaid RAC rules and regulations in order to lessen confusion among physicians and to ensure that states properly balance the interest in overpayment and underpayment audit corrections for Recovery Contractors.
5. Our AMA will petition CMS to amend CMS' rules governing the use of extrapolation in the RAC audit process, so that the amended CMS rules conform to Section 1893 of the Social Security Act Subsection (f) (3) - Limitation on Use of Extrapolation; and insists that the amended rules state that when an RAC initially contacts a physician, the RAC is not permitted to use extrapolation to determine overpayment amounts to

be recovered from that physician by recoupment, offset, or otherwise, unless (as per Section 1893 of the Social Security Act) the Secretary of Health and Human Services has already determined, before the RAC audit, either that (a) previous, routine pre- or post-payment audits of the physician's claims by the Medicare Administrative Contractor have found a sustained or high level of previous payment errors, or that (b) documented educational intervention has failed to correct those payment errors.

6. Our AMA, in coordination with other stakeholders such as the American Hospital Association, will seek to influence Congress to eliminate the current RAC system and ask CMS to consolidate its audit systems into a more balanced, transparent, and fair system, which does not increase administrative burdens on physicians.
7. Our AMA will: (A) seek to influence CMS and Congress to require that a physician, and not a lower level provider, review and approve any RAC claim against physicians or physician-decision making, (B) seek to influence CMS and Congress to allow physicians to be paid any denied claim if appropriate services are rendered, and (C) seek the enactment of fines, penalties and the recovery of costs incurred in defending against RACs whenever an appeal against them is won in order to discourage inappropriate and illegitimate audit work by RACs.
8. Our AMA will advocate for penalties and interest to be imposed on the auditor and payable to the physician when a RAC audit or appeal for a claim has been found in favor of the physician.

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

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

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