REPORTS OF THE BOARD OF TRUSTEES

The following reports were presented by David H. Aizuss, MD, Chair:

1. ANNUAL REPORT

Reference committee hearing: see report of Reference Committee F.

HOUSE ACTION: FILED

The Consolidated Financial Statements for the years ended December 31, 2025 and 2024 and the Independent Auditor's report have been included in the 2025 Annual Report, that is included in the Handbook mailing to members of the House of Delegates.

2. NEW SPECIALTY ORGANIZATIONS REPRESENTATION IN THE HOUSE OF DELEGATES

Reference committee hearing: see report of Reference Committee on Ethics and Bylaws.

HOD ACTION: RECOMMENDATIONS ADOPTED
REMAINDER OF REPORT FILED
See Policy D-600.984

The Board of Trustees (BOT) and the Specialty and Service Society (SSS) considered the applications of the American Association of Hip and Knee Surgeons, the American Epilepsy Society, and the American Society of Neuroimaging for national medical specialty organization representation in the American Medical Association (AMA) House of Delegates (HOD). The applications were first reviewed by the AMA SSS Rules Committee and presented to the SSS Assembly for consideration.

The applications were considered using criteria developed by the Council on Long Range Planning and Development and adopted by the HOD (Policy G-600.020). (Exhibit A)

Organizations seeking admission were asked to provide appropriate membership information to the AMA. That information was analyzed to determine AMA membership, as required under criterion three. A summary of this information is attached to this report as Exhibit B.

In addition, organizations must submit a letter of application in a designated format. This format lists the above-mentioned guidelines followed by each organization's explanation of how it meets each of the criteria.

Before a society is eligible for admission to the HOD, it must participate in the SSS for three years. These organizations have actively participated in the SSS for more than three years.

Review of the materials and discussion during the SSS meeting at the November 2025 Interim Meeting indicated that the American Association of Hip and Knee Surgeons, the American Epilepsy Society, and the American Society of Neuroimaging meet the criteria for representation in the HOD.

RECOMMENDATION

Therefore, the Board of Trustees recommends that the American Association of Hip and Knee Surgeons, the American Epilepsy Society, and the American Society of Neuroimaging be granted representation in the AMA House of Delegates and that the remainder of the report be filed. (Directive to Take Action)

Fiscal Note: Less than $500

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APPENDIX
Exhibit A

GUIDELINES FOR REPRESENTATION IN & ADMISSION TO THE HOUSE OF DELEGATES:

National Medical Specialty Societies

1) The organization must not be in conflict with the constitution and bylaws of the American Medical Association by discriminating in membership on the basis of race, religion, national origin, sex, or handicap.

2) The organization must (a) represent a field of medicine that has recognized scientific validity; and (b) not have board certification as its primary focus, and (c) not require membership in the specialty organization as a requisite for board certification.

3) The organization must meet one of the following criteria:
   - 1,000 or more AMA members;
   - At least 100 AMA members and that twenty percent (20%) of its physician members who are eligible for AMA membership are members of the AMA; or
   - Have been represented in the House of Delegates at the 1990 Annual Meeting and that twenty percent (20%) of its physician members who are eligible for AMA membership are members of the AMA.

4) The organization must be established and stable; therefore, it must have been in existence for at least 5 years prior to submitting its application.

5) Physicians should comprise the majority of the voting membership of the organization.

6) The organization must have a voluntary membership and must report as members only those who are current in payment of applicable dues are eligible to participate on committees and the governing body.

7) The organization must be active within its field of medicine and hold at least one meeting of its members per year.

8) The organization must be national in scope. It must not restrict its membership geographically and must have members from a majority of the states.

9) The organization must submit a resolution or other official statement to show that the request is approved by the governing body of the organization.

10) If international, the organization must have a US branch or chapter, and this chapter must be reviewed in terms of all of the above guidelines.

RESPONSIBILITIES OF NATIONAL MEDICAL SPECIALTY ORGANIZATIONS

1. To cooperate with the AMA in increasing its AMA membership.

2. To keep its delegate to the House of Delegates fully informed on the policy positions of the organizations so that the delegate can properly represent the organization in the House of Delegates.

3. To require its delegate to report to the organization on the actions taken by the House of Delegates at each meeting.

4. To disseminate to its membership information to the actions taken by the House of Delegates at each meeting.

5. To provide information and data to the AMA when requested.

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Exhibit B - Summary Membership Information

Organization	AMA Membership of Organization's Total Eligible Membership
American Association of Hip and Knee Surgeons	784 of 3,672 (21%)
American Epilepsy Society	389 of 1,961 (20%)
American Society of Neuroimaging	101 of 230 (43%)

3. 2025 GRANTS AND DONATIONS

Informational report; no reference committee hearing.

HOD ACTION: FILED

This informational financial report details all external grants or donations received by the American Medical Association during 2025, including but not limited to federal grants, private grants, and donations or sponsorship support from third parties.

American Medical Association
Grants & Donations Received by the AMA
For the Year Ended December 31, 2025
Amounts in thousands

Funding Institution	Project	Amount Received
Centers for Disease Control and Prevention	Engaging Physicians to Strengthen the Public Health System and Improve the Nation's Public Health	$ 44
Centers for Disease Control and Prevention	Project Firstline: Improving Infection Control Capacity for Frontline Adult-Care Clinicians	1,060
Centers for Disease Control and Prevention	Prevention Rx: Engaging Physicians to Enhance Public Health	1,243
Substance Abuse and Mental Health Services Administration (subcontracted to AMA through American Academy of Addiction Psychiatry)	Providers Clinical Support System - Medications for Opioid Use Disorders	9
Government Funding		**2,356**
American Heart Association	International Congress On Peer Review and Scientific Publication	10
American Medical Association Foundation	Health Equity Acceleration Fund	978
American Medical Association Foundation (supported by Robert Wood Johnson Foundation funding)	The Truth, Reconciliation, Healing, and Transformation Project	198
American Society of Hematology	International Congress On Peer Review and Scientific Publication	10
Institute of Electrical and Electronics Engineers, Inc.	International Congress On Peer Review and Scientific Publication	20
Massachusetts Medical Society	International Congress On Peer Review and Scientific Publication	20
The Physicians Foundation	American Conference on Physician Health	20
Nonprofit Contributors		**1,256**

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American Medical Association
Grants & Donations Received by the AMA
For the Year Ended December 31, 2025
Amounts in thousands

Funding Institution	Project	Amount Received
Elsevier B.V.	International Congress On Peer Review and Scientific Publication	10
MPS Limited	International Congress On Peer Review and Scientific Publication	10
Silverchair Science + Communications, LLC.	International Congress On Peer Review and Scientific Publication	10
Wolters Kluwer Health	International Congress On Peer Review and Scientific Publication	20
Contributors less than $5,000	International Medical Graduates Section Reception	4
Other Contributors		**54**
Total Grants and Donations		**$ 3,666**

4. AMA 2027 DUES

Reference committee hearing: see report of Reference Committee F.

HOD ACTION: RECOMMENDATIONS ADOPTED
REMAINDER OF REPORT FILED
See Policy G-635.130

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

RECOMMENDATION

2027 Membership Year

The Board of Trustees recommends no change to the dues levels for 2027, that the following be adopted and that the remainder of this report be filed:

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

(Directive to Take Action)

Fiscal Note: Minimal

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5. UPDATE ON CORPORATE RELATIONSHIPS

Informational report; no reference committee hearing.

HOD ACTION: FILED

PURPOSE

The purpose of this informational report is to update the House of Delegates (HOD) on the results of the Corporate Review process from January 1 through December 31, 2025.

A summary of corporate activities that associate the American Medical Association (AMA) name or logo with a company, non-Federation association or foundation, or include commercial support, reviewed and recommended by the Corporate Review Team (CRT) during 2025 are outlined on Appendix A.

BACKGROUND

At the 2002 Annual Meeting, the HOD approved revised principles to govern the AMA's corporate relationships, HOD Policy G-630.040 "Principles on Corporate Relationships." These guidelines for AMA corporate relationships were incorporated into the corporate review process, are reviewed regularly, and were reaffirmed at the 2012 and 2022 Annual Meetings. The AMA Corporate Review Team is responsible for reviewing AMA projects to ensure they fit within these guidelines.

YEAR 2025 RESULTS

In 2025, 105 activities were considered and approved through the Corporate Review process. Of the 105 activities recommended for approval, 57 were conferences or events, seven were educational content or grants, 29 were collaborations or affiliations, five were member programs and seven were business arrangements/licensing programs. See Appendix B for details.

CONCLUSION

The Board of Trustees (BOT) periodically evaluates the CRT review process to balance risk assessment with the need for external collaborations that advance the AMA's strategic focus.

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Appendix A

CORPORATE REVIEW PROCESS OVERVIEW

The Corporate Review Team (CRT) includes senior managers from across the organization including Advocacy; the Center for Optimal Health Outcomes; Health, Science and Ethics; Enterprise Communications; Finance; Federation Relations; Health Solutions, Marketing and Member Experience; Medical Education; Office of the General Counsel; Professional Satisfaction/Practice Sustainability; and Publishing.

The CRT evaluates each project submitted to determine fit or conflict with AMA Corporate Guidelines, covering:

- Type, purpose, and duration of the activity;
- Audience;
- Company, association, foundation, or academic institution involved (due diligence reviewed);
- Source of external funding;
- Use of the AMA name and logo;
- Editorial control/copyright;
- Exclusive or non-exclusive nature of the arrangement;
- Status of single and multiple supporters; and
- Risk assessment for AMA.

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The CRT reviews and makes recommendations regarding the following types of activities that utilize the AMA name and logo:

- Industry-supported digital, print, or conference projects directed to physicians or patients that do not adhere to Accreditation Council for Continuing Medical Education (ACCME) Standards and Essentials.
- AMA sponsorship of external events.
- Independent and company-sponsored foundation supported projects.
- AMA licensing and publishing programs. (These corporate arrangements involve licensing AMA products or information to corporate or non-profit entities in exchange for a royalty and involve the use of AMA's name, logo, and trademarks. This does not include database or Current Procedural Terminology (CPT ®) licensing).
- Member programs such as new affinity or insurance programs and member benefits.
- Third-party relationships such as joint ventures, business partnerships, or co-branding programs directed to members or other stakeholders.
- Non-profit association collaborations outside the Federation. The CRT reviews all non-profit association projects (Federation or non-Federation) that involve corporate sponsorship.
- Collaboration with academic institutions in cases where there is corporate sponsorship.

For the above specified activities, if the CRT recommends approval, the project may proceed without any additional approval. However, the Executive Committee of the Board must review and approve CRT recommendations for the following AMA activities:

- Any activity directed to the public with external funding.
- Single-sponsor activities that do not meet ACCME Standards and Essentials.
- Activities involving risk of substantial financial penalties for cancellation.
- Upon request of a dissenting member of the CRT.
- Any other activity upon request of the CRT.

All Corporate Review recommendations are summarized annually for information to the Board of Trustees (BOT). The BOT informs the HOD of all corporate arrangements at the Annual Meeting.

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Appendix B

SUMMARY OF CORPORATE REVIEW
RECOMMENDATIONS FOR 2025

CONFERENCES/EVENTS

Project Number	Project Description	Corporations/Organizations	Approval Date
66659	**ICD Healthcare Burnout Symposium –** Sponsorship with AMA name and logo.	International Conference Development UC San Diego Health The Coalition for Physician Well-Being The Arnold P. Gold Foundation Dr. Lorna Breen Heroes' Foundation	01/02/25
67211	**AAPC HEALTHCON Events -** Repeat sponsorship with AMA name and logo.	American Academy of Professional Coders AHA Coding Clinic Coker Group iCoder MDaudit Rivet Symbion Coding	01/13/25
68163	**Medical Library Association Annual and Chapter Meetings** – Sponsorship with JAMA Network name and logo.	Elsevier Springer Nature Karger Publishers Frontiers Wolters Kluwer Online Computer Library Center Thieme Medical Publishers British Medical Journal Group Wiley EBSCO	01/16/25
68182	**American Society of Bioethics and Humanities Conference –** Sponsorship with AMA Journal of Ethics name and logo.	The Hastings Center for Bioethics American Journal of Bioethics The Journal of Medicine and Philosophy Case Western Reserve University School of Medicine UCLA Health Ethics Center Sutter Health Belmont University Northwell Health Loyola University Bioethics Graduate Programs	01/21/25
68242	**ViVE Sponsorships** – Repeat sponsorships with AMA name and logo.	College of Healthcare Information Management Executives HLTH Inc.	01/27/25
68282	**DeviceTalks Conference –** Sponsorship with VDL name and logo.	WTWH Media	01/31/25

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Project Number	Project Description	Corporations/Organizations	Approval Date
68409	**Machine Learning for Healthcare Conference** – Repeat sponsorship with AMA name and logo.	Mayo Clinic Columbia Data Science Institute Columbia Vagelos College of Physicians and Surgeons Nihon-Kohden LLC Google Deep Mind New York Presbyterian Apple Microsoft Columbia University Johns Hopkins University Duke University	02/03/25
68313	**Becker's Collaborations -** CEO & CFO Roundtables and Virtual Event, White Paper and Annual Hospital Review with AMA name and logo.	Becker's Hospital Review ASC Communications	02/07/25
68402	**March of Dimes Gourmet Gala -** Repeat sponsorship with AMA name and logo.	March of Dimes Blue Cross Blue Shield Foundation Pampers US Advanced Medical Technology Association Abbott Laboratories S&P Global	02/11/25
68548	**Credentialing State Shows –** Repeat sponsorships with AMA name and logo.	Pennsylvania Association of Medical Staff Services Ohio Association Medical Staff Services Florida Association of Medical Staff Services California Association of Medical Staff Services Illinois Association of Medical Staff Services Wisconsin Association of Medical Staff Services New York State Association of Medical Staff Services Texas Society for Medical Services Specialists Tennessee Association of Medical Staff Services New Jersey State Association Medical Staff Services New Mexico Association of Medical Staff Services Georgia Association of Medical Staff Services Baton Health Edge-U-Cate The Greeley Company Hardenbergh Group HealthStream Hospitality Staffing Solutions MD Review MD Staff PennState Health Pennsylvania Medical Society PreCheck Provider Passport PRS Credentialing Services QGenda Symplr	02/14/25

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Project Number	Project Description	Corporations/Organizations	Approval Date
68583	**AZARA User Conference** – Sponsorship with AMA MAP hypertension program name and logo.	Azara Healthcare Upstream USA	02/18/25
68522	**AMA International Medical Graduates Section Annual Meeting Desserts Reception –** Repeat sponsorship with AMA name.	Educational Commission on Foreign Medical Graduates	02/24/25
68703	**HealthStream Thrive25 Annual Conference –** Sponsorship with AMA name and logo.	HealthStream Hardenbergh Group American Board of Medical Specialties Evergreen Health Partners Axuall	02/26/25
68713	**IAIABC Forum and Convention -** Repeat sponsorship with AMA name and logo.	International Association of Industrial Accident Boards and Commissions Deloitte National Council on Compensation Insurance Optum AEG Worldwide The Black Car Fund Sedgwick HealtheSystems Enlyte Concentra SFM Mutual Insurance Official Disability Guidelines by MCG Health Safety National Guidewire Software Sapiens Insurance Software Wisedocs Eckler Ltd. WorkCompCentral Verisk	02/26/25
68764	**Health Care Value Week Value-based Payment Summit -** Collaboration with AMA name and logo.	Accountable For Health America's Health Insurance Plans Blue Cross Blue Shield Association Alliance for Value-based Patient Care American Hospital Association American Medical Group Association America's Physician Groups Association for Behavioral Health and Wellness Better Medicare Alliance Healthcare Leadership Council Margolis Institute for Health Policy Healthcare Transformation Task Force Medical Group Management Association National Association of ACOs National Rural Health Association Paragon Health Institute Partnership to Empower Physician Led Care Population Health Alliance Premier, Inc.	02/27/25

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Project Number	Project Description	Corporations/Organizations	Approval Date
68469	**National Medical Association Events–** Release the Pressure sponsorships of Colloquium and National Convention with RTP name and logo.	National Medical Association Pfizer Eli Lilly PennState Health Campaign for Tobacco Free Kids American Cancer Society Novo Nordisk Humana Biogen Ochsner Health Viiv Healthcare American Academy of Sleep Medicine Foundation American College of Obstetricians and Gynecologists GlaxoSmithKline Mayo Clinic Labcorp Howard University School of Medicine Yale School of Medicine	02/28/25
68849	**Asian American Journalists Association's Annual Convention** – Repeat sponsorship with AMA name and logo.	Asian American Journalists Association The Guardian CNN Axios Scripps Sinclair Nexstar American Heart Association American Association of Retired Persons Northwestern University American University	03/05/25
68883	**i2i Client Conference Sponsorship –** Sponsorship with AMA MAP hypertension program name and logo.	i2i Population Health MedTech Solution SyncTimes Labcorp ChartSpan Sonata Software OptMyCare Sisense	03/06/25
69187	**Chief Medical Officer Exchanges** – Repeat sponsorships with AMA name and logo.	Healthcare Compliance Professionals HealthLeaders Ambience Healthcare Microsoft SaVia Health Solventum Corporation	03/06/25

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Project Number	Project Description	Corporations/Organizations	Approval Date
68863	**National Association of Hispanic Journalists Conference -** Repeat sponsorship with AMA name and logo.	National Association of Hispanic Journalists Robert Wood Johnson Foundation Cedars Sinai Children's Hospital Los Angeles California Health Care Foundation Big Cities Health Coalition Vital Strategies The Commonwealth Fund The John A. Hartford Foundation Patient Centered Outcomes Research Institute Blue Cross of California Foundation The Kresge Foundation Peterson Center on Healthcare The California Endowment	03/07/25
68886	**National Multiple Sclerosis Society's Dinner of Champions –** Repeat sponsorship with AMA name and logo.	National Multiple Sclerosis Society Alliance for Automotive Innovation Biogen MedStar Health Novartis Waldorf Astoria	03/11/25
69178	**ACCME's Learn to Thrive Conference –** Sponsorship with AMA EdHub name and logo.	Accreditation Council for Continuing Medical Education American Board of Medical Specialties BeaconLive Blue Sky eLearn Cadmium LLC CE21 LLC CME Tracker Convey Health Solutions EMedEvents Foundation LMS Freestone LMS HealthLink Dimensions HealthStream InReach CE Insignia Learning Medical Marketing Service Inc Synegen Inc	03/14/25
69434	**Ai4 Technology Conference –** Collaboration with AMA name and logo.	Ai4 Fora Group	03/22/25
69491	**AHCJ Conference –** Repeat sponsorship with AMA name and logo.	Association of Healthcare Journalists Robert Wood Johnson Foundation Children's Hospital Los Angeles Patient Centered Outcomes Research Institute The Commonwealth Fund Medical College of Wisconsin	03/28/25
69643	**Bryce Harlow Foundation 44th Annual Awards Dinner –** Repeat sponsorship with AMA name and logo.	Bryce Harlow Foundation American Express Microsoft Johnson & Johnson Korn Ferry International	03/31/25

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Project Number	Project Description	Corporations/Organizations	Approval Date
69657	**Bernard Lown Awards Dinner** – Repeat sponsorship with AMA name and logo.	The Lown Institute Grimshaw-Gudewicz Foundation Robert Wood Johnson Foundation	04/07/25
70242	**TruBridge National Client Conference** – Repeat sponsorship with AMA name and logo.	TruBridge i2i Population Health Blockit Now Inc SureScripts Wolters Kluwer	04/10/25
70426	**Minority Health Institute's Seventh Annual Summit –** Sponsorship with RTP name and logo.	Minority Health Institute Johns Hopkins Anthem AIDS Healthcare Foundation L.A. Care Health Plan BridgeBio	04/23/25
70453	**Precision Health Information Network Summit –** Repeat sponsorship with AMA name and logo.	Concert Genetics Illumina	04/24/25
69501	**American Conference on Physician Health** – Repeat sponsorship with AMA name and logo.	Stanford Medicine Mayo Clinic The Physician's Foundation	05/01/25
70611	**NAMSS Annual Educational Conference and Exhibition** - Repeat sponsorship with AMA name and logo.	National Association of Medical Staff Services ABMS Solutions QGenda HealthStream MD-Staff Symplr Medicred PreCheck Acorn Credentialing AOA Profiles The Greeley Company Federation of State Medical Boards The Hardenbergh Group Verifiable	05/07/25
70260	**Rock Health Summit –** Repeat sponsorship with AMA name and logo.	Rock Health Foundation Fenwick & West LLP Penner Family Foundation California Health Care Foundation CVS Health Ventures Peterson Health Technology Institute Pivotal Ventures PolicyMap Tulsa Innovation Labs Calm Meditation App Consulate General of Canada CareQuest HopeLab	05/11/25

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Project Number	Project Description	Corporations/Organizations	Approval Date
70726	**CFHA Integrated Care Conference** – Repeat sponsorship with AMA name and logo.	Collaborative Family Healthcare Association Alliance Health Community Care of North Carolina American Psychological Association Concert Genetics EvolveMD Foundation for Health Leadership & Innovation Health Federation of Philadelphia Merakey Education National Register of Health Service Psychologists	05/16/25
70302	**IPPNW Congress –** Sponsorship with Journal of Ethics name and logo.	International Physicians for the Prevention of Nuclear War Japanese Physicians for Prevention of Nuclear War Hiroshima Prefectural Medical Association Nagasaki Prefectural Medical Association	05/16/25
71073	**Institute of Medicine of Chicago Leadership Awards –** Sponsorship with AMA name and logo.	Institute of Medicine Golden Square Association Services Washington Square Health Foundation Johnson & Johnson Hektoen Institute Novo Nordisk Canon USA University of Illinois Health Golz LLC Family Christian Health Center The Portes Foundation	06/02/25
71171	**SAWCA Convention and Luncheon** – Repeat sponsorship with AMA name and logo.	Southern Association of Workers' Compensation Administrators AKERA Claims Solutions American International Group Ametros CompTrust Mutual Insurance Company Concentra Enlyte FAIR Health Healthesystems Meridian Wealth Management National Council on Compensation Insurance ODG by MCG Health Occupational Managed Care Alliance Optum Inc Safety National Casualty Company Sedgwick Trean Corporation Verisk Workers' Compensation Institute	06/09/25
71226	**AAMC Annual Meeting –** Sponsorship with Journal of Ethics name and logo.	Association of American Medical Colleges Elentra Elsevier ECG Management Consultants CU Medicine Colorado Resiliency Arts Lab MGM Resorts	06/16/25

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Project Number	Project Description	Corporations/Organizations	Approval Date
71252	**Greenway ENGAGE Client Summit** – Repeat sponsorship with AMA name and logo.	Greenway Health HealthAsyst Phreesia Inc RevSpring Inc Rivet Health Solventum Corporation	06/23/25
71309	**WOEMA Conference** - Repeat sponsorship with AMA name and logo.	Western Occupational and Environmental Medical Association UC San Diego School of Medicine The Permanente Group Reliant Urgent Care Keystone Industrial Medicine e3 Occupational Health Solutions Institutes of Health Concentra MedTech International Group	06/24/25
71629	**NCOIL Chicago and Annual Meetings –** Sponsorships with AMA name and logo.	National Council of Insurance Legislators	07/07/25
71912	**Healthy Chicago Hypertension Awareness Day –** Collaboration with RTP name and logo.	Healthy Chicago Black Women's Expo MGPG Events	07/24/25
72107	**The Systems Summit on Healthcare Transformation –** Repeat sponsorship with AMA name and logo.	Healing Works Foundation The Princeton School of Public and International Affairs New Jersey Health Foundation	07/31/25
72169	**Vizient Connections Summit –** Sponsorship with AMA name and logo.	Michael Foods ECOLAB The Campbells Company TRONEX Healthcare CDW Corporation AMN Healthcare W.L. Gore and Associates VERTEX Pharmaceuticals MEDLINE Breckenridge Insurance	08/05/25
72797	**AthenaHealth Thrive Summit –** Sponsorship with AMA name and logo.	AthenaHealth Qure4u Software OhMD Software	08/28/25
72796	**Congressional Black Caucus Foundation Phoenix Awards Dinner –** Sponsorship with AMA name and logo.	Congressional Black Caucus Foundation	09/03/25

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Project Number	Project Description	Corporations/Organizations	Approval Date
72324	**Association of American Indians Physicians 53rd Annual Meeting** – Sponsorship with AMA name and logo.	Association of American Indians Physicians National COVID-19 Resiliency Network at the Morehouse School of Medicine Opioid Response Network University of Utah Center for Native Excellence and Tribal Engagement American Association of Retired Persons Johnson & Johnson Deloitte Sacred Circle Healthcare Health Division of the Confederated Tribes of the Goshute Reservation Physicians Committee for Responsible Medicine	08/08/25
72731	**AGMB Conference –** Sponsorship with JAMA Network name and logo.	German Medical Library Association (AGMB) Elsevier Karger Publishers Frontiers Publishing Springer Nature EBSCO	09/03/25
73079	**HLTH Conference** - Repeat sponsorship with AMA name and logo.	HLTH Inc HLTH Foundation	09/17/25
73235	**MD-Staff Educational Conference Sponsorship –** Repeat sponsorship with AMA name and logo.	PreCheck ABMS Solutions The Greeley Company Hardenbergh Group	09/29/25
73773	**National Hispanic Health Foundation Scholarship Gala –** Sponsorship with AMA name and logo.	National Hispanic Health Foundation Eli Lilly Pfizer United Health Foundation Immune Deficiency Foundation Indiana University School of Public Health	10/15/25
73898	**South by Southwest MedTalk Conference** – Repeat sponsorship with AMA name and logo.	South by Southwest RIVIAN DirecTV Austin Convention Center Eventbase Technology Improvado Marketing AI Media	10/24/25
73897	**AIMed Conference –** Sponsorship with AMA name and logo.	AdventHealth Amazon Warehouse Services FPT Software Bayer Kaiser Permanente Institute for Medical Education Kore AI Mayo Clinic Platform Regional One Health Valid AI	10/24/25
73030	**HealthLeaders Chief Executive Officer Exchange –** Repeat sponsorship with AMA name and logo.	Healthcare Compliance Professionals HealthLeaders	10/31/25

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Project Number	Project Description	Corporations/Organizations	Approval Date
74455	**Anarcha, Lucy, Betsey Annual Conference** – Repeat sponsorship with AMA name and logo.	Faith Crusade Montgomery Rescue Mission Robert Wood Johnson Foundation Every Mother Counts	11/19/2025
74501	**STFM Conference on Medical Student Education –** Sponsorship with AMA name and logo.	Society of Teachers of Family Medicine	11/24/25
74808	**MIT AI Conference –** Sponsorship with AMA name and logo.	MIT Critical Data Lab MIT Industry Liaison Program	12/09/25
75147	**HIMSS Global Health Conference & Exhibition –** Repeat sponsorship with AMA name and logo.	Healthcare Information Management Systems Society Elsevier Dedalus Italia S.P.A	12/22/25

EDUCATIONAL CONTENT OR GRANT

Project Number	Project Description	Corporations/Organizations	Approval Date
68850	**AHIMA Workshop –** Repeat training on clinical documentation coding with AMA name and logo.	American Health Information Management Association	03/12/25
69161	**Noodle Nursing Scholar Program Collaboration –** Educational series on BP Measurement with AMA name and logo.	Noodle Corporation Noodle Nursing Scholar Program	03/12/25
70209	**HealthBegins Collaboration –** Collaboration for educational materials with AMA name and logo.	HealthBegins	04/10/25
71371	**IPPNW Webinar –** Educational webinar featuring Journal of Ethics name and logo.	International Physicians for the Prevention of Nuclear War	07/01/25
72560	**Transforming Lifelong Learning through Precision Education –** Grant program for physicians and medical students with use of AMA name.	Georgia Academy of Family Physicians Louisiana State University Health Sciences Center Meritus School of Osteopathic Medicine Mount Sinai Morningside Perelman School of Medicine at the University of Pennsylvania Stanford University University of Cincinnati College of Medicine Arizona State University - John Shufeldt School of Medicine University of Hawaii - John A. Burns School of Medicine University of Illinois College of Medicine University of Michigan University of Wisconsin School of Medicine and Public Health	08/19/25

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Project Number	Project Description	Corporations/Organizations	Approval Date
73202	**Clinical Skills Workshop–** Clinical skills workshop for 2025 AMA Interim Meeting with AMA and AMAF names and logos.	Henry Schein Henry Schein Cares Foundation	10/10/25
74220	**Credentialing School Sponsorship** - Repeat sponsorship with AMA name and logo.	Edge-U-Cate Symplr Federation of State Medical Boards	11/06/25

COLLABORATIONS/AFFILIATIONS

Project Number	Project Description	Corporations/Organizations	Approval Date
66537	**Practice Transformation Survey Assessment** – AMA co-branding with healthcare organizations for physician burnout survey.	CoxHealth Professional Medical Corporation Monmouth Medical Center Franciscan Health Olympia Fields Saint Alphonsus Medical Group Cooper University Health Care Mendocino Community Health Clinic Bay Area Community Health Northwell Health University of Florida College of Medicine Bitterroot Health Atlantic Medical Group Albany Medical College Berkshire Medical Center Owensboro Health Presbyterian Healthcare Services Renown Health University of Central Florida Pacific HealthWorks Sky Lakes Medical Center Berkshire Medical Center Shannon Medical Center South Georgia Medical Center Health Dallas Nephrology Associates McLaren Northern Michigan Comanche County Memorial Hospital Delaware Valley Community Health McLaren Northern Michigan Pacific HealthWorks The Vancouver Clinic Bergen New Bridge Medical Center District Medical Group El Dorado Community Health Centers Hospital Sisters Health System M Health Fairview One Medical Relias Healthcare South Georgia Medical Center Health Texas Health Physicians Group Winslow Indian Health Care Center Adventist Health Alomere Health	01/08/25

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Project Number	Project Description	Corporations/Organizations	Approval Date
66537	**Practice Transformation Survey Assessment** – AMA co-branding with healthcare organizations for physician burnout survey.	Choptank Community Health System Inc Lee Health Cancer Institute Harbor Regional Health Society of Interventional Radiology St. Jude Children's Research Hospital The Medical College of Wisconsin Department of Anesthesiology Trinity Health Livonia University of Minnesota Physicians UT Health San Antonio Physicians UVA Health Wisconsin Northern and Central General Medical Education Consortium	01/08/25
68141	**Medbiquitous Collaboration –** Collaboration on data standards development with AMA name and logo.	Medbiquitous Association of American Medical Colleges	01/23/25
68323	**Healthcare Professional Gun Violence Campaign –** Collaboration with AMA name and logo.	Ad Council	02/06/25
68550	**Prevention Strategy Collaboration with Health Care Organizations –** Update to diabetes prevention program with AMA name and logo.	Community Health Center of Cape Cod Legacy Community Health Center Duncan Regional Hospital CommunityHealth	02/12/25
68516	**Agree-to-Agree Youth Gun Violence Prevention Campaign –** Collaboration with AMA name and logo.	Ad Council AYA Healthcare BJC Health System Children's Hospital Association Dartmouth Health Dartmouth Children's Health Endeavor Health Froedtert Health Hackensack Meridian Health Intermountain Health Johns Hopkins Medicine Kaiser Permanente Levi Strauss & Company LifeBridge Health MedStar Health Michigan Health Northwell Health OhioHealth University of Michigan Yale New Haven Health	02/13/25
68650	**Target BP Promotional Video –** Collaboration with AMA name and logo.	American Heart Association Primary Care Associates of Appleton Heart of Ohio Family Health Chinatown Service Center	02/19/25

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Project Number	Project Description	Corporations/Organizations	Approval Date
68582	**American Medical Group Association –** Sponsorship with AMA name and logo.	American Medical Group Association Abbvie Boehringer Ingelheim Dynavex Epic Indivior Magmutual Insurance Medallion Navina AI Microsoft Nuance PatientPoint PointClickCare The Kinetix Group The Partners Group Vatica Health	02/19/25
68707	**American Telemedicine Association –** Repeat sponsorship with AMA name and logo.	American Telemedicine Association Microsoft Intel eMed TeleHealth CDW Healthcare Abbott Novartis Optum Cigna Mayo Clinic Trinity Health American Hospital Association American Academy of Dermatology	02/28/25
68808	**Abortion Defense Network –** Collaboration with AMA name and logo.	Abortion Defense Network American College of Obstetrics & Gynecology Apiary for Practical Support The Forefront Project Gender Justice The Jane Network Legal Voice National Abortion Federation National Network of Abortion Funds Perkins Coie Physicians for Reproductive Health Pillsbury Winthrop Shaw Pittman LLP Planned Parenthood Pregnancy Justice Reproductive Equity Now Society for Maternal Fetal Medicine Society of Family Planning Women's Law Project	03/04/25

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Project Number	Project Description	Corporations/Organizations	Approval Date
70355	**All In Campaign** – Repeat healthcare workforce wellbeing campaign with AMA name and logo.	Dr. Lorna Breen Heroes Foundation American Association of Nurse Anesthesiology American Dental Association American Hospital Association American Nurses Association American Psychiatric Association Federation of State Physician Health Programs FIGS Heart of Safety Coalition Moral Injury of Healthcare Organizational Wellbeing Solutions	04/17/25
70613	**ACCME Journal of Graduate Medical Education "Reimagining Residency" Edition -** Collaboration with AMA name and logo.	Accreditation Council for Graduate Medical Education Journal of Graduate Medical Education	05/01/25
70551	**COVID-19 Monument of Honor, Remembrance, & Resilience –** Sponsorship of COVID healthcare worker memorial with AMA name and logo.	Hektoen Institute of Medicine Pfizer Illinois Medical District Commission Nephrology Association of Northern Illinois and Indiana Chicago Teachers Union Illinois Health and Hospital Association Fresenius Medical Care The Portes Foundation Illinois Federation of Teachers Strive Health Cook County Teachers Union North Star Investment Management United Food Commercial Workers	05/08/25
70781	**"A Guide to Collaborative Drug Therapy Management" –** Collaboration with AMA name and logo.	American College of Clinical Pharmacology	05/21/25
71006	**2025 Residency Guides** – Collaboration on medical resident guides with AMA name and logo.	Association of American Medical Colleges Organization of Program Directors Association	06/03/25

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Project Number	Project Description	Corporations/Organizations	Approval Date
71130	**Joy in Medicine** – Repeat AMA recognition program for outstanding healthcare organizations.	Akron Children's Hospital Albany Medical Center Albany Medical College Ann & Robert H. Lurie Children's Hospital of Chicago BayCare Medical Group Bristol Health CarePoint Health CenterWell Senior Primary Care Central Ohio Primary Care Central Virginia VA Health Care System Children's Hospital Los Angeles Children's Specialty Group Cooperman Barnabas Medical Center Duly Health and Care Emory Healthcare Forefront Dermatology Houston Methodist Physician Organization Memorial Hermann Health System Minneapolis VA Health Care System Onvida Health Phoenix VA Health Care System Robert Wood Johnson University Hospital RWJBH Community Medical Center Sharp Rees-Stealy Medical Group Sutter Gould Medical Group Texas Valley Coastal Bend Veterans Healthcare System The Queen's Health Systems The University of Texas MD Anderson Cancer Center The University of Vermont Health Network UC San Diego Health University Health/Truman Medical Center University of California San Francisco Health University of Texas Southwestern Medical Center VA Boston Healthcare System VA Greater Los Angeles Healthcare System VA Palo Alto Health Care System Valley Medical Center Virtua Health	06/10/25
71657	**JAMA Network Worldwide –** Updated content agreement for online reference service with AMA name and logo.	USACO Corporation	07/17/25
71357	**The Naloxone Project –** Co-branded information brief for healthcare workers with AMA name and logo.	The Naloxone Project	07/21/25
71560	**Emergency Care for Pregnant Patients –** Collaboration to create guidance document with AMA name.	American College of Obstetricians and Gynecologists Society for Maternal Fetal Medicine Lawyers for Good Government	07/23/25

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Project Number	Project Description	Corporations/Organizations	Approval Date
72225	**"Brother to Brother" Campaign and Maternal Health Roundtable** – Collaboration on heart and maternal health campaigns with RTP name and logo.	Association of Black Cardiologists	08/07/25
72679	**AMA Annual Research Challenge** – Repeat annual AMA branded competition with Laurel Road sponsored prize.	Laurel Road Bank	08/28/25
73018	**Mental Health Parity Collaboration –** Rollout of online tool comparing insurance mental health coverage, with AMA name and logo.	The Kennedy Forum The Ballmer Group New York Community Trust The Arthur M. Blank Foundation Third Horizon Strategies InterKnowlogy American Psychological Foundation Utilization Review Accreditation Commission	09/16/25
73027	**"What Doctors Wish Patients Knew" series –**Cobranded articles with AMA name and logo.	HCA Healthcare	09/25/25
73526	**Health Care Payment Policy Insights Report** - Report with AMA name and logo.	Alliance for Health Policy	10/06/25
73993	**Elsevier Publishing –** Collaboration on textbook with AMA name and logo.	Elsevier	11/14/2025
74666	**Leadership Council for Healthier Communities –** Sponsorship with AMA name and logo.	Creating Healthier Communities Ameriprise Financial Fulcrum Therapeutics Urban Institute Johns Hopkins University The Samaritan Health Project, Inc. Archstone Foundation PK Management Clear Horizon Group American Psychiatric Association Foundation Porter Novelli Health by Design JLL Real Estate Association of American Medical Colleges	11/20/2025
74667	**iHeart Media –** Podcast series with AMA name and logo.	iHeartMedia iHeartPodcasts iHeart Ignite	12/04/25
74338	**Federation of State Physician Health Programs –** Repeat sponsorship with AMA name and logo.	Federation of State Physician Health Programs American Board of Medical Specialties Copic Insurance Coverys Insurance MedPro Group Medical Liability Mutual Insurance Company Physicians Insurance State Volunteer Mutual Insurance Company The Doctors Company	12/06/25

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Project Number	Project Description	Corporations/Organizations	Approval Date
75082	**The Health Management Academy –** Sponsorship with AMA name and logo.	The Health Management Academy	12/19/25

MEMBER PROGRAMS

Project Number	Project Description	Corporations/Organizations	Approval Date
67194	**PhysicianLoans –** Update to affinity program with AMA name and logo.	PhysicianLoans Huntington Bank	01/14/25
67193	**Laurel Road Perks Program** – Update to affinity program with AMA name and logo.	Laurel Road Bank KeyBank National Association	01/16/25
67185	**HP, Inc. Affinity Program –** New member discount program with AMA name and logo.	Hewlett-Packard Inc.	01/21/25
69265	**McGraw-Hill Student Test Prep** - Discount member benefit program with AMA name and logo.	McGraw Hill Boards & Beyond First Aid Forward	03/27/25
69453	**Resolve Member Offer & Incentive** - Discount on contract review services with AMA name and logo.	Resolve, LLC	04/29/25

BUSINESS ARRANGEMENTS/LICENSING PROGRAMS

Project Number	Project Description	Corporations/Organizations	Approval Date
69233	**Official Disability Guidelines (ODG by MCG) –** Licensing of AMA Guides to Permanent Impairment content for ODG by MCG platform with use of AMA Guides name and logo.	MCG Health	03/18/25
69292	**QGenda -** Licensing agreement for AMA VeriCre product with AMA name and logo.	QGenda LLC	03/19/25
70183	**OpenEvidence –** JAMA Network content licensing agreement with JAMA Network name and logo.	Open Evidence Inc	04/25/25
71244	**Validic** – Content licensing agreement with AMA MAP hypertension name and logo.	Validic Inc	06/25/25
71405	**Cedaron -** AMA Guides to Permanent Impairment content licensing agreement with AMA Guides name and logo.	Cedaron	07/15/25

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73591	**ResearchGate -** JAMA Network content licensing agreement with JAMA Network name and logo.	ResearchGate	10/14/25
74378	**Symplr -** Licensing agreement for AMA VeriCre product with AMA name and logo.	Symplr	11/21/25

6. AMA PERFORMANCE, ACTIVITIES AND STATUS IN 2025

Informational report; no reference committee hearing.

HOD ACTION: FILED

Policy G-605.050, "Annual Reporting Responsibilities of the AMA Board of Trustees," calls for the Board of Trustees to submit a report at the American Medical Association (AMA) Annual Meeting each year summarizing AMA performance, activities, and status for the prior year.

INTRODUCTION

The American Medical Association (AMA) is the largest and most influential organization representing the voices of hundreds of thousands of physicians, residents, and medical students across the United States. The AMA advocates for policies that improve access to quality care, strengthen the patient-physician relationship, promote physician autonomy and wellbeing, advance science and technology, and uphold the high medical ethics of the profession. The AMA's mission is to promote the art and science of medicine and the betterment of public health.

Amplifying physician voices and shaping policy

In 2025, the AMA worked to elevate the voices of physicians in Washington, D.C. and across the country to ensure that physician clinical experience and expertise guide the policy changes and technological advances that are critical to medicine's future. At the national level, the AMA continued to push to reform the Medicare reimbursement system, fix prior authorization, promote physician-led care and more by:

- Generating more than $100 million in earned media and ad impressions and driving more than 600,000 physicians and patients to contact their legislators about Medicare payment reform through our FixMedicareNow grassroots campaign.
- Securing a commitment from America's Health Insurance Plans (AHIP) and the Blue Cross Blue Shield Association to lessen the burden of prior authorization in 60 of their member plans.
- Opposing legislation that would expand pharmacists' scope of practice with respect to testing and treating patients for influenza, COVID-19, RSV, and strep throat.

In partnership with state and specialty societies, AMA advocacy protected patients by:

- Blocking nearly 100 bills that would have inappropriately expanded the scope of practice for physician assistants, pharmacists, optometrists and more.
- Providing support and resources to help enact 22 prior authorization bills that sought to decrease reporting requirements, reduce delays in patient care, and improve transparency.
- Partnering with the Dr. Lorna Breen Heroes' Foundation to verify that 40 state medical boards and more than 1,800 health systems (and others) removed stigmatizing mental health questions from their credentialing applications.

The AMA secured an important win for patients when the National Council of Insurance Legislators adopted model legislation that was substantially based on the AMA's state model bill addressing prior authorization.

The AMA was a critical voice for physicians on key legal issues, including the implementation of the No Surprises Act (*TMA v. HHS*), scope of practice challenges (*Palmer v. Bonta*), and e-cigarette regulation (*FDA v. R.J. Reynolds Vapor*), among other matters vital to physicians.

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The AMA continues to serve as a lead plaintiff in a major antitrust case against MultiPlan, a data analytics company accused of creating a price-fixing conspiracy with the largest commercial health insurance companies in the country. The AMA successfully opposed MultiPlan's motion to dismiss the suit, and the case is proceeding with discovery.

In a year of high-profile challenges to public health and public health institutions, physician leadership was more important than ever. The AMA provided steadfast leadership during uncertainty, defended science, and advocated for evidence — not politics — to guide care decisions and public health policy. We accomplished this by:

- Publicly challenging decisions that would weaken recommendations and undermine public confidence in life-saving childhood vaccinations.
- Reaffirming decades of scientific research that showed no link between vaccines and autism.
- Releasing information graphics to clear up confusion around vaccine misinformation and facilitate honest conversations between physicians and patients.

In 2025, as the AMA continued to elevate the voice of physicians and defend science-based medicine—earning 95 billion media impressions valued at $912 million—Dr. John Whyte was welcomed as the new Executive Vice President and CEO, further strengthening the organization's leadership and impact.

Driving the future of medicine

The rapid growth of digital health and augmented intelligence (AI) accelerated in 2025, with more physicians and health systems experiencing their transformative potential. Going forward, it's crucial for physicians to lead the way in shaping and implementing these technologies.

With the launch of the AMA Center for Digital Health and AI in 2025, we are taking the lead in this space. The AMA's new Center for Digital Health and AI was created to give physicians a platform to help establish ethical guardrails, shape policy and support workflow integration so that AI and other digital tools enhance care rather than complicate it. The new center is focusing on:

- Policy and regulatory leadership: Working with regulators, policymakers and technology leaders to shape benchmarks for safe and effective use of AI in medicine and digital health.
- Clinical workflow integration: Creating opportunities for doctors to shape AI and digital tools so they work within clinical workflows and enhance the patient and clinician experience.
- Education and training: Equipping physicians and health systems with the knowledge and tools to integrate AI efficiently and effectively into practice.
- Collaboration: Building partnerships across the tech, research, government and health care sectors to drive innovation aligned with patient needs.

The AMA launched a four-year, $12 million grant program, Transforming Lifelong Learning Through Precision Education, to advance medical education using data and AI. Nearly 200 applications were received, and 11 grants were awarded to over 80 institutions for projects spanning diverse learners, competencies, settings, and technologies.

AMA hosted the ChangeMedEd® 2025 conference in Chicago, attracting 600 attendees and featuring over 140 presentations, 120 posters, and 60 breakout sessions. Thirty "blue sky" AI ideas were presented, with three selected to receive $20,000 AMA grants for further development. Post-conference surveys showed 97% of respondents viewed AMA as a leader in medical education innovation, and 93% plan to apply conference concepts in their work within the next year.

The AMA reported outcomes from its six-year, $20 million Reimagining Residency program, which significantly improved residency training. Highlights include system-wide adoption of interprofessional principles—leading to shorter stays, lower costs, and better patient satisfaction—new national OB/GYN residency selection standards, and better alignment of education and workforce needs in NC, CA, and OR. The program's impact includes:

- 343 residency programs
- ~10,700 medical students
- ~10,400 residents/fellows
- ~2,400 faculty

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In 2025, AMA Ed Hub™ offered more than 9000+ education activities from the AMA and 80+ partner organizations. With 570,000+ registered users, Ed Hub experienced all-time highs in user engagement in 2025:

- 4.6 million visitor sessions
- 750,000 courses completed

Partnering with MMX, Ed Hub leveraged educational initiatives to drive membership growth and value. This collaboration launched the AMA Physician Education Program (PEP) for group physicians, introduced curated members-only bundles, and increased Ed Hub's contribution to membership conversion by over 47%, resulting in more than 5,000 new members.

VeriCre™ gained solid adoption with over 120 customers across 600 sites nationwide, streamlining credentialing and boosting efficiency. Its secure "physician wallet" lets physicians easily manage and share credentials via integration with third-party software.

AMA launched the Value-Based Care Workgroup to enhance the role of Current Procedural Terminology (CPT®) in value-based care, reinforcing the code set's long-term relevance and integrity. The Workgroup secured CPT Editorial Panel approval for updated care management code language—reflecting modern, physician-led, team-based care—for inclusion in the 2027 code set.

The AMA enhanced its CPT Educational Content platform and launched CPT Refresh/Refresh Premium, creating a modern digital system to streamline coding and reduce physician burnout. The platform handled over 21 million API calls this year, a 20 percent increase in content production—delivering over 200 in-depth CPT educational resources to meet evolving healthcare needs.

JAMA Network launched JAMA+ Women's Health, a new digital resource designed to elevate the visibility and accessibility of trusted, peer-reviewed content that advances health care for women.
Removing obstacles that interfere with patient care

Administrative barriers like prior authorization are just one challenge physicians face.
Health disparities—such as food deserts and unsafe housing—can affect patient health as significantly as clinical care.

The AMA launched its first Community Health Impact Lab micro grants in 2025 to invest in physicians who have ideas to address barriers they see in their communities with local, creative and measurable solutions.

- The AMA Community Health Impact Lab is offering up to 20 grants of $50,000 each.
- Grants will help fund physician-led, community-centered projects that improve health outcomes among patient populations who often face obstacles to healthy living in their communities.

This initiative empowers physicians to address community health challenges and drive change, backed by AMA support. Micro grant recipients will be notified in April 2026 and have 12 months to implement their ideas, with guidance from the AMA throughout.

The AMA Joy in Medicine® Health System Recognition Program received a record number of applications in 2025 and honored its largest group of organizations to date (109) bringing the total recognized cohort to 164. This represents a 76 percent increase over 2024.

The AMA's Organizational Biopsy® team partnered with 151 health care organizations—a 32 percent year-over-year increase—to conduct well-being assessments. This growth was supported by the development of innovative tools, such as the Organizational Biopsy Assessment and Resource Calculator, which supported data-driven decisions. These scalable tools also established repeatable usability testing frameworks for other AMA digital products.

The 5th American Conference on Physician Health™, co-sponsored with Mayo Clinic and Stanford Medicine, achieved record attendance and presented the highest number of abstracts to date.

AMA STEPS Forward® enhanced its content library and achieved substantial growth in engagement, with webinar attendance increasing by 180 percent year-over-year and podcast downloads rising by 13 percent year-over-year.

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The AMA, in partnership with The Kennedy Forum, introduced the Mental Health Parity Index—a transformative tool that measures market-level violations of mental health parity laws by commercial health plans, helping state and federal regulators strengthen enforcement.

Leading the charge to improve health outcomes

With firearm injuries now the leading cause of death among U.S. children and teens, the AMA's Firearm Injury Prevention Task Force, the Ad Council, and health care leaders launched a digital resource hub to support clinicians in firearm injury prevention conversations. The launch generated 20 media articles, over 60,000 press release engagements, 51 partner social posts, and 8.5 million potential impressions across media and social channels.

The AMA created the Center for Optimal Health Outcomes (COHO), merging the areas of Improving Health Outcomes and the Center for Health Equity. COHO's work will be focused externally, centered on these interconnected pillars:

- Empower Physicians and Health Systems to Address Social Determinants of Health
- Transform Medical Education
- Foster Collaborative Action and Health System and Community-Centered Solutions
- Advance Data-Driven Approaches and Research

The AMA and AHA recognized nearly 2,400 organizations committed to improving blood pressure control through the 2025 Target: BP Achievement Awards. A total of 2,393 eligible organizations across 49 states and territories served over 38 million patients.

To support the Million Hearts campaign, the AMA partnered with the Centers for Disease Control and Prevention (CDC) and Alliance Chicago, engaging 5 Health Center Controlled Networks and 19 community health centers to prevent heart attacks and strokes in over 900,000 adults—focusing on minority, rural, and medically underserved communities.

In 2025, the AMA strengthened its commitment to West Side United with an additional $3 million multi-year investment as an Anchor Mission Partner, contributing to a combined $177 million mobilized for local housing, financing, purchasing, and job creation initiatives. The AMA also provided $250,000 in direct support to West Side United to boost community engagement.

Membership

The AMA reached a historic milestone of more than 303,000 dues-paying members, the highest level in AMA history, representing the largest year-over-year increase on record at 11.5%. Growth among dues-paying physicians was especially strong, increasing 21% year over year, setting another record and reinforcing the AMA's growing relevance and value to practicing physicians.

EVP Compensation

During 2025, pursuant to his employment agreement, total cash compensation paid to James L. Madara, MD, as AMA Executive Vice President through June 2025 included $720,739 in salary and $1,339,047 in incentive compensation for 2024, reduced by $1,565 in pre-tax deductions. Other taxable amounts per the contract were: an $81,000 contractual payment in lieu of deferred compensation; $24,102 in imputed earnings for life insurance, and $1,350 paid for parking.

Dr. Madara remained on the payroll through December 2025 to provide transition support. Total compensation during this period was $476,499 in salary, reduced by $1,564 in pre-tax deductions. Other taxable amounts per the contract were: $24,102 in imputed earnings for life insurance, $1,350 paid for parking and $1,100 for health club dues.

During 2025, pursuant to his employment agreement, total cash compensation paid to John J. Whyte, MD included $787,500 in salary and a $150,000 sign-on bonus, reduced by $6,204 in pre-tax deductions. Other taxable amounts per the contract were as follows: $2,860 imputed earnings for life insurance, $525 for a cell phone stipend, $1,820

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paid for parking. $1,458 paid for health club dues and $11,686 for travel expenses to and from the Chicago office. Dr. Whyte's employment began on June 1, 2025.

For additional information about AMA activities and accomplishments, please see the "AMA 2025 Annual Report."

7. ANNUAL UPDATE ON ACTIVITIES AND PROGRESS IN TOBACCO CONTROL: MARCH 2025 THROUGH FEBRUARY 2026

Informational report; no reference committee hearing.

HOUSE ACTION: FILED

This report summarizes trends and news on tobacco usage, policies, and tobacco control advocacy activities from March 2025 through February 2026. The report is written pursuant to American Medical Association (AMA) Policy D-490.983, "Annual Tobacco Report."

TOBACCO USE AT A GLANCE

The United States has continued to see decreases in tobacco use. Adult tobacco use dropped from 19.3 percent in 2022 to 16.4 percent in 2023.[1] Furthermore, current tobacco use among middle and high schoolers dropped from 10 percent in 2023 to 8.1 percent in 2024.[2] However, tobacco product use remains the leading cause of preventable disease and death in the United States.[3] There is limited availability of detailed information about tobacco trends in the last year because: (1) 2025 National Youth Tobacco Survey (NYTS) data collection was suspended midstream with the dismantling of the Office of Smoking and Health (OSH) and (2) there are few published analyses of 2025 National Health Interview Survey (NHIS) data.[4]

According to the 2024 Behavioral Risk Factor Surveillance System (BRFSS), 11percent of adults report current smoking, with the highest rates among Indian and Alaskan Native individuals (22 percent) and the lowest rates among Hawaiian/Pacific Islanders and Hispanic individuals (5 percent and 10 percent respectively).[5] Recent data from the Monitoring the Future study shows that in 2025, past 30-day nicotine use (e.g., cigars, cigarettes, hookah, vaping, nicotine pouches, smokeless tobacco) among 12th graders increased from 17 percent in 2024 to 22 percent in 2025—though little change occurred among 8th and 10th graders. This reflected small, cumulative increases across multiple tobacco products rather than a dominant change in any single drug. In 2025, lifetime use of nicotine pouches increased in all grades and vaping nicotine in the past 30 days increased in 10th and 12th grades.[6]

Adult Tobacco Use

In 2022, NHIS found that cigarettes were the most commonly used tobacco product among adults, followed by electronic cigarettes (e-cigarettes), cigars, smokeless tobacco, and pipes.[7] E-cigarettes were the second most commonly used tobacco product among U.S. adults.[8] E-cigarette use is increasing amongst adults, with 4.5 percent of adults using e-cigarettes in 2019 and 6.5 percent in 2023.[9] Among adults who smoke e-cigarettes, younger adults are more likely to report having never smoked cigarettes.[10] In 2022, 66% of adults aged 18-24 reported never smoking cigarettes, compared to 21.6% of adults aged 25-44 years and 11.3% of adults aged 45-64 years.[11]

Youth Tobacco Use

E-cigarettes are the most used tobacco product among youth in the United States.[12] In 2024, 5.9 percent(1.63 million) of middle and high school students reported currently using e-cigarettes.[13] This was a decrease from 7.7 percent in 2023.[14] Among students who reported currently using e-cigarettes, 87.6 percent used flavored e-cigarettes, 38.4 percent used an e-cigarette on at least 20 of the last 30 days, and 26.3 percent used an e-cigarette every day.[15] E-cigarettes remained the most used tobacco product among kids, and nicotine pouches were the second most used tobacco product.[16] Separate data from the CDC Foundation found that nicotine pouch use among youth ages 13-20 increased by nearly fourfold from 2022 to 2025. [17]

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Effects of Tobacco Use

Smoking combustible tobacco products can cause many diseases, including cancer, cardiovascular disease, and lung disease.[18] Cigarette smoking kills more than 480,000 Americans each year.[19] Cigarette smoking costs the United States more than $600 billion in 2018, including more than $240 billion in healthcare spending and nearly $372 billion in lost productivity.[20] Similarly, smokeless tobacco puts users at risk for cancers of the mouth, esophagus, and pancreas.[21] Regardless of whether a tobacco product is combustible, use of tobacco products can expose users to toxic substances and lead to nicotine addiction.[22]

NOTABLE FEDERAL ADMINISTRATIVE ACTIONS

The Centers for Disease Control and Prevention (CDC)'s Office on Smoking and Health (OSH) was the federal government's primary mechanism for meeting its obligations to prevent and reduce tobacco by educating the public about the dangers of smoking and tobacco use. [23] On April 1, 2025, nearly all OSH staff and contractors were terminated.[24]

The OSH was also responsible for the *Tips from Former Smokers* media campaign, which was also terminated. [25] The *Tips* campaign featured real people from diverse backgrounds living with serious long-term health effects from smoking and secondhand smoke exposure.[26] From 2012-2018, the *Tips* campaign helped approximately one million people successfully quit smoking, prevented an estimated 129,000 early deaths, and contributed to $7.3 billion in savings
on smoke-related healthcare costs.[27] The termination of the campaign left at least $65 million in congressionally directed tobacco prevention and cessation funding unused in 2025.[28]

On April 1, 2025, a significant number of staff at the U.S. Food and Drug Administration (FDA)'s Center for Tobacco Products (CTP) were terminated or otherwise removed.[29] The CTP oversees the implementation of the Family Smoking Prevention and Tobacco Control Act and is entirely funded by tobacco industry user fees.[30,31] Some of CTP's responsibilities include setting performance standards, reviewing premarket applications for new and modified risk tobacco products, requiring new warning labels, and establishing and enforcing advertising and promotion restrictions.[32] While some staff have been rehired, the restructuring has reduced the Center's capacity to enforce tobacco restrictions and thoroughly review tobacco product applications.[33,34] Furthermore, several actions from the Center for Tobacco Products actions will facilitate easier access to tobacco and nicotine products in the U.S. including: (1) authorizing the sale of 20 different Zyn products, (2) setting up a fast-track review process for premarket tobacco applications for nicotine pouches and (3) authorizing additional menthol flavored e-cigarettes for sale.[35]

Millions of dollars in federal grants from the CDC to state and local health departments were delayed in 2025.[36] The CDC typically directs the money it receives from Congress to state and local health departments.[37] With the start of the new administration, the White House began to apportion money to CDC on a month-by-month basis.[38] As a result, funds for state programs to prevent and reduce tobacco use were delayed by months.[39] The delay caused extensive changes to several state tobacco control programs, including reductions in quitline or phone counseling services for tobacco users.[40]

EFFORTS TO ADDRESS TOBACCO CONTROL

Changes to State Cigarette Taxes

In 2025, Indiana increased its cigarette tax by $2.00 per pack, bringing its state cigarette tax to $2.995.[41] Maine increased its cigarette tax by $1.50 per pack, bringing its state cigarette tax to $3.50 per pack.[42] Hawaii and New Jersey also passed small increases to their state cigarette taxes.

On the other hand, Alabama passed a reduction in its tax on heated tobacco products.[43] This is a policy that has been pushed by Phillip Morris International (PMI) as its *IQOS* heated tobacco products re-enter the U.S. market.[44] Heated tobacco products heat tobacco sticks, rather than ignite it.[45] According to PMI, the produced aerosol is a healthier alternative to smoking.[46] While heated tobacco products generally emit lower levels of harmful ingredients than regular cigarettes, there is limited research on their short- and long-term health effects.[47]

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Funding for State Tobacco Prevention and Cessation Programs

Tobacco prevention and cessation programs are highly cost-effective.[48] For example, California's long-running tobacco control program has saved the state an estimated $155 in healthcare costs for every $1 invested.[49] Additionally, state tobacco prevention and cessation programs allow resources to be targeted to alleviate disparities in tobacco use and outcomes.[50] In fiscal year 2026, 12 states have registered funding increases of nearly $1 million or more.[51]

AMA LITIGATION CENTER

The AMA Litigation Center continues to be active in state and federal courts around the country in matters involving tobacco control and regulation of flavored electronic nicotine delivery systems (ENDS). In April 2025, the United States Supreme Court issued a favorable decision in *FDA v. Wages and White Lion Investments*, which reversed a Fifth U.S. Circuit Court of Appeals ruling in favor of ENDS manufacturers and sellers. If the Court upheld the lower court ruling, companies could have marketed products that were clearly designed to appeal to children, with names such as "Jimmy the Juice Man Peachy Strawberry", "Suicide Bunny Mother's Milk and Cookies", "Pink Lemonade", "Iced Pineapple Express" and "Killer Kustard Blueberry." The FDA had denied the companies' applications for premarket approval of the tobacco products. The companies challenged the agency's decision, arguing that the FDA did not give them fair notice about the evidentiary and comparative requirements used during the application stage and that the agency had changed its position on scientific evidence. The AMA joined several Federation members and anti-smoking partners in a brief explaining the harm caused by these products. The brief urged the court to conclude that the FDA was correct in how it determined that the companies should not be able to market the flavored e-cigarette liquids. The Supreme Court ruled that the FDA did not act in an arbitrary and capricious manner when it denied the companies' applications and remanded the case to the Fifth Circuit to review other legal arguments.

The AMA continues to join amicus briefs supporting the FDA's efforts to regulate the marketing and sale of flavored products. In January 2026, the AMA joined several Federation members and anti-smoking organizations in a brief to the Sixth Circuit on *Breeze Smoke LLC v. FDA*. Under the Family Smoking Prevention and Tobacco Control Act, the FDA must approve marketing plans before companies can go forward with them. The companies must demonstrate, among other things, that marketing the product would be "appropriate for the protection of public health". The FDA denied flavored e-cigarette makers their request to market certain products.
E-cigarette companies sought review of the FDA's decision, claiming the administration did not consider certain evidence they submitted about the products' potential public health benefits, such as reduced harm compared to smoking and marketing plans to curb youth uptake of vaping. They also claim, among other things, that the FDA essentially put a ban on marketing these products without a formal rulemaking process. In the brief, the AMA and others said the FDA followed the law and that the decision to not allow the marketing to move forward was the right one for public health.

Additionally, the AMA has filed briefs supporting state and local regulation of flavored tobacco products and will continue to look for ways to support tobacco control in the courts.

AMA ADVOCACY

In June 2025, the AMA sent a letter to the White House Office of National Drug Control Policy (ONDCP) to comment on the areas under consideration for the Administration's 2026 drug policy priorities. The AMA expressed that it shares the Administration's goal to prevent the initiation of drug use before it starts—particularly among youth and adolescents. The AMA advocated for increased study of why youth and adolescent use of some illicit substances, such as tobacco, may be decreasing so that we can better understand and build on those best practices. The AMA also urged ONDCP's help to support and/or identify opportunities to not only increase access to effective treatment for nicotine and other substance use, but also to support efforts to increase access to comprehensive mental health care, behavioral health counseling and medications that suppress cravings and withdrawal symptoms.

In July 2025, the AMA sent a letter to the Massachusetts legislature in support of House Bill 2562 and Senate Bill 1568, which would prohibit the sale of tobacco products to individuals born on or after January 1, 2006.

In August 2025, several AMA staff participated in the National Conference on Tobacco or Health (NCOTH) in Chicago. This included speaking in a panel presentation on "The Impact of the Public Health Community on Tobacco Litigation" by Lenoard Nelson.

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In October 2025, the AMA signed onto a letter to the Food and Drug Administration commenting on the Proposed Rulemaking on a Tobacco Product Standard for Nicotine Yield of Cigarettes and Certain Other Combusted Tobacco Products, urging the agency to finalize a comprehensive rule that will reduce nicotine levels in combustible tobacco products.

Also in October 2025, the AMA signed onto a letter to the chief appropriators in Congress urging them to reject proposals to dramatically cut funding for tobacco prevention programs carried out by the CDC and to maintain adequate funding for such programs instead. On February 3, 2026, Congress enacted the Consolidated Appropriations Act, 2026, which provided level funding for CDC's tobacco prevention activities, a significant victory.

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8. COUNCIL ON LEGISLATION SUNSET REVIEW OF 2016 HOUSE POLICIES

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS
REMAINDER OF REPORT FILED

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

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

2. In the implementation and ongoing operation of our AMA policy sunset mechanism, the following procedures shall be followed: (a) Each year, the Speakers shall provide a list of policies that are subject to review under the policy sunset mechanism; (b) Such policies shall be assigned to the appropriate AMA councils for review; (c) Each AMA council that has been asked to review policies shall develop and submit a report to the HOD identifying policies that are scheduled to sunset; (d) For each policy under review, the reviewing council can recommend one of the following actions: (i) retain the policy; (ii) sunset the policy; (iii) retain part of the policy; or (iv) reconcile the policy with more recent and like policy; (e) For each recommendation that it makes to retain a policy in any fashion, the reviewing council shall provide a succinct, but cogent justification; or (f) The Speakers shall determine the best way for the HOD to handle the sunset reports.

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

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

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

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

RECOMMENDATION

The Board of Trustees recommends that the House of Delegates policies that are listed in the appendix to this report be acted upon in the manner indicated and the remainder of this report be filed.

APPENDIX – Recommended Actions

Policy Number	Title	Text	Recommendation
D-125.993	Medicare Part D Guidelines	Our AMA will continue to advocate to CMS, and if appropriate, to the United States Pharmacopeia, our AMA's Principles of a Sound Drug Formulary System (as described in BOT Rep. 28, I-00) with respect to drug categories and classes to be covered under Medicare Part D.	Retain – this policy remains relevant.
D-140.968	Standardized Advance Directives	Our AMA will endorse the "Uniform Health-Care Decisions Act," which was drafted and adopted by the National Conference of Commissioners on Uniform State Laws	Sunset this policy. The 1993 Uniform Health-Care Decisions Act from the

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Policy Number	Title	Text	Recommendation
		(NCCUSL) in 1993, and work with our state medical societies to advocate for its adoption in the states.	Uniform Law Commission has been withdrawn and replaced with a more recent version. Also see Board of Trustees Report 12-A-26, which discusses this topic.
D-165.989	Managed Care Organization Reimbursement Formulas	Our AMA will continue to assist states medical associations in their efforts to enact meaningful legislation that protects patients and patient access through network adequacy provisions.	Retain – this policy remains relevant.
D-185.982	Health Coverage for Nutritional Products for Inborn Errors of Metabolism	Our AMA: (1) will support legislation mandating insurance coverage with minimal deductible or copays for specialized medical food products used to treat inborn errors of metabolism; and (2) will advocate with the Department of Health and Human Services and members of Congress for the regulation of specialized nutritional products for the medical treatment of inborn errors of metabolism as drugs.	Retain – this policy remains relevant.
D-185.993	Advocacy for Repeal of the Uniform Individual Accident and Sickness Policy Provision Law (UPPL)	Our AMA will support state and specialty medical societies and the public health associations in their efforts to secure repeal of laws and state insurance codes which allow for the denial of insurance payments for the treatment of injuries sustained as a consequence of the insured person being intoxicated due to alcohol or under the influence of narcotics.	Retain – this policy remains relevant.
D-190.977	Insurance Reimbursements	Our AMA will: (1) seek legislation requiring managed care companies and any third party carrier including Medicare to request a refund from physicians in the same time period they give physicians to file a claim in the contract; and (2) seek legislation that managed care companies and any third party carrier including Medicare in no case be allowed more than 180 days to request a refund from a physician.	Retain – this policy remains relevant.
D-270.990	Diagnosis of Disease and Diagnostic Interpretation of Tests Constitutes Practice of Medicine to be Performed by or Under the Supervision of Licensed Physicians	Our AMA will pursue all appropriate legislative, regulatory and legal actions to counter expansions of the scope of work by PhD clinical lab scientists and other non-physician laboratory personnel to authorize the independent practice of medicine by any individual who has not completed the state's requirements for licensure to engage in the practice of medicine.	Retain – this policy remains relevant.
D-290.998	Medicare/Medicaid Dual Eligibles	Our AMA will pursue all appropriate measures including, but not limited to, the development and passage by Congress of legislation to require the federal government to directly provide or mandate that states provide full reimbursement for Medicare deductibles and co-payments for all patients who are Medicare/Medicaid dual eligible.	Retain – this policy remains relevant.

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Policy Number	Title	Text	Recommendation
D-305.972	Title VII Funding	Our AMA will (1) partner with all relevant stakeholders to petition Congress to reinstate funding for Title VII to at least fiscal year 2005 levels of $300 million and (2) endeavor to educate legislators in Congress about how Title VII-supported programs address health professional shortages, increase the diversity of the workforce, equip health professions students to work in health centers and underserved communities, and ensure that health professionals are ready to address health-related emerging issues.	Retain – this policy remains relevant.
D-330.904	Opposition to the CMS Medicare Policies That Undermine Access to the Best Course of Treatment ~~Part B Drug Payment Model~~	~~1. Our AMA will request that the Centers for Medicare & Medicaid Services (CMS) withdraw the proposed Part B Drug Payment Model.~~ ~~2. Our AMA will support and actively work to advance Congressional action to block the proposed Part B Drug Payment Model if CMS proceeds with the proposal.~~ ~~3~~1. Our AMA will advocate against policies that are likely to undermine access to the best course of treatment for individual patients and oppose demonstration programs that could lead to lower quality of care and do not contain mechanisms for safeguarding patients. 42. Our AMA will advocate for ensuring that CMS solicits and takes into consideration feedback from patients, physicians, advocates, or other stakeholders in a way that allows for meaningful input on any Medicare coverage or reimbursement policy that impacts patient access to medical therapies, including policies on coverage and reimbursement.	Retain in part and modify the title. Sunset clauses 1 and 2; retain clauses 3 and 4. The AMA submitted a letter to Centers for Medicare & Medicaid Services (CMS) in May 2016 on the proposed Part B Drug Payment Model. Due to strong opposition, CMS did not finalize this model in 2016.
D-330.905	Expedited Review for Clerical Errors on Medicare Enrollment Applications	1. Our AMA will urge the Centers for Medicare & Medicaid Services (CMS) to create an expedited process to review minor clerical errors on enrollment applications that result in CMS deactivating the physician's billing privileges. 2. Our AMA will urge CMS to remove a physician from a potential fraud and abuse review if there is proof that the error is only related to a clerical mistake. 3. Our AMA will urge CMS to create a process that not only reactivates a physician's billing privileges but also retroactively applies the effective date to the initial date when the minor clerical error occurred and applies no penalty to payments due for care provided to Medicare beneficiaries during this time frame.	Retain – this policy remains relevant.
D-330.906	Minimize Provider Burden for Meaningful Use Audit	1. Our AMA will advocate for all audit programs to have a "look back period" of no more than two years. 2. Our AMA will advocate against the "zero tolerance" policy of the current "Meaningful	Sunset this policy. This policy is tied to the Centers for Medicare & Medicaid Services

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Policy Number	Title	Text	Recommendation
		Use" audit program and any similar programs proposed by the Centers for Medicare and Medicaid Services, whereby physicians lose their total incentive payment rather than receive a payment proportional to their success. 3. Our AMA will advocate to reform the Centers for Medicare and Medicaid Services "Meaningful Use" audit program.	"Meaningful Use" program, which no longer exists in its original form. The Meaningful Use incentive program for physicians ended years ago and was folded into the Merit-based Incentive Payment System under MACRA.
D-335.982	Statute of Limitations for Medicare and RAC "Lookbacks"	Our AMA will work with Medicare to reduce the "Lookback" period to be no longer than the length of time allowed to submit a claim for consideration.	Retain – this policy remains relevant.
D-35.979	Opposition to the Department of Veterans Affairs Proposed Rulemaking on APRN Practices	1. Our AMA will express to the U.S. Department of Veterans Affairs (VA) that the plan to substitute physicians by using Advanced Practice Registered Nurses (APRNs) in independent practice, not in physician-led teams, is antithetical to multiple established policies of our AMA and thus should not be implemented. 2. Our AMA staff will assess the feasibility of seeking federal legislation that prevents the VA from enacting regulations for veterans' medical care that is not consistent with physician-led health care teams or to mandate that the VA adopt policy regarding the same. 3. Our AMA will call upon Congress and the Administration to disapprove or otherwise overturn rules and regulations at the federal level that would expand the scope of practice of APRNs, and other non-physicians in unsupervised practice. ~~comment to the Director of Regulation Management within the Department of Veterans Affairs of this position during the current comment period.~~ 4. Our AMA will collaborate with other medical professional organizations to vigorously oppose the ~~final adoption~~ of the VA's ~~proposed rulemaking~~ expanding the role of APRNs and other non-physicians within the VA in unsupervised practice.	Retain this policy with amendments. Clauses 3 and 4 should be amended.
D-355.996	Limitations on Reports by Insurance Carriers to the National Practitioner Data Bank Unrelated to Patient Care	1. Our AMA will seek legislation and/or regulation that would require the Health Resources and Services Administration (HRSA) to clarify that reports to the National Practitioner Data Bank (NPDB) of medical malpractice settlements by physicians be limited to those cases in which the named physician was directly involved in the provision of or failure to provide healthcare services. 2. Our AMA will seek legislation and/or regulation that would require HRSA to audit the NPDB for reports on physicians who were not involved in the treatment of a plaintiff, but were reported as a result of a healthcare entity's	Retain in part. Clause 4 has been accomplished and can be deleted. Board of Trustees Report 04-I-17 on this subject was included in the 2017 Interim Meeting House of Delegates Handbook. Clauses 1-3 remain relevant.

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Policy Number	Title	Text	Recommendation
		settlement of a claim that included the names of those physicians in their administrative roles at the entity. 3. Our AMA will seek legislation and/or regulation that would require HRSA to remove reports from the NPDB of any physician who was reported as the result of the settlement of a claim by a healthcare entity where the physician was not involved in the treatment of the plaintiff. ~~4. Our AMA will provide a report to the House of Delegates at the 2017 Interim Meeting regarding our AMA's interactions with HRSA and detailing the actions taken or planned by HRSA to eliminate inappropriate reporting of physicians to the NPDB.~~	
D-390.951	CMS Revalidation of Medicare Billing Privileges	Our AMA will advocate for the Centers for Medicare & Medicaid Services (CMS) to adopt the practice of sending revalidation notices to physicians using certified mail with return receipt, thus ensuring that such notices are actually sent by CMS and received by the physician.	Sunset this policy. The Centers for Medicare & Medicaid Services has moved toward an electronic, self-service model. Notices are now sent by email in addition to U.S. mail, due dates are posted publicly months in advance, and PECOS is the primary mechanism for managing enrollment. Advocating specifically for certified mail with return receipt does not align with CMS' current direction and would likely be viewed as inconsistent with the agency's push toward modernization and paperless processes.
D-440.929	Nominations for and Improvement of the Position of the United States Surgeon General	Our AMA will convey to the Presidential Transition Team support for an enhanced role for the Surgeon General in addressing important matters of public health.	Sunset this policy. This directive has been accomplished. In 2016, the AMA met with presidential transition teams of both major party candidates to discuss their positions on a wide range of health policy issues, including public health issues that could be affected by the Surgeon General. After the election, our AMA resumed discussions with the president-elect's transition team. As part of these discussions, AMA advocated for an enhanced

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Policy Number	Title	Text	Recommendation
			role for the Surgeon General that includes more resources to address matters of public health.
D-450.955	Remove Pain Scores from Quality Metrics	Our AMA will work with the Centers for Medicare & Medicaid Services to remove uncontrolled pain scores from quality metrics that impact reimbursement for services rendered in the nursing facilities and from the five-star rating system for nursing facilities.	Retain – this policy remains relevant.
D-478.982	Redefine "Meaningful Use" of Electronic Health Records	1. Our AMA will work with the federal government and the Department of Health and Human Services to: (A) set realistic targets for meaningful use of electronic health records such as percentage of computerized order entry, electronic prescribing, and percentage of inclusion of laboratory values; and (B) improve the electronic health records incentive program requirements to maximize physician participation. 2. Our AMA will continue to advocate that, within existing AMA policies, the Centers for Medicare & Medicaid Services suspend penalties to physicians and health care facilities for failure to meet Meaningful Use criteria.	Sunset this policy. "Meaningful Use" has been replaced by the Promoting Interoperability (PI) Program for hospitals and, for clinicians, it is now a core component of the Merit-based Incentive Payment System (MIPS) under the Quality Payment Program (QPP).
D-480.967	Integration of Mobile Health Applications and Devices into Practice	Our AMA will: (1) assess the potential liability risks to physicians for using, recommending, or prescribing mHealth apps, including risk under federal and state medical liability, privacy, and security laws; and (2) assess the feasibility of state and federal legislation, as well as other innovative alternatives, in an effort to mitigate the physician's potential risk of liability from the use or recommendation of mHealth apps.	Retain – this policy remains relevant.
D-480.968	Telemedicine Encounters by Third Party Vendors	1. Our AMA ~~will develop model legislation and/or regulations~~ supports requiring telemedicine services or vendors to coordinate care with the patient's medical home and/or existing treating physicians, which includes at a minimum identifying the patient's existing medical home and/or treating physicians and providing to the treating physician a copy of the medical record, with the patient's consent. 2. ~~The model legislation and/or regulations will also~~ Our AMA also supports require~~e~~ing the vendor to abide by laws addressing the privacy and security of patients' medical information 3. Our AMA ~~will include in that model state legislation~~ supports the following concepts based on AMA policy: (a) A valid patient-physician relationship must be established before the provision of telemedicine services; (b) Physicians and other health practitioners delivering telemedicine services must be licensed in the state where the patient receives services, or be	Retain with amendments.

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Policy Number	Title	Text	Recommendation
		providing these services as otherwise authorized by that state's medical board; and (c) The standards and scope of telemedicine services should be consistent with related in-person services. 4. Our AMA will educate and advocate to AMA members on the use and implementation of telemedicine and other related technology in their practices to improve access, convenience, and continuity of care for their patients.	
D-505.998	International Trade Agreements	Our AMA will: (1) monitor developments on US international trade agreements that involve the provision of medical services and the distribution and advertising of alcohol and tobacco; (2) in collaboration with interested members of the Federation and other professional organizations, advise the US Trade Representative on trade issues that could affect physicians or the provision of medical services, and advocate applicable AMA policy; (3) in collaboration with interested members of the Federation and other professional organizations, advise the US Trade Representative on trade issues that involve the distribution and advertising of alcohol and tobacco, and other pertinent public health issues, and advocate applicable AMA policy; and (4) continue to strongly advocate for US ratification of the Framework Convention on Tobacco Control.	Retain – this policy remains relevant.
D-95.973	Fraudulent Use of Prescriptions	Our AMA: (1) will promote the efforts for state run electronic Prescription Monitoring Programs to allow individual physicians to access records of their prescribing of opioids, for their entire panel of patients, including patient names and prescription information; and (2) will study current pathways that physicians have available to report possible fraudulent use of their prescriptions and disseminate this information throughout organized medicine.	Retain – this policy remains relevant.
H-100.966	Tracking and Punishing Distributors of Counterfeit Pharmaceuticals	Our AMA supports legislation making the production and distribution of counterfeit pharmaceuticals a felony.	Retain – this policy remains relevant.
H-110.989	Pay for Delay Arrangements by Pharmaceutical Companies	Our AMA supports: (1) the Federal Trade Commission in its efforts to stop "pay for delay" arrangements by pharmaceutical companies and (2) federal legislation that makes tactics delaying conversion of medications to generic status, also known as "pay for delay," illegal in the United States.	Retain – this policy remains relevant.
H-120.929	Protect Individualized	Our American Medical Association ~~will advocate that~~ supports the US Food and Drug	Retain with amendments.

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Policy Number	Title	Text	Recommendation
	Compounding in Physicians' Offices as Practice of Medicine	Administration ~~remove~~ in excluding physician offices and ambulatory surgery centers from its definition of a compounding facility.	
H-120.934	Appropriate Use of Compounded Medications in Medical Offices	Our American Medical Association supports regulatory changes to improve access to (1) the compounding and repackaging of manufactured FDA-approved drugs and substances usually prepared in the office-based setting and (2) purchasing from compounding pharmacies of FDA-approved drugs, repackaged or compounded for the purpose of in-office use.	Retain – this policy remains relevant.
H-175.986	Bounty Hunter Provision of the Health Insurance Portability and Accountability Act of 1996	The AMA will work toward amending the Health Insurance Portability and Accountability Act of 1996 by imposing civil monetary penalties for fraudulently and falsely reporting physician fraud or abuse.	Sunset this policy. The intent of this policy—to protect physicians from malicious or unfounded fraud allegations—is comprehensively achieved through several AMA policies requiring a knowing and willful intent standard, preserving the government's burden of proof, and ensuring robust due process protections during fraud and abuse investigations. See AMA Policies H-175.981 Fraud and Abuse Within the Medicare System; H-175.985 - Kennedy-Kassebaum: Fraud and Abuse; H-235.965 - Physician Involvement in Hospital or Health Care Corporate Compliance Committees Concerning Fraud and Abuse; H-175.982 - Due Process for Physicians; H-330.943 - Physicians' Rights; H-175.973 - Medicare Investigation Search and Seizure Process.
H-270.953	Tax Exemptions for Feminine Hygiene Products	Our AMA supports legislation to remove all sales tax on feminine hygiene products.	Retain – this policy remains relevant.
H-270.966	Disclosure of Drug Use and Addiction Treatment History in Public Assistance Programs	Our AMA opposes: a) requiring that housing applicants consent to the disclosure of medical information about alcohol and other drug abuse treatment as a condition of renting or receiving Section 8 assistance; and b) requiring applicants and/or beneficiaries of Temporary Assistance for Needy Families (TANF, "welfare") and/or the Supplemental Nutrition Assistance Program	Retain – this policy remains relevant.

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		(SNAP, "food stamps") to disclose medical information, including alcohol and other drug use or treatment for addiction, or to deny assistance from these programs based on substance use status.	
H-270.968	Preservation of Political Advocacy by Nonprofit Organizations	The AMA continues to oppose a federal initiative that would impose restrictions on advocacy activities of federal grantees that preclude them from both utilizing private funds for advocacy activities as well as delivering government-funded services.	Retain – this policy remains relevant.
H-290.964	CMS Audits and Clawbacks	Our AMA will undertake advocacy efforts to: 1) Persuade CMS to redefine "primary care provider" for purposes of the regulations governing the enhanced payments to primary care physicians mandated by section 1202 of the Health Care and Education Reconciliation Act of 2010 ("Section 1202"). Such definition should include the current providers board certified in a specialty considered primary care; or providers attesting to the 60% threshold under the same methodology as used in the parallel statutory formula in Section 5501(a) of PPACA; or, in states utilizing managed care organizations, providers who are, or have been held out by such MCOs as primary care providers by having patients assigned to such primary care providers and holding such providers out to the public as primary care providers; and the 60% Threshold formula previously utilized in attestation. 2) Persuade CMS to order that the audits conducted, or to be conducted, of the enhanced payments to primary care physicians, by state Medicaid agencies or their agents be conducted pursuant to the amended flexible formula redefining "primary care provider." 3) Persuade CMS to order that state Medicaid agencies, or their agents, immediately cease recoupments, or hold amounts of funds already recouped in trust, until a new audit using the redefined formula can be completed.	Sunset this policy. The temporary Medicaid "fee bump" paid to primary care providers under the ACA expired at the end of 2014. Medicaid RAC audits typically look back at payments for 3-5 years, and therefore the time period for such audits related to the ACA primary care bump has passed. For RAC audit issues unrelated to the ACA Medicaid primary care fee bump, the AMA continues to engage in advocacy to improve the RAC audit process under Policies D-320.991 - Creating a Fair and Balanced Medicare and Medicaid RAC Program, and D-330.915 - RAC Audits of E&M Codes.
H-290.978	Medicare/Medicaid Dual Eligible Reimbursement	Our AMA seeks the repeal of Section 4714 of the Balanced Budget Act of 1997 and restore the requirement that states pay the deductible, copayment and coinsurance amounts for Medicare/Medicaid dual-eligible patients.	Retain – this policy remains relevant.
H-330.995	Amendments to the Medicare Civil Penalties Section of the Social Security Act	The AMA supports amendment of the Social Security Act to permit trial de novo for a physician who so requests when the sum of the penalties levied is greater than $10,000 and/or when a suspension from the Medicare program is applied.	Retain – this policy remains relevant.

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Policy Number	Title	Text	Recommendation
H-355.974	National Practitioner Data Bank	1. Our AMA will advocate to the Health Resources and Services Administration that a physician's surrender of clinical privileges or failure to renew clinical privileges while under investigation should not be reported to the National Practitioner Data Bank unless the physician has been notified that an investigation is underway.	Retain – this policy remains relevant.
H-370.968	Endorsement of the Uniform Anatomical Gift Act (2006)	Our AMA endorses the Uniform Anatomical Gift Act of 2006, and urges all constituent state medical societies to work with donation stakeholders, including organ procurement organizations, eye banks, tissue banks, and other donation-related organizations, toward persuading their state legislatures to adopt UAGA (2006) in place of earlier versions of the UAGA.	Retain – this policy remains relevant.
H-383.987	Restrictive Covenants in Physician Contracts	Our AMA will provide guidance, consultation, and model legislation concerning the application of restrictive covenants to physicians upon request of state medical associations and national medical specialty societies.	Retain – this policy remains relevant.
H-390.853	Protecting Patient Access to High Quality Imaging Services	Our AMA actively supports repeal or delay of the provision under Section 5102 of the Deficit Reduction Omnibus Reconciliation Act of 2005 that reduces the technical component payment (including the technical component of the global payment) for an imaging service under the physician payment schedule if it exceeds (without regard to geographic wage adjustment factor) the outpatient department payment schedule amount for the service established under the Medicare prospective payment system for hospital outpatient departments.	Retain – this policy remains relevant.
H-390.898	Equity in Medicare Payment Levels	Our AMA: (1) adopts as a major legislative priority the adequate funding of the Medicare program; and (2) supports the initiation of legislation to prevent any further reduction of the current Medicare limiting charges.	Sunset this policy. This policy has been superseded by AMA Efforts on Medicare Payment Reform D-400.982; Health System Reform Legislation H-165.838; Physician Payment Reform H-400.972; Sequestration D-390.946; Preventing Imminent Payment Cuts and Ensuring the Sustainability of the Medicare Program D-390.921; and Saving Traditional Medicare H-390.832.

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Policy Number	Title	Text	Recommendation
H-40.970	The Uniformed Services University of the Health Sciences	The AMA fully supports the continuation of the Uniformed Services University of the Health Sciences as an institution and urges the Executive and Legislative Branches of the United States Government to fulfill their responsibility to our armed forces by fully funding the Uniformed Services University of the Health Sciences.	Retain – this policy remains relevant.
H-400.989	Physician Negotiations	The AMA supports federal legislation that would allow the AMA and state medical associations, on behalf of physicians, to negotiate payment schedules on federal and state policies, respectively, impacting on physician reimbursement.	Retain – this policy remains relevant.
H-410.949	Dry Needling is an Invasive Procedure	Our AMA recognizes dry needling as an invasive procedure and maintains that dry needling should only be performed by practitioners with standard training and familiarity with routine use of needles in their practice, such as licensed medical physicians and licensed acupuncturists.	Retain – this policy remains relevant.
H-435.952	Savings Accounts for Extended Reporting Endorsement Policies and Other Liability Insurance Costs	Our AMA supports changes to the Internal Revenue Code to allow a pre-tax Extended Reporting Endorsement Savings Account whereby the amount of money contributed before taxes and interest on earnings from those monies be allowed to grow tax free until such time as an extended reporting endorsement must be purchased and that the balance of any remaining funds would return to the physician without IRS penalty and be subject to taxation at that time.	Retain – this policy remains relevant.
H-435.958	Immunity from Professional Liability Tort for Volunteer Services During State or National Emergencies	The policy of the AMA is to formulate and support federal legislation granting legal immunity, including medical liability immunity, for volunteer medical services arising from declared state or national emergencies.	Retain – this policy remains relevant.
H-435.960	Physician Relief from Product Class Actions	Our AMA: (1) asks Congress to pass legislation which prevents naming the treating physician as a party to product liability lawsuits when the treating physician has used a Food and Drug Administration-approved drug or device; and (2) promotes the introduction of legislation which would exempt physicians who have properly prescribed usage of Food and Drug Administration-approved medications from liability in class action suits against pharmaceutical companies.	Retain – this policy remains relevant.
H-435.967	Report of the Special Task Force and the Advisory Panel on Professional Liability	1. It is the policy of the AMA that effective medical liability reform, based on the California Medical Injury Compensation Reform Act (MICRA) model, is integral to health system reform. The AMA's MICRA-based federal tort reform provisions include: (a) a $250,000 ceiling on non-economic damages, (b) the offset of	Retain – this policy remains relevant.

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		collateral sources of plaintiff compensation, (c) decreasing incremental or sliding scale attorney contingency fees, (d) periodic payment of future awards of damages, and (e) a limitation on the period for suspending the application of state statutes of limitations for minors to no more than six years after birth.	
H-435.976	Liability Protection for Medical Volunteers	It is the policy of the AMA to endorse the concept of liability protection for medical volunteer services and to promote legislative efforts to achieve that goal.	Retain – this policy remains relevant.
H-478.985	Patient Safety Incidents Related to Use of Electronic Health Records	Our AMA supports the Office of the National Coordinator for Health IT (ONC) efforts to implement a Health IT Safety Center to minimize EHR-related patient safety risks through collection, aggregation and analysis of data reported from EHR-related adverse patient safety events and near misses.	Sunset this policy. The Office of the National Coordinator for Health IT (ONC) efforts to implement the "Health IT Safety Center" never materialized. Instead of a centralized, independent center, ONC shifted to a collaborative approach to safety, which included SAFER (Safety Assurance Factors for Electronic Health Record Resilience) Guides, voluntary reporting, integrating safety into certification, and industry collaboration.
H-478.986	Merit-Based Incentive Programs	Our AMA will advocate to make the certified vendor-based EHRs accountable for the provision of reports in a format suitable to satisfy physician reporting requirements.	Retain – this policy remains relevant.
H-95.927	Universal Prescriber Access to Prescription Drug Monitoring Programs	Our AMA supports legislation and regulatory action that would authorize all prescribers of controlled substances, including residents, to have access to their state prescription drug monitoring program.	Retain – this policy remains relevant.
H-95.92	Model State Legislation Promoting the Use of Electronic Tools to Mitigate Risk with Prescription Opioid Prescribing	1. Our AMA supports the ability of prescription drug monitoring programs (PDMPs) to have the capability for physicians to know when their patients have received a prescription for controlled substances from multiple prescribers or multiple pharmacies within a short time frame. 2. Our AMA will advocate to key stakeholders, including the National Association of State Controlled Substances Authorities, the National Association of Boards of Pharmacy, and the National Governors Association, to ensure that efforts to reduce Multiple Provider Events (MPEs) are done in a manner that supports continuity of care.	Retain – this policy remains relevant.

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		3. Our AMA will work with the Centers for Disease Control and Prevention (CDC), Substance Abuse and Mental Health Services Administration (SAMHSA) and other relevant federal agencies, to better understand the factors that lead to MPEs and develop medically and ethically appropriate strategies for reducing them. 4. Our AMA will advocate for the interoperability of state PDMPs with electronic health records (EHRs). 5. Our AMA will advocate for the Centers for Medicaid and Medicare Services (CMS) and Office of the National Coordinator for Health Information Technology (ONC) to better incorporate feedback from physicians to focus on outcomes and focusing ONC certification on testing for product safety, security, usability, and interoperability.	
H-95.929	Support for Prescription Drug Monitoring Programs	Our AMA will: (1) continue to encourage Congress to assure that the National All Schedules Prescription Electronic Reporting Act (NASPER) and/or similar programs be fully funded to allow state prescription drug monitoring programs (PDMPs) to remain viable and active; and (2) work to assure that interstate operability of PDMPs in a manner that allows data to be easily accessed by physicians and does not place an onerous burden on their practices.	Sunset this policy. PDMPs are largely ubiquitous in states, and interstate interoperability, while not universal, is common. This policy is also covered by H-95.939 - Development and Promotion of Single National Prescription Drug Monitoring Program.
H-95.939	Development and Promotion of Single National Prescription Drug Monitoring Program	Our American Medical Association (1) supports the voluntary use of state-based prescription drug monitoring programs (PDMP) when clinically appropriate; (2) encourages states to implement modernized PDMPs that are seamlessly integrated into the physician's normal workflow, and provide clinically relevant, reliable information at the point of care; (3) supports the ability of physicians to designate a delegate to perform a check of the PDMP, where allowed by state law; (4) encourage states to foster increased PDMP use through a seamless registration process; (5) encourages all states to determine how to use a PDMP to enhance treatment for substance use disorder and pain management; (6) encourages states to share access to PDMP data across state lines, within the safeguards applicable to protected health information; and (7) encourages state PDMPs to adopt uniform data standards to facilitate the sharing of information across state lines.	Retain – this policy remains relevant.
H-95.986	State Legislation to Monitor Prescription of Schedule II Drugs	The AMA believes that it is important for each state to assess its own drug diversion problem and, taking into consideration the strengths of various available programs, to tailor remedial	Sunset this policy. Each state has robust policies that accomplish

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		action to the specific problems of the state involved.	this. The AMA also has multiple policies addressing the need for multifaceted state and national efforts. These include: H-95.896 - Calling for a Multifaceted Approach to the Illicit Fentanyl Crisis; and H-95.940 - Addressing Emerging Trends in Illicit Drug Use.

9. AMERICAN MEDICAL ASSOCIATION OPTIMAL HEALTH OUTCOMES ANNUAL REPORT

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: REFERRED WITH A REPORT BACK AT I-26

BACKGROUND

At the 2018 Annual Meeting, the House of Delegates (HOD) adopted Policy D-180.981, directing our American Medical Association (AMA) to "develop an organizational unit, e.g., a Center or its equivalent, to facilitate, coordinate, initiate, and track AMA health equity activities" and instructing the "Board to provide an annual report to the House of Delegates regarding AMA's health equity activities and achievements." The HOD provided additional guidance via Policy H-180.944: "Health equity, defined as optimal health for all, is a goal toward which our AMA will work by advocating for health care access, research, and data collection; promoting equity in care; increasing health workforce diversity; influencing determinants of health; and voicing and modeling commitment to health equity." HOD policy was followed by creation of the AMA Center for Health Equity (Center) in April 2019, the AMA's Organizational Strategic Plan to Embed Racial Justice and Advance Health Equity for 2021-2023 (Plan) in May 2021, and the successor 2024-2025 Plan in June 2024. In 2022, updated Policy H-65.946 specified that this report will also include "updates on [the AMA's] comprehensive diversity and inclusion strategy." Towards the end of 2025, the AMA made the decision to rebrand and reframe its work in the pursuit of improving health outcomes; merging the Center for Health Equity and the Improving Health Outcomes (IHO) business unit into the Center for Optimal Health Outcomes (COHO) with the goal of building on the momentum established by the Center for Health Equity to engage communities in addressing health disparities and leveraging IHO staff's clinical expertise, health system engagement, and community health organization partnerships. This report marks the seventh AMA Optimal Health Outcomes Annual Report.

DISCUSSION

Our AMA has committed to advancing health outcomes and embedding equity across the organization and beyond. In 2025, the Center continued to collect enterprise-wide equity related work and track progress across all the AMA's Business Units (BU). This report outlines the activities conducted by our AMA during calendar year 2025, divided into the four COHO pillars, demonstrating relevance, impact, and thought leadership: (1) Community Health Impact, (2) Health Systems Engagement, (3) Policy Development and (4) Data and Research.

Community Health Impact
The following are some of the relevant accomplishments toward community health impact during 2025:

- At the 2025 Annual and Interim HOD meetings, several reports, resolutions, and education sessions were presented, including the Council on Ethical and Judicial Affair report: "Laying the First Steps Towards a Transition to a Financial and Citizenship Need Blinded Model for Organ Procurement and Transplantation." The Council on Science and Public Health presented various reports on topics such as: Addressing Social Determinants of Health Through Closed Loop Referral Systems, Disaffiliation from Honor Medical Societies

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due to Perpetuation of Racial Inequities in Medicine, Explainability of Artificial/Augmented Intelligence and Machine Learning Algorithms and Addressing the Health Issues Unique to Minority Communities in Rural Areas. Additionally, at the 2025 HOD Annual Meeting, the AMA hosted the Health Equity Open Forum: Leveraging the National Release the Pressure Campaign to Address Heart Disease focused on showcasing effective clinical practices and community-driven initiatives led by coalitions to advance heart health. A total of 68 physicians attended, including six past presidents of the National Medical Association (NMA).

- The AMA launched the Community Health Impact Lab micro grants that will award a total of $1 million to support 20 physician-led initiatives aimed at improving health outcomes in their communities. The grants will help physicians make a difference at the local level on critical issues like food insecurity, caregiver support, maternal health and much more. The awardees will be announced in 2026.
- The AMA committed an additional $3 million multi-year investment as a West Side United Anchor Mission Partner, contributing to a combined $177 million financial mobilization for projects on Chicago's west side, including housing, loans, local purchasing, and job creation and provided $250,000 in direct support to West Side United to strengthen engagement and programming capacities.
- In its sixth year, the AMA continued to promote the annual Ad Council's flu vaccination national media campaign with new English/Spanish public service advertisements (PSAs) encouraging people to get vaccinated against seasonal flu to protect themselves and their community.
- The AMA conducted 44 burnout assessments at federally qualified health centers (FQHCs) and/or community health centers, all organizations serving patients from predominantly and historically underserved communities. Several participating FQHCs were recognized through the AMA's Joy in Medicine® Health System Recognition Program. In addition, AMA staff had the opportunity to shadow professionals at an FQHC located in Chicago's south side (Alivio Medical Center) and met with its leadership team to learn more about community needs and challenges. Lessons learned by staff were used to inform and expand the reach and impact of the AMA's work.
- The AMA, in collaboration with The Kennedy Forum and Third Horizon, launched a new open-access visual interactive mapping tool, the Mental Health Parity Index (MHPI). The tool allows physicians, patients, policymakers, and other stakeholders to assess how well commercial insurance plans are performing with regard to mental health parity laws. Specifically, this new tool analyzes commercial insurance plans based on access, coverage and payment for mental health and substance-use services as compared with physical health services using data published by individual insurance plans. The tool was piloted in Illinois, and the aim is to expand nationally.
- The AMA and the Ad Council, in collaboration with a coalition of health care leaders, launched a new digital injury prevention resource hub at Agree To Agree to empower physicians and other health care professionals to confidently engage patients in conversations related to firearm injury prevention. The digital resource hub features the national Agree to Agree campaign's videos, fact sheets, toolkits and conversation guides for clinicians to help patients and their families understand the risks associated with unsecured firearms and best practices for secure storage to help reduce firearm related injuries and deaths.
- The AMA launched a structured private practice incubator program to support a select group of physicians through the process of starting their own practice called the Independent Practice Incubator (IPI). The IPI was launched as a pilot program to test the market and to be available for physicians who might lack financial resources to engage with consultants or other external partners. As part of the application, the participants were asked if there were any special populations that they were interested in serving upon the opening of their practices; a number of those in the program look to start their own practices to focus on underserved communities.
- AMA STEPS Forward® continued to hold events, reaching a wider audience of attendees, while maintaining discounted attendance for FQHCs and safety-net providers. The bootcamps offer evidence-based time management and team-based care strategies to provide quality patient care. In 2025, an updated STEPS Forward resource page was created to specifically guide and support FQHCs and safety-net providers on the AMA site.
- New STEPS Forward® content helped address determinants of health and differences in health outcomes. For example, 2025 STEPS Forward® podcast content included nine optimal health outcomes-related episodes, including (1) Screening for Prediabetes: Pearl of the Month, (2) How to Take a Patient-Centered Approach to Cancer Care, (3) Help for Patients with Uncontrolled Hypertension: Pearl of the Month, (4) One

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Federally Qualified Health Center's Journey to Joy in Medicine and (5) A Lifeline for Moms: Providing Whole Person Care in Maternal Health Settings.

- In 2025, the AMA content on optimal health outcomes experienced a 50 percent increase in engagement from 2024, reaching three million website users. The AMA completed 16 website accessibility improvements across its websites. As part of the AMA's efforts to complement and enhance physician professional development, the AMA launched the AMA Physician Education Program (PEP) to provide a flexible and robust continued learning experience specifically curated for physicians. Topics covered range from optimizing health outcomes, quality and safety, well-being, leadership development and more.
- On the AMA Ed Hub™ site, the AMA published 128 new optimal health outcomes-related activities and renewed 101, with user engagements reaching over 300,000. Notably, the AMA, in partnership with the Docs with Disabilities Initiative, completed filming for a nine-part webinar series titled *Caring for People with Disabilities* with publication on the AMA Ed Hub™ planned for 2026. Additionally, the AMA hosted the new podcast episode Microplastics Infiltrate Our Bodies: How Can Physicians Help? which explores the impact of microplastics on public health and reducing practice exposure to microplastics.
- Our AMA continued to follow the Enterprise Social Responsibility (ESR) team's community engagement framework to build meaningful relationships with local organizations. In 2025, the ESR team hosted 51 community engagement events across 16 community organizations, including Erie Neighborhood House, Gardeneers, MyBlock MyHood MyCity, Nourishing Hope, Imagine Englewood if, Pilsen Food Pantry and Cardz for Kidz. This year two new community partnerships were established with Growing Home and Project Linus to support their work to address the social determinants of health and move toward community health impact.
- The AMA offered internships and fellowships to various groups. As an example, AMA IT hosted 29 Chicago Public School high school student interns from historically underrepresented backgrounds and provided students with the opportunity to visit the AMA, engage with AMA IT professionals and learn about the AMA's history and its role in promoting national health and well-being. Additionally, the JAMA Network manuscript editing teams offered a summer medical editing internship designed for third- and fourth-year college students to gain exposure to medical editing and publishing as a career. The JAMA Editorial Fellowship Program also welcomed ten early career academic physicians and nurses in the fully remote fellowship program, intended to engage around editorial decision-making and enhance scientific communication skills. Lastly, the AMA continued the Summer Health Law Internship for a rising third-year law student, with a focus on differences in health outcomes and law.
- The AMA's Release the Pressure (RTP) campaign focused on addressing and improving heart health among those with the highest burden of hypertension by encouraging them to prioritize their blood pressure. The AMA Foundation, the Minority Health Institute, the National Medical Association (NMA), the American Heart Association (AHA), and the Association of Black Cardiologists (ABC) were engaged through RTP. RTP had a presence at conferences and conventions, including the NMA Colloquium on African American Health and the Congressional Black Caucus Foundation's 54th Annual Legislative Conference, engaging over 113 physicians.

Updates on the AMA's diversity and inclusion strategy included a number of efforts and initiatives:

- Internally, our AMA supports initiatives to enhance employee experience, engagement and well-being, anchored in four strategic areas: (1) Foundational Infrastructure, (2) Access and Fairness, (3) Skills-Based Learning and (4) Inclusive Culture and Climate. In 2025, the AMA consulted an external vendor to conduct the 2025 Employee Engagement Survey to provide current insights into employee experience, including critical engagement index metrics. Results will guide strategies to improve inclusion outcomes.
- The AMA continues to foster inclusion and belonging across the organization through nine Employee Resource Groups (ERGs) that organize intersectional programming designed to advance inclusive learning, cultivate community, and support personal and professional development of members through the following events: book clubs, volunteering, panels, and professional development workshops. All ERGs are open to all employees.
- Staff continued to surpass their individual, voluntary learning goals, averaging more than 20 hours of flexible learning across related health topics in 2025. Within BUs, staff have led educational activities and events to

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strengthen community engagement and improve community health outcomes. For example, the AMA's Education Center held monthly learning sessions focused on optimal health outcomes and inclusion, offering over 15 hours toward individual learning goals. Additionally, the AMA's Health Solutions unit engaged in bias and engagement training which focused on employee inclusion. As part of this training, all staff completed a self-paced 90-minute course titled Breaking Bias Foundations from Be More with Anu. Furthermore, 19 AMA staff members also completed the three day in-person BRAVE leadership training that centers a trauma-responsive approach for leaders to enhance inclusion and retention of staff.

Health Systems Engagement
The following are some of the relevant accomplishments toward health systems engagement during 2025:

- The AMA and the American Heart Association (AHA) recognized nearly 2,400 organizations that committed to improving blood pressure control rates by submitting data to the 2025 Target: BP Achievement Awards. Over 38 million patients were served by 2,393 total eligible participating health care organizations across 49 U.S. states and territories.
- To advance improvements in maternal health, the AMA developed four new tools and resources to help health care organizations and clinical care teams improve blood pressure monitoring and management during pregnancy and postpartum period, including two AMA MAP HTN™ educational resources for patients and clinical teams.
- To advance the national Million Hearts campaign, the AMA, in partnership with the CDC and Alliance Chicago, engaged five Health Center Controlled Networks and 19 community health centers with an aim to prevent heart attacks and strokes in over 900,000 adult patients, with a focus on minority, rural and medically under-resourced communities.
- Over 100 health care organizations used AMA solutions to help their physicians and care teams improve cardiovascular disease in patients. Through this collaboration, more than 4.1 million patients with hypertension were reached and over 2.3 million patients with hypertension were impacted to achieve improved blood pressure control; 39 percent of which, where data was available, were from historically underserved communities.
- In 2025, the AMA launched the new two-year AMA Transforming Lifelong Learning Through Precision Education portfolio to accelerate seamless lifelong learning and advance educational equity. As part of the portfolio, the AMA will award a total of $12 million in education grant funding to a total of 11 selected grant teams, each receiving $1.1 million over four years. Grantees represent more than 80 institutions, including medical schools, residency programs, health systems, and specialty societies across the country. The selected grant teams will join the ChangeMedEd Consortium, which focuses on advancing precision medical education.
- The AMA published playbooks and other educational resources for physicians, practices and health systems, such as one of the AMA STEPS Forward® toolkits https://edhub.ama-assn.org/steps-forward/module/2830076 focused on quality improvement goals for practices. This STEPS Forward for Smaller Practices toolkit offers guidance on how a practice can better understand its patient population and community by examining population data, as well as intersectionality of identities.
- In 2025, the AMA hosted its sixth episode of the National Health Equity Grand Rounds webinar series, *Creating Conditions Vital to Health: Health Care's Role in Economic Progress,* at Rush Medical Center's Rubschlager Building in Chicago. Health care leaders discussed how health systems can invest in their communities to address vital conditions and improve health outcomes for all. This event engaged 19 health care organizations, and a total of 362 physicians joined the conversation.
- Three new collaborators joined the AMA's Ed Hub™ in 2025, including the Institute for Exceptional Care, Cleveland Clinic Center for Continuing Education and University of Washington. These organizations will be contributing to equity-focused content on the AMA Ed Hub™ site and expand AMA high-impact learning.
- The AMA's 2025 media sponsorships focused on reaching diverse audiences, supporting events with the National Association of Hispanic Journalists and the Asian American Journalists Association.
- In 2025, the AMA concluded the first cohort of the Equitable Professional Societies Learning Network aimed to help 17 state and specialty societies gain the knowledge, skills, resources and tools to operationalize structural changes for optimal health outcomes.

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- The third cohort of the Medical Justice in Advocacy Fellowship, an educational initiative in collaboration with Morehouse School of Medicine's Satcher Health Leadership Institute, culminated at the 2025 Interim meeting of the House of Delegates, where 10 physician leaders were celebrated and presented their optimal health outcomes project concepts. The fourth cohort of the Medical Justice in Advocacy Fellowship will begin in 2026.
- AMA staff continued to be present throughout 2025 at underrepresented physician convenings to grow and foster relationships, as well as learn about health care priorities of these groups. Staff participated in various conferences to support building alliances, learning about the context necessary for restorative practice and incorporating context into the AMA's own work. These conferences included: National Hispanic Medical Association 28th Annual Conference, National Medical Association 123rd Annual Convention and Scientific Assembly and National Colloquium on African American Health, Association of American Indian Physicians 53rd Annual Meeting and Health Conference, National Council of Asian Pacific Islander Physician's He Huliau i ka Pono Conference, GLMA's 43rd Annual Conference on LGBTQ+ Health, among others. Staff gained insights into incorporating inclusive practices into the AMA's work.
- The AMA's Truth, Healing, and Reconciliation Taskforce (TRHT) focused on organizational transformation within and beyond the AMA toward restorative justice to promote truth, reconciliation and healing in medicine and medical education. In 2025, the TRHT taskforce concluded after two years having engaged six professional societies, three health care organizations and two institutions. There was a total of six education sessions focused on restorative justice in medicine with a total of 285 physicians in attendance across all sessions.
- As part of The AMA Foundation's Optimal Health Outcomes Accelerator fund, the AMA completed work toward the Equity and Justice in Medical Education (EJME) collaborative grant focused on promoting equitable practices and diversity in the admissions process by forging more productive relationships between the AMA and underrepresented physician and student organizations. A total of six convenings were held to foster collaboration between participants with the hope of developing common approaches that will leverage collective influence. The participating organizations included: the National Medical Association, National Hispanic Medical Association, Association of American Indian Physicians, National Council of Asian Pacific Islander Physicians, Asian Pacific American Medical Student Association, Latino Medical Student Association, Association of Native American Medical Students and Student National Medical Association.

Policy Development

The following are some of the relevant accomplishments toward policy development during 2025:

- Optimal health outcomes-related policy priorities can be seen throughout the AMA's engagement with Congress, the Administration, state legislatures, and other policymakers, in the form of advocacy letters, presentations and testimony to state legislatures, national and state medical organizations and countless additional opportunities that engaged organized medicine and policymakers. In 2025, the AMA continued to actively voice support for:
    - International medical graduates;
    - Migration and refugee population health and safety;
    - Nutrition programs expansion and culturally respectful dietary guidelines;
    - Medicaid coverage expansion;
    - Medicaid and Children's Health Insurance Program coverage extension;
    - Maternal and child health programs;
    - Protecting reproductive health;
    - Advancing data privacy principles and protecting the abuse/misuse of sensitive health data;
    - Protections for physicians who seek care for wellness and burnout;
    - Student loan accessibility and adequacy;
    - Increased funding for graduate medical education;
    - Telehealth flexibilities in Medicare;
    - Reducing the prior authorization burden on patients; and
    - Addressing quality and administrative barriers in Medicare Advantage and other insurance plans.

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- The AMA continues to amplify voices of historically underrepresented individuals through its litigation efforts. Litigation efforts in 2025 ranged across topics including preventive care costs under the Affordable Care Act (ACA), smoking cessation efforts and regulations, access to health care and protecting the patient-physician relationship, among others. The AMA's work in the courts helped achieve favorable outcomes in several litigation efforts in addition to supporting state medical societies' efforts.
- The AMA's Office of International Relations (OIR) reviewed the World Medical Association's (WMA) policies through an optimal health outcomes lens. The AMA contributed to the revision of the WMA's Statement on Trans People, supported the reaffirmation of the WMA's resolution on human rights violation against Uighur People in China, and contributed to the WMA's Statement on Ageing, advocating for aging physicians' contributions.
- The AMA continued to update internal practices in line with inclusion efforts. For example, the AMA continues to work toward identifying and replacing offensive terminology across the enterprise through institutional level policy. The AMA conducted a comprehensive search for outdated terms within its IT systems and has embarked on instituting these updates to replace harmful language.

Research

The following are some of the relevant accomplishments toward research during 2025:

- The AMA continues to be a partner on the National Quality Forum's Advancing Collection of Standardized Symptoms Data. The initiative aims to engage physicians in data standard development by standardized patient symptom data across care settings to improve diagnosis, measurement and quality of care. The initiative focuses on improving patient-focused outcomes.
- In 2025, the AMA Guides to the Evaluation of Permanent Impairment Sixth Edition updated its pulmonary function chapter in accordance with existing AMA policies on race as a social construct and national standards of care. Specifically, a race-neutral approach to pulmonary function test interpretation algorithms was implemented by reporting and interpreting results using average reference equations rather than using race-based calculations. An additional update was the acknowledgement that pulse oximetry can have measurement errors in people with dark skin pigmentation and a call to mitigate these errors whenever possible.
- AMA staff co-authored more than 30 peer reviewed publications, including papers in Journal of the National Medical Association, JAMA Network Open, New England Journal of Medine and Journal of General Internal Medicine, as well as contributed to the American College of Cardiology and American Heart Association Joint Committee on Clinical Practice Guidelines.
- The AMA Journal of Ethics published optimal health outcomes-related issues such as Surgical Care of Incarcerated Patients (April 2025), Private Equity in Health Care (May 2025), Rural US Emergency Medical Services (July 2025) and Screening Children for Structural Drivers of Health (September 2025).
- The JAMA Network continued curating and sharing digital content relating to health outcomes across its publications, distributed to more than 13,000 subscribers. As an example, the JAMA Network launched the JAMA+ Women's Health, a new digital resource aimed to elevate the visibility and accessibility of trusted, peer-reviewed content that advances health care for women across the globe. Recognizing that women's health is comprehensive, JAMA+ Women's Health showcases rigorous studies that include or focus exclusively on women from across JAMA and the 12 JAMA Network journals. Furthermore, the AMA contributed to the JAMA publication Toward a Safer World by 2040, capturing proceedings from the JAMA Summit on Firearm Violence, charting an innovative roadmap toward reduction in firearm harms by 2040.
- The JAMA Network held its quarterly Equity, Diversity, and Inclusion (EDI) editor meetings to support EDI related concerns and share best practices across the network. Additionally, JAMA Network published a Research Letter titled *Equity, Diversity, and Inclusion Concerns from JAMA Network Peer Reviewers*, which discussed results related to EDI framing, methods, terminology and language concerns gathered across all JAMA Network journals' peer reviewer forms. Results were also presented at the 2025 Peer Review Congress.
- Diverse representation among AMA publications remained a goal in 2025. The AMA updated 30 illustrations for the 2026 CPT Professional book to reflect all populations. Input was gathered from internal and external

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reviewers. This progress is contributing to the AMA's five-year plan to update over 100 CPT Professional book illustrations to depict authentic and diverse individuals.

- The AMA integrated equitable practices across its market and user experience research by aligning research questions with AMA's data privacy practices, ensuring populations of focus were appropriately represented and considering vendors based on their expertise and experience working with participants involved in the research. Additionally, the AMA conducted a market assessment to analyze how other organizations have diversified medical illustrations in their materials.

CONCLUSION

This report highlights only a portion of the work accomplished in 2025. AMA staff continued to make great strides and fulfilled their Business Unit annual goals. Staff devoted countless hours to learning how they can collaborate to improve health outcomes and apply those insights within and beyond the organization.

10. AMA EFFORTS ON MEDICARE PAYMENT REFORM

Informational report; no reference committee hearing.

HOD ACTION: FILED

At the 2023 American Medical Association (AMA) Annual Meeting of the House of Delegates (HOD), the HOD adopted Policy D-385.945, "Advocacy and Action for a Sustainable Medical Care System" and amended Policy D-390.922, "Physician Payment Reform and Equity." Together, they declare Medicare physician payment reform as an urgent advocacy and legislative priority, call on the AMA to implement a comprehensive advocacy campaign, and for the Board of Trustees (the Board) to report back to the HOD at each Annual and Interim meeting highlighting the progress of our AMA in achieving Medicare payment reform until a predictable, sustainable, fair physician payment system is achieved. In addition, the House adopted Policy D-400.981 "Increasing Transparency of AMA Medicare Payment Reform Strategy" at the Annual 2025 House of Delegates Meeting, which calls on the AMA to:

1. 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.

2. 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.

The Board has prepared the following report to provide an update on AMA activities for the year to date. (Note: This report was prepared in March based on approval deadlines and more recent developments may not be reflected herein.)

AMA ACTIVITIES ON MEDICARE PHYSICIAN PAYMENT REFORM

The AMA's Medicare physician payment reform efforts were initiated early in 2022, following the development of a set of principles outlining the "Characteristics of a Rational Medicare Payment System" which were endorsed by 124 state medical associations and national medical specialty societies. These principles identified strategies and goals to: (1) ensure financial stability and predictability for physician practices; (2) promote value-based care; and (3) safeguard access to high quality care.

Subsequently, the AMA worked with Federation organizations to identify four general strategies to reform the Medicare payment system, including:

- Automatic annual payment updates based on the Medicare Economic Index (MEI);
- Updated policies governing when and how budget neutrality adjustments are made;
- Simplified and clinically relevant policies under the Merit-based Incentive Payment System; and
- Greater opportunities for physician practices that want to transition to advanced alternative payment models (APMs).

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At the heart of the AMA's unwavering commitment to reforming the Medicare physician payment system lie four central pillars that highlight our strategic approach: legislative advocacy; regulatory advocacy; Federation engagement; and grassroots, media, and outreach initiatives. Grounded in principles endorsed by a unified medical community, our legislative efforts drive the advancement of policies that foster payment stability and promote value-based care. We actively champion reform through regulatory channels, tirelessly engaging with crucial agencies such as the Centers for Medicare & Medicaid Services (CMS) and the White House to address impending challenges and ensure fair payment policies. Our Federation engagement fosters unity and consensus within the broader medical community, pooling resources and strategies to amplify our collective voice. Lastly, our continued grassroots, media, and outreach efforts bridge the gap between policymakers and the public, ensuring our mission is well-understood and supported from all quarters. Together, these pillars fortify our endeavors to achieve a more rational Medicare physician payment system that truly benefits all.

Legislative Advocacy

Physicians continue to face significant financial instability under the current Medicare physician payment system. The calendar year (CY) 2025 Medicare Physician Fee Schedule finalized a 2.83 percent reduction in physician payment rates, continuing a pattern of recurring cuts that has persisted for several years.

In response to sustained advocacy from the AMA, Federation partners, and the broader physician community, Congress included a provision in the One Big Beautiful Bill Act (OB3) providing a 2.5 percent Medicare physician update for 2026 to partially mitigate these reductions.

While this action provided temporary relief, it addressed only a portion of the cut and did not resolve the structural flaws that continue to destabilize Medicare physician payment.

Beginning in 2026, statutory updates of 0.25 percent for most physicians and 0.75 percent for qualifying participants in advanced alternative payment models take effect under MACRA, but these updates are not tied to inflation and fall far short of projected increases in practice costs.

CMS estimates that the MEI, which measures changes in physician practice costs, will increase by 2.7 percent in 2026, further widening the gap between payment and the cost of delivering care.

As a result, Medicare physician payments have effectively declined by approximately 33 percent since 2001 when adjusted for inflation in practice costs.

During this period, physician practices have experienced significant increases in expenses related to staffing, technology, regulatory compliance, and facility costs. This growing imbalance is placing increasing pressure on physician practices across the country. Small, rural, and independent practices are particularly vulnerable to continued payment instability.

When practices are forced to close, consolidate, or limit the number of Medicare patients they can treat, access to care is threatened for millions of seniors and patients with disabilities.
Expanding the physician workforce alone will not solve these access challenges if newly trained physicians enter a Medicare system that remains financially unsustainable.

Fixing the broken Medicare physician payment system therefore remains one of the AMA's highest legislative priorities. The AMA continues to work closely with congressional leaders and Federation partners to move beyond the annual cycle of payment cuts and temporary patches and instead enact durable structural reforms that stabilize physician payment and support patient access to care.

As a result of sustained advocacy by the AMA and the physician community, bipartisan legislation has been introduced that reflects elements of the AMA-developed framework—Characteristics of a Rational Medicare Physician Payment System. The AMA continues to urge Congress to advance several key reforms designed to modernize the Medicare physician payment system and restore long-term stability.

The current Medicare physician payment system is characterized by stagnant base payments, the absence of permanent annual inflationary updates, and excessive administrative burdens. Unlike hospitals and other Medicare providers,

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physicians do not receive automatic inflationary adjustments tied to rising practice costs. This pattern of recurring reductions and structural instability is undermining the financial viability of physician practices nationwide.

To address these challenges, the AMA continues to advocate for several core legislative reforms designed to stabilize and modernize Medicare physician payment.

Medicare Reform: Automatic Annual Inflation-Based Updates

First, the AMA continues to advocate for the establishment of a permanent annual inflationary update for physician services tied to the MEI to ensure that Medicare physician payments more accurately reflect the real costs of delivering care. Unlike hospitals and other Medicare providers, physicians do not receive automatic inflationary adjustments, leaving practices increasingly vulnerable as staffing, technology, compliance, and other operational expenses continue to rise. In the previous Congress, H.R. 2474, the Strengthening Medicare for Patients and Providers Act, would have provided a permanent MEI-based update and garnered more than 170 bipartisan cosponsors. The AMA continues to support similar legislation, including H.R. 6160 introduced in the 119th Congress, which would establish a permanent MEI-based update and help restore stability and predictability to Medicare physician payment.

Medicare Payment Reform: Budget Neutrality

Second, the AMA continues to advocate for modernization of Medicare's budget neutrality requirements to prevent destabilizing payment reductions that occur when services are revalued or new services are added to the physician fee schedule. Current statutory thresholds and inaccurate utilization projections frequently trigger across-the-board reductions in physician payments, contributing to instability in the Medicare physician payment system. The AMA supports legislative efforts to raise the budget neutrality threshold and improve the accuracy and transparency of utilization estimates for newly unbundled services assigned projected utilization. Legislation introduced in the previous Congress, H.R. 6371, the Provider Reimbursement Stability Act, provides a framework for updating these outdated statutory requirements. The AMA continues to work with congressional leaders to advance legislation that would modernize budget neutrality policies and promote greater predictability in Medicare physician payment.

Medicare Payment Reform: Revising the MIPS Program

Third, the AMA continues to advocate for meaningful reforms to the Merit-based Incentive Payment System (MIPS) to reduce administrative burden and better align performance measurements with meaningful improvements in patient outcomes. While MIPS was intended to promote value and quality within the Medicare program, its current structure imposes significant reporting requirements that disproportionately affect small, rural, and independent physician practices, often without demonstrable improvements in quality of care. The AMA is working with Federation organizations on the introduction and advancement of legislative and regulatory reforms that streamline reporting requirements, improve measure relevance, and reduce unnecessary administrative complexity so that physicians can devote more time and resources to patient care rather than compliance activities.

119th Congress AMA Advocacy Highlights

In early 2025, Representatives Greg Murphy, MD, (R-NC) and Jimmy Panetta (D-CA) introduced H.R. 879, the Medicare Patient Access and Practice Stabilization Act, bipartisan legislation designed to address the 2.83 percent Medicare physician payment cut that took effect on January 1, 2025, and to provide a positive payment update to help stabilize physician practices. The legislation reflected growing bipartisan concern about the financial pressures facing physician practices and the potential impact of continued payment instability on patient access to care.

The AMA worked closely with the bill sponsors and congressional physician leaders to support the legislation and ensure it reflected the real-world costs of delivering care and the operational challenges facing physician practices. The bill quickly became a focal point for physician advocacy, drawing broad support across the physician community. More than 120 bipartisan House members cosponsored the legislation, and over 80 physician organizations, including all 50 state medical associations, joined a coalition letter urging Congress to act.

Although H.R. 879 was not ultimately enacted as a standalone measure, the legislation played an important role in elevating Medicare physician payment reform as a priority issue for Congress. The bill helped frame the policy debate around the need for immediate relief from payment cuts while reinforcing the broader call for structural reforms to stabilize the Medicare physician payment system and protect patient access to care.

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Alternative Payment Model (APM) Progress and H.R. 7148

H.R. 7148, the Consolidated Appropriations Act, 2026, included several important AMA-supported provisions restoring incentives for participation in advanced Alternative Payment Models (APMs). Specifically, the legislation reinstated APM incentive payments at 3.1 percent for the 2026 performance year (2028 payment year) and reduced the Qualifying Participant (QP) revenue threshold from 75 percent back to 50 percent for the same performance year. These changes help restore meaningful incentives for physician participation in value-based care and reduce barriers that had limited participation following the expiration of the original APM bonus and the automatic increase in the QP threshold in 2025.

The law also includes several Medicare extenders that expire at the end of 2026. As a result, Congress will again need to address key Medicare payment policies, creating an opportunity for the AMA to continue advancing broader Medicare physician payment reforms, including efforts to secure a physician payment update for 2027.

National Advocacy Conference – February 2026

At the February 2026 National Advocacy Conference (NAC), the following lawmakers expressed the need for Medicare physician payment reform: Senator Peter Welch (D-VT) and Representatives Greg Murphy (R-NC), Kim Schrier (D-WA), Mariannette Miller-Meeks (R-IA), John Joyce (R-PA), Jill Tokuda (D-HI), and Steven Horsford (D-NV). More than 500 physician advocates attended NAC and participated in Capitol Hill meetings and distributed advocacy kits urging lawmakers to support legislation that:

- Provides annual inflationary updates tied to practice costs
- Reforms budget neutrality
- Improves MIPS
- Expands APM options

These reforms were framed as essential to preserving patient access to care by stabilizing physician practices and thereby ensuring America's seniors have timely access to high-quality care.

Grassroots, Media, and Outreach

The AMA has maintained a continuous drumbeat of grassroots contacts through its Physicians Grassroots Network, Patients Advocacy Network, and its Very Influential Physicians program.
Op-eds have been placed in various publications from AMA leaders, as well as from "grasstops" contacts in local newspapers. Digital advertisements are running targeted specifically to publications read on Capitol Hill, and media releases have been issued to highlight significant developments.

The AMA has a dedicated Medicare payment reform web site, www.FixMedicareNow.org, which includes a range of AMA-developed advocacy resource material, updated payment graphics, and a new "Medicare basics" series of papers describing in plain language specific challenges
presented by current Medicare payment policies and recommendations for reform.

To support the Medicare legislation cited above, the AMA has been engaged in a major grassroots campaign to engage patients and physicians in our lobbying efforts. The following statistics from January through the end of December 2025 result from the Fix Medicare Now campaign and engagement with the Physician Grassroots Network and Patients Action Network.

- 103+ million in earned media and ad impressions
- 3.9+ million media and ad engagements
- 944,000+ pageviews
- 910,000+ site users
- 100,000+ contacts to Congress
- 260+ third-party media placements and grass top contacts made in key Congressional districts

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Senate Legislation and H.R. 1

In April 2025, Senator Roger Marshall (R-KS) introduced the Senate companion bill, S. 1640. AMA advocacy staff were highly involved in drafting this legislation, ensuring it was responsive to the real-time 2025 Medicare cuts.

Separately, H.R. 1, the One Big Beautiful Bill (OBBB) initially included strong Medicare physician payment reform provisions, including a 75 percent MEI update for 2026 and a permanent annual update of 10 percent of MEI thereafter. These provisions marked the first time since MACRA in 2015 that physician payment updates would be permanently built into baseline Medicare rates.

The AMA advocacy team was instrumental in the development and inclusion of these House-passed Medicare provisions. Section 44304, which linked the update to inflation in practice costs using the MEI, reflected AMA policy and decades of advocacy, and was recently echoed in recommendations by the Medicare Payment Advisory Commission (MedPAC).

These provisions passed the House of Representatives. However, the Senate scaled the proposal back to a temporary 2.5 percent update for 2026.

The final version of H.R. 1, passed by the Senate, retained only the temporary one-year 2.5 percent conversion factor update—with no permanent, inflation-adjusted fix. Still, the inclusion of any update represented forward movement and provides important momentum for continued advocacy in the 119th Congress.

Federation Engagement

The AMA continues to work closely with state medical associations and national medical specialty societies to build alignment around shared principles for Medicare physician payment reform. Through ongoing coordination with Federation partners, the AMA has strengthened advocacy efforts, reinforced consistent policy messaging, and demonstrated broad physician support for legislative solutions that stabilize Medicare physician payment and protect patient access to care.

At the same time, the AMA continues to advance several legislative initiatives aimed at addressing structural challenges within the Medicare physician payment system. AMA advocacy staff are working closely with House Ways and Means Committee Chairman Jason Smith (R-MO) and Representative Greg Murphy, MD, (R-NC) on the reintroduction of updated legislation to reform Medicare's budget neutrality policies. As part of this effort, bipartisan staff from the relevant House and Senate committees of jurisdiction recently participated in a technical assistance briefing with CMS, confirming that the proposed reforms could be implemented operationally. The AMA is also working to secure bipartisan support for the legislation, including Democratic cosponsors from the Ways and Means and Energy and Commerce Committees.

In parallel, the AMA is advancing legislation to reform MIPS. This proposal was developed through a physician-led Medicare MIPS working group convened by the AMA and reflects extensive collaboration among physician organizations to identify practical reforms that reduce administrative burden, improve fairness, and preserve incentives for high-quality care. The AMA is currently working with congressional offices and physician organizations to finalize the legislation and build support for its introduction.

Advocacy with MedPAC and Looking Forward

The AMA continues to engage with MedPAC as it evaluates the adequacy of Medicare physician payment and develops recommendations to Congress. During its December 2025 meeting, MedPAC discussed a potential recommendation to update Medicare physician payment rates in 2027 by current law plus 0.5 percent, which would result in an update of approximately 1.25 percent for clinicians participating in advanced alternative payment models and 0.75 percent for other physicians. However, the cost of providing care is expected to increase by approximately 2.1 percent, meaning that such a recommendation would allow the gap between physician payment and practice cost inflation to continue widening.

In recent comments submitted following the meeting, the AMA urged MedPAC to recommend that Congress update physician payment in 2027 by the full increase in the MEI. The AMA emphasized that aligning physician payment

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updates with practice cost inflation is necessary to improve payment stability, preserve private physician practices, and maintain patient access to care.

The AMA also highlighted MedPAC data showing emerging access challenges for Medicare beneficiaries. In 2025, 29 percent of beneficiaries reported waiting six or more weeks to see a new primary care physician and 31 percent reported similar waits to see a new specialist. At the same time, growth in spending under the Medicare Physician Fee Schedule has remained modest compared to other components of Medicare Part B, with physician fee schedule spending per beneficiary increasing far more slowly than overall Part B spending in recent years.
The AMA will continue working with MedPAC to ensure that its recommendations to Congress reflect the growing gap between physician payment and practice cost inflation and the potential implications for patient access to care.

Call to Action

Congress must urgently address a broken Medicare payment system that places enormous financial pressure on physicians and threatens access to care. The AMA continues to urge lawmakers to:

- Enact a positive update to keep up with inflation; and
- Implement a long-term fix that ensures payment adequacy and stability, including reforms to budget neutrality and MIPS and expanded APM options.

Physician practices have lost 33 percent to inflation since 2001. Physician ownership of practices has also collapsed, dropping from 61 percent in 2001 to under 50 percent in 2016. This erosion threatens the viability of community-based care.

Fixing this system will remove a major financial stressor for physicians, protect patient access, and stabilize our health care infrastructure. The House-passed provisions of H.R. 1 provide a critical foundation for comprehensive reform. Ensuring regular, adequate payment updates is vital to practice sustainability, advancing value-based care models, and safeguarding access to care for Medicare beneficiaries—especially in rural and underserved communities, where practices treat four times as many Medicare patients as those in metropolitan areas.

As physicians across the country continue to share their stories and advocate for reform, there is hope that our united efforts will eventually break through the political and financial barriers that have hindered progress. The AMA will continue to fight tirelessly until a sustainable, fair, and effective Medicare physician payment system is achieved.

STRATEGIC REVIEW OF MEDICARE PAYMENT REFORM ADVOCACY

In response to Policy D-400.981, the AMA is conducting a comprehensive review of its Medicare payment reform advocacy strategy. This effort includes evaluating opportunities to engage external advocacy consultants and refining internal processes to identify barriers, assess strategic gaps, and develop targeted recommendations to strengthen ongoing reform efforts. While this work is ongoing at the time this report was prepared, the AMA remains committed to advancing this review and will provide an update at the 2026 Interim Meeting.

CONCLUSION

The AMA will continue to press Congress to address the structural flaws in the Medicare physician payment system and enact reforms that ensure stability for physician practices and protect patient access to care. While progress has been made through sustained advocacy and engagement with policymakers, meaningful reform will require continued legislative action.

The AMA will remain actively engaged with Congress, the Administration, and Federation partners to advance policies that stabilize Medicare physician payment, reduce administrative burden, and support physician participation in innovative care delivery models. Continued engagement from physicians across the Federation will remain essential as these efforts move forward.

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11. AMA PUBLIC HEALTH STRATEGY UPDATE

Informational report; no reference committee hearing.

HOD ACTION: FILED

Policy D-440.922, "Full Commitment by our AMA to the Betterment and Strengthening of Public Health Systems" adopted by House of Delegates (HOD) at I-21 directed our American Medical Association (AMA) to:

> develop an organization-wide strategy on public health including ways in which the AMA can strengthen the health and public health system infrastructure and report back regularly on progress.

Policy D-145.992, "Further Action to Respond to the Gun Violence Public Health Crisis" has also called for the AMA to report annually to the House of Delegates on our AMA's efforts relating to legislation, regulation, and litigation at the federal, state, and local levels to prevent gun violence.

This informational report is an effort to provide regular updates on the status of the AMA's mission critical public health work to the HOD.

DISCUSSION

What is Public Health?

Since its founding in 1847, the AMA's mission has been "to promote the art and science of medicine and the betterment of public health." According to the Centers for Disease Control and Prevention (CDC), public health is "the science and art of preventing disease, prolonging life, and promoting health through the organized efforts and informed choices of society, organizations, public and private communities, and individuals."[1] Public health promotes and protects the health of people and the communities where they live, learn, work and play.[2] Public health practice is a different field than clinical medicine with different motivating values, responsibilities, and goals.[3] While a doctor treats people who are sick, those working in public health try to prevent people from getting sick or injured in the first place. A public health professional's duty is to the community rather than an individual patient.

Connection with Health Equity

It is important to acknowledge that health equity is a central concept in public health and is essential to improving the health of populations. The AMA's health equity strategy recognizes that structural and social drivers of health inequities shape a person's and community's capacity to make healthy choices, noting that downstream opportunities provided by the health care system and individual-level factors are estimated to only contribute 20 percent to an individual's overall health and well-being, while upstream opportunities of public health and its structural and social drivers account for 80 percent of impact on health outcomes.[4] Progress towards the AMA's health equity strategy is reported in the Board of Trustees (BOT) annual health equity report. (See BOT Report 9-A-26, "American Medical Association Health Equity Annual Report.")

AMA PUBLIC HEALTH AND PREVENTION ACTIVITIES

1. Promote evidence-based clinical and community preventive services.

A. Serve as a liaison to the U.S. Preventive Services Task Force (USPSTF), the Advisory Committee on Immunization Practices (ACIP), and the Community Preventive Services Task Force (CPSTF) and support the dissemination of recommendations to physicians.

Last year saw major disruptions to federal advisory committees whose goal is to develop recommendations for clinical and community preventive services, this included the longest government shutdown in history in the fall of 2025. CPSTF did not convene at their normally scheduled times to discuss evidence-based recommendations in 2025. CPSTF met for the first time in February 2026 after nearly a year and a half of not convening.

In early 2025, the structure of the USPSTF was being challenged in the courts. On June 27, 2025, the U.S. Supreme Court ruled in *Kennedy v. Braidwood Management, Inc.* that the structure of the USPSTF was constitutional. The

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Court upheld the Affordable Care Act's (ACA) requirement that private insurers cover USPSTF "A" and "B" rated preventive services without cost-sharing. The Supreme Court also confirmed the HHS Secretary's authority to remove and appoint members of the task force.

The USPSTF did not convene at their normally scheduled times in July and November of 2025. The USPSTF was expected to meet early March of 2026, but that meeting was postponed. Task Force recommendations are not being published on a regular basis and there are concerns about staffing support for the task force within the Agency for Healthcare Research and Quality given reductions in force at the agency.

- On July 27, 2025, the AMA sent a letter to the Secretary of the Department of Health and Human Services (HHS), expressing deep concern with the reports of his intention to remove all of the members of the USPSTF and commit to the long-standing process of regular meetings to ensure their important work can continue without interruption.

The ACIP has continued to meet, but the removal and replacement of all ACIP members, as well as changes to the vaccine recommendations have been extremely concerning. The following list represents the AMA's response to the changes to ACIP:

- On June 9, 2025, the AMA issued a statement on the removal of the 17 sitting members of ACIP and noting that it undermines trust in a process that has saved countless lives.
- On June 12, 2025, the AMA issued a statement on new members of the ACIP selected without transparency and proper vetting.
- On June 13, 2025, the AMA sent a letter to Senate leadership regarding the actions by HHS to terminate the appointments of the 17 voting members of the ACIP and urged an inquiry into the circumstances surrounding the decision to remove and replace all sitting members.
- On June 18, 2025, the AMA sent a letter to HHS expressing significant concern regarding the recent action to terminate the entirety of the membership of the ACIP.
- On August 1, 2025, ACIP medical society liaison organizations issued a joint statement regarding their removal from ACIP vaccine workgroups.
- On September 19, 2025, the AMA issued a statement on ACIP's new MMRV vaccine recommendations.
- Oct. 15, 2025, the AMA joined an amicus brief in the case of *AAP vs. Kennedy* calling for government recommendations regarding the COVID-19 vaccine to reflect the full body of medical evidence and to follow the statutorily process for the provision of vaccine guidance.
- On December 5, 2025, the AMA issued a statement on ACIP vote to weaken the birth-dose recommendation for the hepatitis B vaccine.
- On December 15, 2025, the AMA issued a statement on the CDC hepatitis B birth dose decision.
- On January 5, 2026: the AMA issued a statement on changes to the childhood vaccine schedule.
- On January 23, 2026, the AMA issued a statement on the ACIP chair's comments on polio, routine vaccinations.

The AMA House of Delegates voted in November of 2025 to amend AMA policies to support ACIP recommendations as of May 1, 2025, as well as subsequent recommendations by national medical specialty societies. AMA statements in support of evidence-based vaccine recommendations were as follows:

- On June 25, 2025, the AMA and 79 medical societies issued a joint statement backing vaccination against respiratory viruses.
- On October 30, 2025, the AMA issued a statement urging vaccination in advance of respiratory virus season.
- On January 26, 2026, the AMA formally endorsed the 2026 AAP childhood and adolescent immunization scheduled, which recommends routine, comprehensive immunization from birth through 18 years.
- On February 3, 2026, the AMA urged the public to get vaccinated against measles as cases rise and the U.S. at real risk of losing its measles elimination status.
- On February 10, 2026, the AMA and the Vaccine Integrity Project announced the launch of a structured, evidence-based review process to assess vaccine safety and effectiveness for the 2026-2027 respiratory season. The review will focus on immunizations for influenza, COVID-19, and respiratory syncytial virus (RSV) and will help inform the recommendations developed by national medical specialty societies.

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B. Help prevent cardiovascular disease (CVD) by addressing major risk factors (work led by the Center for Optimal Health Outcomes team)

The AMA is committed to improving the health of the nation and reducing the burden of chronic diseases. Our primary focus is preventing cardiovascular disease (CVD), the leading cause of death in the U.S., accounting for one in four deaths among adults.[5] Two major risk factors for CVD are hypertension and type 2 diabetes.

- To prevent CVD and address related health inequities, the AMA is developing and disseminating CVD prevention solutions in collaboration with health care and public health leaders. These solutions educate clinical care teams and patients, guide health care organizations (HCOs) in clinical quality improvement and promote policy changes to remove barriers to care. The AMA disseminates these solutions through strategic alliances with various organizations including the CDC, the American Heart Association (AHA), and West Side United in Chicago.
- The AMA MAP ™ Hypertension clinical quality improvement program was designed to improve hypertension management and control. The free program has demonstrated effectiveness in a variety of health care settings from large health care organizations (HCO) to community health centers. Participating HCOs are provided with clinical based practice facilitation and a personalized dashboard with performance metrics.[6] The AMA MAP ™ set of solutions is expanding to include management for other cardiovascular disease risk factors, including cholesterol, prediabetes, and post-partum hypertension.
- AMA MAP™ houses a suite of tools and resources designed to help organizations build and integrate diabetes prevention strategies into their organizations. AMA has worked with more than 80 health care organizations across the country to increase identification and management of patients with prediabetes.
- The AMA was awarded a multi-year CDC grant to implement three projects aimed at improving the quality of cardiovascular disease-related preventive care in Community Health Centers/Federally Qualified Health Centers. The funding will allow AMA to scale its existing quality improvement program. The goal is to help 500,000 patients achieve blood pressure control.
- Additionally, the AMA, in collaboration with the AHA, developed Target: BP™, which recognizes organizations that have achieved milestones in their commitments to improving blood pressure control.
- The AMA established the U.S. Blood Pressure Validated Device Listing (VDL)—a trusted resource for clinicians, care teams, and patients alike. The VDL features blood pressure devices independently validated for clinic accuracy.

C. Counseling Patients on Nutrition to Promote a Healthy Diet

The AMA strongly supports the role of physicians in counseling patients on healthy diets and nutrition. The AMA has made it a priority to help physicians translate nutrition science into practical advice for patients, recognizing that dietary choices are key drivers of chronic diseases such as heart disease, diabetes, and obesity.

- On May 30, 2025, the AMA sent a letter to the Food and Drug Administration (FDA) on the proposed rule entitled "Food Labeling: Front-of-Package Nutrition Information." The letter noted support for requiring most foods to display a nutrition facts information box on the principal display panel regarding the relative levels of saturated fat, sodium, and added sugars in a serving of food.
- On August 15, 2025, the AMA commented on the Alcohol and Tobacco Tax and Trade Bureau's (ATTB) proposed rule entitled "Alcohol Facts Statements in the Labeling of Wines, Distilled Spirits, and Malt Beverages." The letter indicated the AMA's strong support for the creation of an alcohol facts statement, which will lead to greater consumer understanding about the associated dietary and health impacts of consuming alcoholic products.
- On September 29, 2025, the AMA responded to a Request for Information (RFI) from the FDA and the U.S. Department of Agriculture (USDA) titled "Ultra-Processed Foods; Request for Information." The letter shared concern about the risks posed by ultra-processed foods (UPFs) and agreed that a uniform definition of UPFs could benefit research, policymaking, and members of the public seeking to make informed and healthy nutrition choices.
- On January 7, 2026, the AMA released a press statement applauding the Administration's new Dietary Guidelines for spotlighting the highly processed foods, sugar-sweetened beverages, and excess sodium that fuel heart disease, diabetes, obesity, and other chronic illnesses.

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- On March 5, 2026, the AMA joined the Department of Health and Human Services (HHS) and the U.S. Department of Education at a convening of leaders from 53 of the nation's top medical schools across 31 states to announce commitments to meaningful nutrition training beginning in the next academic year.
- On March 24, 2026, the AMA announced the launch of a nutrition education initiative to equip physicians and medical students with practical, evidence-based knowledge and tools to help patients live healthier lives. The program will feature webinars, roundtables, and additional resources on the AMA Ed Hub™. This work is part of an ongoing effort by the AMA to advance nutrition education across the medical education continuum and elevate nutrition as a core component of patient care.

D. Screening and Reducing Risk for Dementia *(CDC funded)*

To advance the "Navigating Brain Health and Dementia Project," the AMA has completed and continues to advance the following activities and deliverables:

- The AMA completed a needs assessment to better understand the current knowledge, daily practices, challenges, and training needs of physicians and other health care professionals in the prevention, screening, diagnosis, and treatment of Alzheimer's disease and related dementias (ADRD). The findings from the needs assessment are being used to inform the development of educational materials and were submitted as an abstract to the 2026 Alzheimer's Association International Conference. A peer-reviewed publication is also being drafted.
- The AMA convened a work group of clinicians and researchers with subject matter expertise in ADRD research, clinical care, and education to provide feedback and guidance on the development of educational materials. The workgroup has participated in monthly meetings, provided feedback on the design and interpretation of a needs assessment, contributed topic and content ideas for upcoming CME modules and short videos, and will serve as subject matter experts on three upcoming webinars.
- The AMA will host three webinars on ADRD in March, April, and May of 2026. The webinar topics focus on (1) Detection and Diagnosis of Dementia in Primary Care, (2) Lifestyle Approaches to Promote Brain Health: Maintaining Cognitive Health Over the Life Course, and (3) Building a Stronger Brain Health Care Team.
- There are also two continuing medical education (CME) modules in development. The first is comprised of three mini modules focused on (1) Recognizing Cognitive Concerns in Primary Care Settings, (2) Choosing and Applying Diagnostic Aids for Cognitive Impairment and Dementia, and (3) Communicating Results of Cognitive Assessments and Next Steps. A second module will focus on post-diagnosis care.

E. Improving the implementation of routine screening for HIV, STI, Viral Hepatitis and latent tuberculosis (LTBI). *(CDC funded)*

The AMA continues to work on the "Promoting HIV, Viral Hepatitis, STDs and LTBI Screening in Hospitals, Health Systems and Other Healthcare Settings" project. The scope of this project has included developing, piloting and launching a toolkit that outlines ways to increase routine screening for HIV, STIs, viral hepatitis and LTBI. The toolkit contains two different sets of strategies – one targeted to community health centers (CHCs) and a second to emergency departments (EDs). In the past year the AMA has been working to scale the adoption and implementation of the quality improvement strategies in the toolkit across CHCs and EDs.

- The toolkit was launched to the public in March 0f 2024.[7] Since its launch, the toolkit has had over 27,000 page views, over 18,000 views of the launch series webinars and over 1,400 downloads of the PDF toolkit.
- In 2025, 15 CHCs and EDs from across the country were selected to participate in a 6-month Community of Practice (CoP). The AMA hosted five 30-minute tele-mentoring sessions to advance quality improvement strategies within the toolkit. The AMA also hosted six 60-minute office hour sessions where CoP members could discuss their challenges in implementing routine screening.
- The AMA also identified three national organizations to promote the routine screening toolkit to their members during 2025 (Alliance Chicago, Society of Academic Emergency Medicine, and the National Coalition of STD Directors).
- In 2026, the AMA is expanding to host a CoP that is open to any CHC or ED that wants to start or expand routine screening for these infectious diseases. A work group of four experts is meeting monthly to shape the hour-long office hours. Once again, the office hours will serve as a safe place for clinicians to share their challenges and get assistance with everything from patient education to care team workflow to EMR optimization.

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- The toolkit will be expanded in 2026 with webinars focusing on improving routine screening in specific populations with a focus on patients with substance use disorders, patients who are pregnant, and rural populations.
- In addition to the work on the routine screening toolkit, the AMA has also received funding from the CDC to explore barriers in accessing preventive medications including pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP) for HIV and doxycycline post-exposure prophylaxis (doxy PEP) for STIs to inform the development of tools and resources to help overcome these barriers.
- The AMA worked with a vendor to conduct two discussion groups looking at barriers to PrEP and doxy PEP prescribing. Five SMEs and three non-SMEs gave their thoughts on current challenges and potential solutions. The AMA will develop a work group to use these findings to develop targeted education and resources to improve access to these interventions.

F. Promote evidence-based preventive services to the public.

While the AMA's primary audience has historically been physicians, there are limited instances where the AMA has partnered on public information campaigns on select priority issues. This work has been made possible through partnerships with other health-related organizations and the Ad Council. The AMA will explore opportunities for future campaigns on an ongoing basis.

Get My Flu Shot. The Ad Council and the AMA have partnered since the 2020-2021 flu season through an annual campaign to motivate more people to get vaccinated against seasonal influenza (flu) to protect themselves and their loved ones. During a severe season, flu has resulted in as many as 41 million illnesses and 710,000 hospitalizations among the U.S. population. This year's campaign features a public service announcement (PSA) titled "No Time for Flu" that illustrates how getting sick with flu does not just mean feeling ill—it could significantly disrupt the lives of individuals and their families. The Get My Flu Shot campaign PSAs were launched nationwide to reach people with the message that a flu shot can help you stay healthy, reduce risk of severe outcomes, such as hospitalization and death, and avoid missing work, school, or special moments with family and friends. PSAs are available to run in English and Spanish across all platforms, in donated time and space throughout flu season. The campaign ads direct audiences to GetMyFluShot.org for more information, including where to get a flu vaccine in their area. Some highlights from the 2025-26 flu campaign are as follows:

- The donated media value for the current flu season reached $1.49 million. The most support has come from TV ($1,024,041), closely followed by digital ($468,499).
- A media tour was held on December 9, 2025, featuring three spokespeople from the AMA included 30 interviews in English and Spanish. Over 100 placements were secured across TV, radio, and digital, with a reach of 45.1 million digital impressions and 1.1 million broadcast impressions.
- Across both Black and Hispanic audiences, respondents aware of the PSAs are significantly more likely to report receiving a flu vaccine (65 percent), compared to not-aware respondents (48 percent), based off our most recent December 2025 tracking survey.

2. Responding to public health crises impacting physicians, patients, and the public.

The AMA's public health work has also been focused on preparing for and responding to public health crises. These crises are often associated with significant health risk for patients, raising concerns among physicians. However, these crises are unlikely to be solved in a clinical setting alone. The AMA's response to public health crises is typically focused on (1) ensuring physicians and trainees have the data and resources needed; (2) identifying evidence-based policies and interventions; (3) elevating the voices of physician leaders through AMA channels and platforms; and (4) convening and collaborating with stakeholders to advance priority policies and interventions.

A. Address the public health crisis of climate change.

At the 2022 Annual Meeting of the House of Delegates, policy was adopted declaring "climate change a public health crisis that threatens the health and well-being of all individuals." Since the A-25 meeting, AMA has accomplished the following activities and continues to follow the strategy to address climate change and health adopted at the I-24 HOD meeting:[9]

- The AMA continues to make climate change and sustainability education available via the Ed Hub™ from a variety of sources including the UC Center for Climate, Health, and Equity, Stanford Medicine, AMA Journal

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of Ethics, the Journal of the American Medical Association (JAMA), and the American Public Health Association (APHA).

- In 2025, the AMA organized a three-part webinar series on climate and health, which is available on AMA's Ed Hub. The three webinars covered the hidden health impacts of climate change, planning for climate resilience in the health care sector, and decarbonizing health care.
- The AMA is in the process of developing a CME module for physicians and trainees on climate change and health. The focus of the module is to bring awareness to physicians about the impact of climate change on the nation's health and to empower physicians to begin conversations with their patients about how climate change is affecting their health and what they can do about it.
- In December 2024, AMA developed and distributed a survey to physicians to assess perceptions on climate change and health, including the level of importance and relevance of climate change to physicians, understanding day-to-day effects of climate change that physicians may be experiencing or anticipating experiencing in the future, and exploring what the AMA's role should be in supporting physicians on climate change. Findings from this survey were presented at the APHA 2025 Annual Conference (November 2025) and an abstract on the survey findings has also been accepted at National Association of City and County Officials annual conference (April 2026). A publication intended for a peer-review journal is drafted with intended publication in 2026.
- AMA staff moderated a panel discussion entitled "Clinician and Health System Responses to Extreme Weather," at the inaugural Illinois Extreme Weather and Health summit, held on November 12-13, 2025, in Chicago, IL.
- The AMA continues to engage in the Medical Society Consortium on Climate and Health (MSCCH), which brings together associations representing over 600,000 clinical practitioners.[12] The AMA sits on the executive committee of this group and through the MSCCH the AMA represents the U.S. to the Global Climate and Health Alliance. Additionally, the AMA was a sponsor of the MSCCH Annual Convention, held in March 2026 in Arlington, VA.
- The AMA is a member and sponsor of the National Academy of Medicine (NAM) Action Collaborative on Achieving a Climate Resilient and Sustainable Health Sector (Climate Collaborative) and is represented on the Steering Committee and served as a co-lead of the Health Care Delivery Workgroup (Phase 1 and 2). The Health Care Delivery Workgroup focused on three deliverables in Phase 2, which included:
    - Hosting the "Building Momentum to Act on Health Care Decarbonization" Webinar Series**.** All recordings, slides, and resources have been published. We also developed a 1-page overview summarizing key findings and takeaways from the series.
    - Developing a list of Key Actions for Health Professionals to Advance Sustainable Health Care (Health Professionals Shortlist), which has been published.
    - Developing a Climate Journey Map: Clinical Pathway, which was published. We are continuing to review new resource submission monthly with Journey Map updates published on a quarterly basis.
    - The Committee's Phase 3 work will focus on redefining quality through climate action and building the evidence.
- Additionally, the AMA participates in the American Lung Association's Healthy Air Partners campaign, which is a coalition of 40 national public health, medical, nursing and health care organizations engaged in healthy air advocacy efforts.[13] The Coalition is united in its calling for strong federal laws and policies to slash air pollution and address climate change, recognizing climate change can affect air quality, and certain air pollutants can affect climate change. The AMA also became a member of the newly formed Alliance for Heat Resilience and Health, which includes over a dozen national organizations working in collaboration to advance protective standards, proactive emergency plans, and local and state-based engagement around extreme heat.
- In terms of advocacy efforts, the AMA joined with partners or submitted comments separately on the following:
    - On February 4, 2026, the AMA joined 19 medical and health organizations in a letter opposing the National Highway Traffic Safety Administration's proposed weakening of fuel efficiency standards for vehicles and light trucks.
    - On September 22, 2025, the AMA joined 120+ medical and health organizations in a letter opposing the EPA's proposed repeal of the 2009 Greenhouse Gas Endangerment Finding and Greenhouse Gas Vehicle Standards.
        - The AMA provided testimony to the EPA affirming the importance of the Greenhouse Gas Endangerment finding and noting the public health impacts of climate change.

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- On August 7, 2025, sent a letter opposing the EPA's proposed rule to repeal Greenhouse Gas Emissions Standards for Fossil Fuel-Fired Electric Generating Units.

B. Prevent firearm injuries and deaths.

In the 1980's the AMA recognized firearms as a serious threat to the public's health as weapons are one of the main causes of intentional and unintentional injuries and deaths. At the 2016 Annual Meeting, following the Pulse nightclub shooting, policy was adopted declaring that "gun violence represents a public health crisis which requires a comprehensive public health response and solution." Since that time firearm injuries and deaths have increased, and disparities have widened.[15]

- The AMA continues to convene its Firearm Injury Prevention task force, which is charged with advising the AMA Board of Trustees on the role of organized medicine in firearm injury prevention and developing resources for physicians and trainees on firearm injury prevention to increase counseling of high-risk patients and awareness of available interventions. The AMA task force was extended by the AMA Board of Trustees for an additional 2-year term from December 2025 – December 2027.
- Task force members have participated in *AMA Update* video and podcast episodes on the health system role in firearm injury prevention (featuring the American Pediatric Surgical Association representative) and Extreme Risk Protection Orders (featuring the Society of Critical Care Medicine representative and the Johns Hopkins Center for Gun Violence Solutions).
- On November 25, 2025, the updated CME module "Health Care Strategies for Firearm Injury Prevention" was published on the Ed Hub™. This interactive module contains updated data on the epidemiology of firearm morbidity and mortality in the U.S. and helps physicians understand how to effectively counsel patients and communicate about reducing the risk of firearm injury and death.

Agree to Agree. The AMA is collaborating with the Ad Council on the Agree to Agree initiative, which is focused on finding common ground to reduce the impact of firearm violence on children and teens across all communities in the U.S. This campaign launched in early 2025 and is focused on reaching distinct audiences, including parents and those with children in their lives who have a vested interest in protecting our youth and health care professionals who witness the impact of firearm violence firsthand. The initiative will expand to provide additional resources and tools to reach specific audiences and communities with the goal of addressing all forms of firearm violence as part of our comprehensive approach to combating this complex crisis. "Agree to disagree" is a phrase that ends a conversation, the goal of this campaign is to start a conversation.

- On Thursday, March 6, 2025, AMA participated in a Washington Post Live conversation about how gun violence has impacted communities around the country, initiatives to find common ground, and efforts to bolster public safety and health.
- On October 23, 2025, the Ad Council in partnership with the American Medical Association, through the work of the task force and a coalition of health care and business leaders, launched new firearm injury prevention creative and an expanded digital resource hub for health care professionals at AgreeToAgree.org/Healthcare. The resource hub provides links to educational materials to support physicians having effective conversations about firearm injury prevention with patients, parents, other health care professionals and community members.
- In the first year of the Agree to Agree campaign, it has:
    - Received 35.4 million in total donated media resulting in 2.4 billion impressions.
    - Reached 69.5 percent of the audience in first 4 months of campaign launch, according to a Nielsen One study.
    - All three impact goals were met. Respondents aware of the campaign advertising are significantly more likely than those not aware to: (1) know firearm injuries are the leading cause of death for youth, (2) believe they have a role to play, and (3) report having had a conversation about preventing youth firearm injury and deaths.
    - Agree to Agree was number one for share of voice for the Gun Violence Safety category for 2025.

C. Respond to emerging and remerging infectious disease threats and prepare for future pandemics.

Infectious diseases continue to evolve and advance throughout the U.S. Pathogens that were once geographically limited are now advancing beyond traditional borders. Measles, which was once eliminated in the U.S., continues to

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surge with 2,284 confirmed cases in 2025. The U.S. is on pace to surpass that number in 2026, with 1,362 cases already reported as of March 12, 2026. The AMA is relied upon as a source of information by physicians and patients, the AMA must maintain the ability to respond and share information and advocate for physicians, patients, and the public in line with AMA policies.

- The AMA is currently maintaining resources pages on multiple pathogens including dengue, measles, respiratory syncytial virus, Bordetella pertussis, oropouche virus and more. We continue to create additional infectious disease related resources for physicians on the AMA website to help ensure the continued availability of information should other sources not remain available.
- The AMA is a collaborator in Project Firstline, the CDC's National Training Collaborative for Healthcare Infection Control. Project Firstline offers educational resources in a variety of formats to meet the diverse learning needs and preferences of the health care workforce. Over the past year, the AMA has partnered with the CDC on four webinars. The recordings are available on the AMA Ed Hub™:
    - "Measles on the Rise: How to Prepare and Respond in Your Clinic"
    - "Overcoming Infection Prevention and Control Challenges in Rural Health Care"
    - "Preventing and Responding to Respiratory Infections and Outbreaks in Long-Term Care"
    - "Pertussis: Trends, Treatment, and Prevention"
- On October 22, 2025, the AMA partnered with the CDC on a Clinician Call to bring attention to the rise in West Nile virus cases, specifically in neuroinvasive disease. It highlighted a case where West Nile virus was transmitted via solid organ transplants. This webinar highlighted the AMA's ability to quickly develop, promote and execute a webinar based on a current infectious diseases threat.

D. End the nation's drug overdose epidemic.

Ending the nation's drug overdose epidemic will require increased physician leadership, a greater emphasis on overdose prevention and treatment, and better coordination and amplification of the efforts and best practices already occurring across the country.

- The AMA makes education available to physicians on this topic via the AMA Ed Hub™ to help physicians gain critical knowledge around acute and chronic pain management, substance use treatment, overdose prevention, and pain treatment to meet regulatory requirements. Courses are developed by AMA as well as by other partners.
    - In 2025, the AMA developed and disseminated physician education, "Safer Prescribing of Opioids for Pain Management: Bridging Guidelines and Practice Through Interactive Learning" to support physician's improving their opioid prescribing. This education received two Brandon Hall Group Educational Awards for Leaders in Education Technology – Best E-learning, Blended, Flipped Classroom Solution and Learning and Development Technology Award – Best Advance in Education Delivered Through Technology.
    - In 2025, the AMA developed additional episodes of the physician education podcast series on "The Opioid Overdose Epidemic." Podcast episodes feature experts who shared relevant research, insights, and experience to help physicians of all specialties in addressing the opioid overdose epidemic. In 2025, podcast engagement included 26,757 downloads, with a high interest in the following topics: "Opioid Prescribing and Appropriate Pain Management,"" Opioid Overdose Prevention," and "Opioid Use Disorder Treatment."
    - In the past year, the AMA supported the content for the physician education series module "Practical Guidance for Pain Management." This content was made available to help physicians meet the DEA's MATE Act requirements, effective as of June 27, 2023.
- The AMA continues to convene the Substance Use and Pain Care Task Force, which supports and guides the development of the annual Overdose Epidemic Report on the overdose epidemic outlining current data, policy, updates, clinical accomplishments and what still needs to be done.[21] This group meets on a quarterly basis throughout the year to engage with stakeholders and experts with emerging barriers, challenges and development of solutions
- The AMA is also a member of the Providers Clinical Support System (PCSS), which is made up of a coalition of major health care organizations all dedicated to addressing this health care crisis and is led by the American Academy of Addiction Psychiatry. PCSS provides evidence-based training and resources to give health care providers the skills and knowledge they need to treat patients with opioid use disorders and chronic pain.[20]

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- The AMA is a sponsor of the National Academy of Medicine, Action Collaborative on Combatting Substance and Opioid Crises. The Action Collaborative is committed to proactively driving structural change by developing, curating, and implementing multi-sector solutions designed to reduce substance misuse and improve outcomes for individuals, families, and communities affected by addiction.
- The AMA was awarded funding from the CDC in 2024 and continued work to develop and implement a clinician toolkit focused on the recommendations and guiding principles of the 2022 Clinical Practice Guideline for Prescribing Opioids for Pain that is specifically tailored to community health centers (CHCs). During the two-year project period, the AMA will partner with the National Association of Community Health Centers to develop an actionable toolkit resource for clinicians and will implement the toolkit resource in CHCs. The toolkit will provide an extensive, multidisciplinary, evidence-based educational experience for clinicians working in CHCs that is unique and sensitive to the needs of CHCs while also preparing them to serve as content experts and agents of change for their local healthcare communities regarding pain care.

- The AMA continues to be a data resource for stakeholders, policymakers, clinicians, and researchers with its "End The Epidemic" website and data dashboard. This website maintains up to date resources for stakeholders to utilize and an interactive data dashboard to highlight regional differences and trends of the drug overdose epidemic.
- The AMA released its 2025 Substance Use and Treatment: Progress, Policy and Future Directions Report showing increases in polysubstance use, naloxone access for life-saving intervention, and policy promoting evidence-based care but underscoring ongoing challenges as the nation's drug overdose epidemic continues.

3. Strengthen the health system through improved collaboration between medicine and public health.

The AMA is collaborating with leading health care organizations to strengthen the interface between public health and health care. In November 2023, AMA and health care partners announced the Common Health Coalition: Together for Public Health, a partnership between AMA and four other leading healthcare organizations, including: AHIP (formerly America's Health Insurance Plans), Alliance of Community Health Plans, American Hospital Association , and Kaiser Permanente.[22] The Common Health Coalition is focused on translating the hard-won lessons and successes of the COVID-19 pandemic response into actionable strategies that will strengthen the partnership between our health care and public health systems.

- The Coalition's founding members have called on health care and public health organizations across the country to consider joining this effort. Interested organizations can learn more and take steps to join us by visiting the website, https://commonhealthcoalition.org/.
- As of 2025, the Common Health Coalition has grown to more than 300 member organizations across over 45 U.S. states and territories.
- The 2026 Common Health Challenge is focused on Regional Action Networks or collaborations between health care and public health organizations working across geographic borders and sectors to tackle shared health priorities, improving outcomes for patients and communities through sustained efforts in areas such as chronic disease reduction and interoperable data sharing. Through catalyst awards, the Coalition will fund vanguard organizations that demonstrate a strong capacity to strengthen partnership between health care and public health in their community.

In addition, the AMA took the following actions:

- On August 1, 2025, the AMA issued a leadership viewpoint noting that slashing the National Institutes of health funding imperils the foundation of medical research, which has played a critical role in improving the nation's health.
- On August 28, 2025, the AMA issued a press statement noting that the removal of CDC Director Susan Monarez and the resignations of other senior CDC leaders are highly alarming at a challenging moment for public health. In the wake of CDC budget cuts and the termination of hundreds of employees earlier this year, the AMA is deeply concerned that this turmoil leaves us highly susceptible to public health threats.

4. Combat the spread of misinformation and disinformation.

The AMA remains engaged in external collaborations to address mis- and disinformation, such as the Coalition for Trust in Health & Science.

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- The Coalition for Trust in Health and Science's vision is for all people to have equitable access to accurate, understandable, and relevant information to make personally appropriate health choices and decisions. The AMA is an active member, engaging with leadership and participating in programming.
- The AMA was an active participant in the Mitigating Medical Misinformation Workgroup, but that group has decided to meet less frequently and incorporate its work into the broader Coalition for Trust in Health & Science.
- On March 5, 2026, the AMA issued a statement on the new survey findings from the Annenberg Public Policy Center, which highlight a widening trust gap in the nation's health information landscape and underscore the importance of trusted medical voices grounded in science. The survey found that physicians and medical organizations remain among the most trusted sources of public health information, with about 73 percent of Americans expressing confidence in the American Medical Association (AMA). Overall, by a two-to-one margin, those polled said they would accept AMA's recommendations (35 percent) over the CDC's (16 percent) if the two bodies issued conflicting statements on vaccine safety. The findings come at a time when confidence in federal health agencies has unfortunately declined, even as Americans continue to rely heavily on physicians and medical experts for credible, evidence-based information about health and disease prevention.

The AMA will continue to evaluate opportunities to work with the Ad Council and other health-related organizations on future evidence-based public information campaigns.

CONCLUSION

The current political environment has elevated the critical importance of AMA's role of promoting and disseminating evidence-based public health policy and content. The AMA continues to advance its mission, to promote the art and science of medicine and the betterment of public health. The highlighted accomplishments in this report capture a fraction of the work accomplished from March of 2025 – March of 2026 related to the AMA's public health strategy. The AMA will continue to engage on these critical issues to maintain the organization as a trusted source of information for physicians and the public and to help protect the health of the nation.

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12. THE UNIFORM HEALTH-CARE DECISIONS ACT

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: RECOMMENDATIONS ADOPTED
REMAINDER OF REPORT FILED
See Policies H-85.956, H-85.957, H-140.826, H-140.845 and H-140.970

This American Medical Association (AMA) Board of Trustees (Board) report responds to the referral of Board Report 13-A-25, "The Uniform Health-Care Decisions Act," which arose from Resolution 250-A-24, "Endorsement of the Uniform Health-Care Decisions Act," introduced by the Michigan Delegation which was also referred. Resolution 250-A-24 proposed amending Policy D-140.968, "Standardized Advance Directives," as follows:

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

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

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UHCDA provisions related to mental health and expressed that the UHCDA inadequately addressed complex issues that would negatively impact medical practice.

Board Report 13-A-25 examined the binary question of whether the AMA should endorse the 2023 UHCDA as adopted by the Uniform Law Commission (ULC) and did not seek or recommend changes to the UHCDA or address broader policy issues. The report recommended against endorsement of the 2023 UHCDA and recommended rescinding Policy D-140.968 as outdated.

At the 2025 Annual Meeting, testimony requested that Board Report 13-A-25 be referred back to the Board for further study rather than proceeding with the recommendation to rescind AMA Policy D-140.968. Testimony expressed concerns that rescinding the policy would leave the AMA without guidance on standardized advance directives and urged the Board to develop affirmative policy addressing advance care planning.

This report responds to the referral by clarifying the scope and intent of the Board's prior recommendations, acknowledging the concerns raised, and reaffirming the extensive body of existing AMA policy that already addresses advance care planning, advance directives, surrogate decision making, and related ethical and clinical issues.

BACKGROUND

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

In 1993, the ULC, then known as the National Conference of Commissioners on Uniform State Laws, promulgated the UHCDA, a third-generation model bill that addressed advance health care directives and health care decision-making on behalf of patients lacking capacity. Subsequently, the AMA adopted policy to endorse the 1993 UHCDA. Six states (AK, HI, ME, MS, NM, and WY) enacted the 1993 UHCDA. In 2020, the ULC appointed a drafting committee to modernize and expand the UHCDA, and in 2023, the ULC approved the 2023 UHCDA.

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

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

To date, two states (DE and NV) have enacted the 2023 UHCDA.

AMA POLICY

As noted, AMA Policy D-140.968, "Standardized Advance Directives," is narrowly focused on endorsement of the 1993 UHCDA and urges state medical societies to advocate for its adoption. Beyond policy on the UHCDA, the AMA maintains a robust and comprehensive set of policies that address advance care planning across clinical, ethical, and public policy dimensions.

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

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Policy H-140.845, "Encouraging the Use of Advance Directives and Health Care Powers of Attorney," outlines the AMA's commitment to encouraging the use and awareness of advance directives and Durable Powers of Attorney for Health Care. The policy urges health care providers to educate young adults, nursing home residents, physicians, and medical students about advance directives and designating health care proxies. It promotes ensuring care plans, including advance directives, are on file and accompany patients when transferred between facilities. The policy encourages states and specialty societies to address technical issues with these documents and for medical offices to make related information easily accessible. The policy calls for collaboration with insurers, states, Congress, and federal agencies to expand public education, include materials during Medicare enrollment and driver's license renewal, and provide incentives for advance directive completion. Additionally, it supports ongoing efforts to help physicians educate patients about advance directives and advocates for the secure electronic storage of these documents.

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

Policy H-140.970, "Decisions to Forgo Life-Sustaining Treatment for Incompetent Patients," outlines best practices for making decisions about life-sustaining treatment for incompetent patients, emphasizing the importance of advance directives, such as living wills and designated proxies, to ensure a patient's wishes are respected. If no directive exists, family or close associates serve as surrogate decisionmakers, guided by the patient's known preferences or best interests; physicians must provide all relevant information. The policy instructs that institutional ethics committees with diverse representation should support sound decision-making, especially in contentious cases requiring review. Judicial intervention should be a last resort, focused on assigning decision makers rather than making treatment choices. When the patient's wishes are unknown, surrogates' genuine concern should guide decisions. Special consideration and support are advised for cases involving permanently unconscious patients or seriously ill newborns, including parental counseling and ethics consultations. Hospitals must have protocols to guide capacity assessment, surrogate identification, and dispute resolution in line with these principles.

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

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

DISCUSSION

Advance care planning is an important aspect of ensuring patient treatment preferences are respected in the event the patient is unable to communicate their wishes. Central to respecting patient autonomy at the end of life or during incapacity is the use of advance directives, a health care power of attorney, and other advance care planning instruments. However, laws governing these instruments may vary across states and this inconsistency can create confusion, complexity, and barriers to effective health care decision-making, ultimately undermining the very goals of advance care planning. A uniform approach among state laws could help minimize confusion and inconsistency and promote high-quality patient care and effective communication and decision-making between patients, families, and health care professionals, particularly in cases when medical decision-making may occur across state lines, amidst conflict between family members or when a patients' preferences have not been made clear. The 2023 UHCDA provides a framework for the creation, execution, and recognition of advance care planning tools, the delegation of health care decision-making, and the relevant duties of agents and health care providers. Indeed, existing AMA policy

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aligns with the goals of the 2023 UHCDA. However, inconsistencies between the 2023 UHCDA, AMA policy, and clinical practice raise concerns about AMA endorsement of the 2023 UHCDA.

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

Additionally, there are 2023 UHCDA provisions that directly conflict with existing AMA policy. AMA Policy H-140.970, "Decisions to Forgo Life-Sustaining Treatment for Incompetent Patients," states that, in the absence of an advance directive, the patient's family should become the surrogate decisionmaker regarding decisions to forgo life-sustaining treatment, whereas the 2023 UHCDA first prioritizes "an adult the individual has identified, other than in a power of attorney for health care, to make a health-care decision for the individual if the individual cannot make the decision" before family. AMA policy also identifies when decisions to forgo life-sustaining treatment warrant institutional or judicial review, including when there is a dispute among family members and no designated decisionmaker, and when there is no available family willing to be the patient's surrogate decisionmaker. In contrast, the 2023 UHCDA instructs health care providers to comply with the decision of a majority of the family members when there is a dispute and authorizes non-family members to function as surrogate decision makers according to a priority list. AMA policy also advocates for institutional ethics committees, whereas the 2023 UHCDA makes no mention of ethics committees. The 2023 UHCDA also authorizes and promotes mental health advance directives, whereas AMA policy merely recognizes the potential benefit of such directives and urges further study.

The 2023 UHCDA also conflicts with AMA policies that vigorously support and advocate for appropriate physician supervision of non-physician clinical staff in all areas of medicine. Specifically, the 2023 UHCDA authorizes a "responsible health-care professional" to determine whether a patient lacks capacity when a physician, psychologist, physician assistant, advanced practice registered nurse, or social worker is unavailable, and a prompt decision is necessary to avoid loss of life or serious harm. The 2023 UHCDA does not require the "responsible health-care professional" to have any specific training, expertise, or license. AMA Policy H-160.949, "Practicing Medicine by Non-Physicians," expressly opposes state legislation allowing non-physician groups to engage in the practice of medicine without physician training or appropriate physician supervision.

It is critical to note that AMA does not endorse the actions of other organizations with which it does not completely and wholly agree. Though individuals may disagree about the appropriate weight to be given to the concerns and conflicts discussed in this report, the Board finds the lack of perfect alignment determinative. Therefore, the Board continues to recommend against endorsement of the 2023 UHCDA.

The Board appreciates the thoughtful testimony provided at the 2025 Annual Meeting and recognizes the importance of advance care planning in ensuring that patients' treatment preferences are respected. The Board acknowledges that concerns were expressed that rescinding

Policy D-140.968 would leave the AMA without direction on advance care planning and standardized advance directives. It is important to clarify, however, the scope of Policy D-140.968 and the breadth of the AMA's existing policy framework. Policy D-140.968 addresses only the AMA's endorsement of the 1993 UHCDA model act. Since the 1993 model act has been replaced by the 2023 version, Policy D-140.968 has become obsolete and should be sunset (as recommended in Board Report 8 being presented at the 2026 Annual Meeting). However, sunsetting this policy would not leave the AMA without direction on advance care planning. The AMA maintains extensive and robust policy addressing advance directives, advance care planning, powers of attorney for health care, surrogate decision-making, and related issues, as detailed in the AMA Policy section of this report and Board Report 13-A-25.

The Board recognizes the desire expressed in testimony for the AMA to take a leadership role in crafting an alternative to the 2023 UHCDA. However, the Board must note that the ULC's development of the 2023 UHCDA reflects the culmination of an intensive, multi-year process led by ULC involving extensive stakeholder engagement, legal

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expertise, and multiple iterations of drafting and revision and consideration of complex legal, ethical, and clinical issues across diverse practice settings and state regulatory environments. Attempting to replicate or improve upon such a comprehensive effort is beyond the scope of a Board report.

Moreover, large-scale changes to AMA policy, particularly those that would establish new substantive positions or reconcile complex legal, ethical, and clinical issues, are most appropriately initiated by the House of Delegates through resolutions or by Councils reports that allow for thorough vetting, stakeholder input, and deliberative consideration. The Board respectfully submits that it would be inappropriate for a Board report to attempt to craft new comprehensive policy on these issues, as this would bypass the deliberative processes of the House of Delegates that are designed to ensure thoughtful policy development with appropriate input from the Federation.

In this context, the Board believes it is important to reaffirm the AMA's existing comprehensive policy framework on advance care planning, which already provides substantial guidance for the AMA's advocacy work and for physicians' clinical practice. These policies address the core concerns raised in testimony regarding standardized advance directives, mental health advance directives, surrogate decision-making, and capacity determination, and demonstrate the AMA's longstanding commitment to promoting advance care planning, respecting patient autonomy, and ensuring appropriate surrogate decision-making. Reaffirmation of existing policy underscores that the AMA already has extensive guidance to inform its work, while preserving the ability of the House of Delegates or AMA councils to propose and consider new or revised policy in the future through established processes.

RECOMMENDATIONS

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

1. That Policy H-85.957, "Encouraging Standardized Advance Directives Forms Within States," be reaffirmed. (Reaffirm HOD Policy)
2. That Policy H-140.845, "Encouraging the Use of Advance Directives and Health Care Powers of Attorney," be reaffirmed. (Reaffirm HOD Policy)
3. That Policy H-85.956, "Educating Physicians About Advance Care Planning," be reaffirmed. (Reaffirm HOD Policy)
4. That Policy H-140.970, "Decisions to Forgo Life-Sustaining Treatment for Incompetent Patients," be reaffirmed. (Reaffirm HOD Policy)
5. That Policy H-140.826, "Use of Psychiatric Advance Directives," be reaffirmed. (Reaffirm HOD Policy)

Fiscal Note: Less than $500.

REFERENCES

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

13. REDUCING RISK OF FEDERAL INVESTIGATION OR PROSECUTION FOR PRESCRIBING CONTROLLED SUBSTANCES FOR LEGITIMATE MEDICAID PURPOSES

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: RECOMMENDATIONS ADOPTED
REMAINDER OF REPORT FILED
See Policy D-120.916

At the 2025 Annual Meeting of the American Medical Association (AMA) House of Delegates (HOD) Resolution 209, "Reducing Risk of Federal Investigation or Prosecution for Prescribing Controlled Substances for Legitimate Medical Purposes," was introduced by the American Society of Addiction Medicine and the American Academy of Hospice and Palliative Medicine. The first item in the resolve of Resolution 209-A-25 was adopted and became Policy

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H-95.894 and calls for the AMA to "support legislative, regulatory, and other advocacy efforts that advance the adoption of a conjunctive 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."

The second item in the resolve of Resolution 209-A-25 was referred. This item asked the AMA to:

> 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."

This report studies the issues raised by providing relevant background, discussing issues raised by the resolution, citing AMA policy, and making recommendations.

BACKGROUND

The term, "legitimate medical purpose," appears multiple times in the Controlled Substances Act (CSA), but the CSA does not provide a specific definition for "legitimate medical purpose."[1] Regulations implementing the CSA, which are supposed to guide the U.S. Drug Enforcement Administration (DEA), also do not specifically define the term.[2] For example, Section 1306.04 of the CSA provides, in part, that "A prescription for a controlled substance to be effective must be issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his professional practice."[3] Multiple provisions in Section 1300 (and elsewhere) in the CSA use essentially the same language with respect to electronic prescriptions, prescriptions obtained via a telemedicine encounter, and other situations.[4] The CSA, however, does not actually define what constitutes a "legitimate medical purpose." Examples within the CSA's regulatory framework that mirror the CSA include:

- A "valid prescription" means a prescription that is issued for a legitimate medical purpose by an individual practitioner licensed by law to administer and prescribe the drugs concerned and acting in the usual course of the practitioner's professional practice."[5]
- "A prescription for a controlled substance to be effective must be issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his professional practice."[6]

Despite the lack of a clear definition, the term, "legitimate medical purpose," is commonly used by the DEA and the courts to identify situations that are contrary to a legitimate medical purpose. Representative examples include:

- "[T]he Agency concludes that Respondent issued multiple controlled substance prescriptions other than for a legitimate medical purpose while acting in the usual course of professional practice, prescribed controlled substances without an appropriate prior examination and a medical indication, and failed to maintain adequate and accurate records relating to the provision of services, thus committing multiple violations of California law and, therefore, of federal law."[7]
- "Respondent issued prescriptions for his own personal use to feed his addiction, not for a legitimate medical use."[8]
- "[T]hese prescriptions were issued without a legitimate medical purpose, outside the usual course of professional practice, and beneath the standard of care because Respondent failed to appropriately establish or document a medical indication."[9]

One of the purposes of the DEA Practitioner's Manual is to provide guidance to practitioners, but the manual similarly does not clarify what is—and is not—a "legitimate medical purpose." For example, the manual states that, "There is a legitimate need for controlled substances, and DEA does not want to hinder their legitimate prescribing, administering, and dispensing."[10] The DEA additionally tells practitioners that,

> Federal controlled substance laws are designed to function in tandem with state-controlled substance laws. DEA works in cooperation with state professional licensing boards and state and local law enforcement officials to make certain that pharmaceutical controlled substances are prescribed, administered, and dispensed for a legitimate medical purpose in the usual course of professional practice.[11]

The "tandem" nature cited by DEA also is not clearly defined, but as described in more detail below, highlights the essential role that state medical boards play in regulating the practice of medicine.

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The lack of clarity in federal law, however, has not stopped the DEA from prosecuting physicians for the alleged failure to meet the "legitimate medical purpose" standard. In *City and County of San Francisco v. Purdue Pharma*,[12] for example, the court said that "An illegitimate prescription is one that is not written by a prescriber or not filled by a patient for the purpose of medical treatment." In *Akhtar-Zaidi v. DEA*,[13] the court said that the physician's "prescriptions were not issued for a legitimate medical purpose because his medical diagnoses were unsupported by the nature and extent of the examinations he conducted and the limited information received from the undercover officers." In *Ruan v. United States*,[14] the U.S. Supreme Court said that "medically legitimate" means "treating the relevant disease or injury." In another example, in *United States v. Feingold*, the court sought, among other things, to distinguish legitimate from illegitimate by explaining that the standard of care helps define when a practitioner acts like a doctor; that malpractice is when a the practitioner acted like a "bad doctor" and a drug "pusher" is one "whose conduct is without a legitimate medical justification." Notably, in *Feingold*,[15] the defendant prescribed opioids to patients who he did not examine, in exchange for painting his house, in excessive quantities, and even after the state revoked his authority to prescribe narcotics.

Just as it is highly challenging to identify a specific definition for "legitimate medical practice," there does not appear to be a reliable, comprehensive source to try and understand how often physicians may be subject to investigations or sanctions where "legitimate medical purpose" is used. Several sources, recent and historical, provide some limited insight. The U.S. Department of Justice Criminal Division, for example, reports that its "Strike Force Operations" have resulted in hundreds of indictments, many of which involve charges relating to alleged inappropriate prescribing of opioid analgesics and other controlled substances.[16] Between 2006 and 2016, the National Association of Attorneys General (NAAG) studied the cases of 378 physicians who, since 2006, had been charged and whose cases were resolved and/or sentences rendered by Dec. 31, 2016.[17] More than 300 physicians pled guilty, and of the 69 who pled "not guilty," and chose a trial, only one was acquitted. While some of those cases involved allegations concerning controlled substances, a definitive number was not reported.

The standard used to evaluate and/or investigate physicians' actions at the state level typically comes from how the state medical board defines and regulates the practice of medicine. In a review of the definition of "practice of medicine" from 44 states, DC, Guam, and the Northern Mariana Islands, the term "legitimate medical purpose" does not appear.[18] (See Appendix A, "Practice of Medicine—Location Defined.") Common terms in state definitions, however, include treat or treatment; prescribe, prescribing or prescription; diagnose or diagnosis; disease, condition, prevent and prevention; and other terms. The U.S. Code of Federal Regulations generally defers to state law in lieu of providing a specific definition for the practice of medicine.

Similar to not knowing precisely how many physicians are investigated at the federal level for allegedly failing to meet the "legitimate medical purpose" standard, it is not clear how many state investigations occur because investigations are not necessarily publicly reported. With respect to sanctions at the medical board level, the Federation of State Medical Boards (FSMB) report that there was an average of 3,167 physicians disciplined per year between 2021 to 2024.[19] The FSMB information reviewed does not detail the reasons for the discipline, but one reason boards investigate and discipline physician includes "prescribing drugs in excessive amounts without legitimate reason."[20] A cross-sectional study of 3,128 disciplinary proceedings across five states (CA, FL, NY, PA, and TX) found that, "the top 5 reasons for physician discipline across all 5 states were practitioner negligence (1911 [28.7 percentage]), other (1102 [16.6 percentage]), problematic record-keeping (990 [14.9 percentage]), inappropriate prescribing (901 [13.5 percentage]), and criminal activity (599 [9.0 percentage])."[21] This data, however, do not account for investigations that closed without a charge, sanction or other action.

DISCUSSION

For investigations that do occur, the DEA may choose to inspect records, gain entry to the practice, conduct interviews and take other actions, which are extremely disruptive to a practice. This broad authority under the CSA often occurs through the use of administrative subpoenas or warrants, or criminal warrants. [22] [23] These investigations by law enforcement (or medical boards) have significant adverse effects on physicians. Researchers describe that investigations create "feelings of anger, depression, anxiety, shame, powerlessness, isolation, being betrayed, less confidence in clinical decision-making."[24] Even the mere threat of an investigation being initiated can have a chilling effect on a physician's practice. Physicians also face practical effects, including the potential for temporary or long-term suspension of practice, considerable financial expense, disruption to providing care due to inspections and records review, and the time and legal costs to properly respond to the investigation. In addition, when an investigation becomes public, whether it leads to formal charges or not, there is an immediate, adverse effect on the physician's

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reputation in the community, including among colleagues. To be clear, the AMA does not support illegal prescribing or other similar actions by physicians, but the Board of Trustees (the Board) points out that the adverse effects cited above occur whether or not the investigation leads to formal charges. These are some of the reasons why physicians fear the DEA and other law enforcement.

While DEA and law enforcement accurately say that they do not regulate the practice of medicine, the threat of investigation is real for many physicians, particularly those who prescribe controlled substances. One qualitative survey found that such fear resulted in reductions of prescribers willing to provide opioid therapy, patients being removed from practices, and patients turning to illicit substances if their physician no longer provided care.[25] It is not surprising that law enforcement investigations—because they require a higher standard of proof for conviction than how a medical board determines if the standard of care was met—are invasive, complicated, and time consuming for all involved. Physicians describe decisions whether to prescribe opioids and other controlled substances as putting them "between a rock and a hard place," with researchers noting that physicians acutely understand that, "An investigation alone can be devastating, and a finding of liability can trigger a cascade of consequences that make it impossible to practice medicine."[26]

In the prosecutions cited above, the main question ultimately was a binary one: Did the physician meet the "legitimate medical purpose" standard? The DEA, for its part, has said that it "does not define or regulate the practice of medicine; instruct practitioners on what type, or what strength of a Schedule II-V Controlled Substance they can or must prescribe; dictate how frequently a practitioner must see a patient; [or] dictate what tests a practitioner must conduct."[27] The DEA has further explained that, "the types of cases in which physicians have been found to have dispensed controlled substances improperly under Federal law generally involve facts where the physician's conduct is not merely of questionable legality, but instead is a glaring example of illegal activity."[28] The DEA and courts, moreover, make their determinations on a case-by-case basis.[29] [30] A review of the types of cases where a DEA registrant was found to be acting outside the course of usual professional practice and where a prescription was not for a legitimate medical purpose typically included multiple factors, which might include one or more of the following: high doses/quantities of opioid analgesics; combination prescriptions for opioids, benzodiazepines and muscle relaxants; patients who receive multiple prescriptions for controlled substances from multiple providers; and unusual geographic distances.

The above factors are analyzed by the courts for determining whether to convict an individual under the CSA. As noted in *Feingold* and exemplified in the NAAG data cited and other cases—the facts are typically so extreme that acquittals are rare if a case is brought to trial. While there is a lack of data as to how often criminal investigations occur, it is reasonable to suggest that there are a far greater number of such investigations. That is, prosecutors tend to strongly prefer winnable cases versus those where it was questionable that there was a deviation from "legitimate medical purpose." The U.S. Supreme Court, in *Gonzalez v. Oregon*, analyzed the relationship between the CSA and a state's authority to regulate the practice of medicine, and stated that,

> The statute and our case law amply support the conclusion that Congress regulates medical practice insofar as it bars doctors from using their prescription-writing powers as a means to engage in illicit drug dealing and trafficking as conventionally understood. Beyond this, however, the statute manifests no intent to regulate the practice of medicine generally."[31] In Gonzalez, the Court found that the federal government must give extraordinary deference to a state's authority to regulate the practice of medicine, including that the U.S. Attorney General "is not authorized to make a rule declaring illegitimate a medical standard for care and treatment of patients that is specifically authorized under state law.[32]

The AMA strongly supports the practice of medicine being regulated at the state level. It follows that interpreting whether an act is consistent with the practice of medicine or "legitimate," should be based on state definition. This approach has several clear benefits from the vague, non-defined approach used for investigations under the CSA. First, nearly every state specifically defines the practice of medicine—and has a medical board with the expertise and experience to determine whether the standard of care has been met.[33] (See Appendix A, "Practice of Medicine – Location Defined") Second, while there are slight differences between how states specifically define "the practice of medicine," there are common themes across all of the definitions. This includes treating injury or disease, whether physical or mental; examining patients as well as managing disease; interpreting tests and providing medical opinions; and performing surgery and other procedures. While some definitions are more expansive than others, all contain much more substance than simply "legitimate medical purpose."

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This is not to say that a medical board investigation is any less intrusive or burdensome than one conducted by law enforcement. Rather, within the scope of this report, state regulation provides a more well-defined starting point to guide investigations rather than what currently is used under the CSA. Even though the Board recognizes that there are differences in how states define the practice of medicine, having law enforcement use state definitions would help provide a clearer distinction to help law enforcement distinguish between practices by clinicians that do not have a "legitimate medical purpose" from clinicians whose practices may treat patients with different levels of complexity, and who may require different treatments. Notably this includes addiction medicine physicians who may prescribe medications for opioid use disorder (MOUD) at higher rates than other specialists; pain medicine, oncologists, hospice or palliative care physicians who may prescribe opioids at higher rates than other specialists; or psychiatrists who may prescribe benzodiazepines or stimulants at higher rates than other specialists.

In addition to the physicians who face an investigation that yields no charges—or when a physician's office is closed temporarily or a conviction leads to permanent closure—there is always massive disruption to the practice and patients. For example, if a physician's DEA registration is suspended, every patient receiving controlled substances still requires a physician's care.[34] And if a pharmacy no longer is authorized to dispense buprenorphine, for example, in a rural area, hundreds of patients will be affected.[35] To try and help mitigate the harms associated with the sudden closure of a clinic or pharmacy, the U.S. Centers for Disease Control and Prevention (CDC) operate the "Opioid Rapid Response Program" (ORRP) to help mitigate patient harm and work with state health officials when physicians are no longer authorized to provide care due a law enforcement or similar action against them.[36] The ORRP has worked in 40 states since 2021 and "received over 240 notifications from federal law enforcement about potential disruptions to healthcare for patients receiving controlled substance medications." Finally, the Association of State and Territorial Health Officials published a 2021 guide that provides further information for states.[37]

AMA POLICY

The AMA broadly recognizes that the nation's overdose epidemic is complicated. (H-95.981, Federal Drug Policy in the United States) AMA policy addresses the need for protections for patients with pain (D-120.932, Inappropriate Use of CDC Guidelines for Prescribing Opioids) as well as for individuals with an opioid use disorder. (D-95.972, Expanding Access to Buprenorphine for the Treatment of Opioid Use Disorder) AMA policy also emphasizes the need for balance by the DEA to support patients with pain while taking steps to reduce misuse and diversion of controlled substances. (D-120.971, Promoting Pain Relief and Preventing Abuse of Controlled Substances) AMA policy also highlights the need for working with law enforcement on educational outreach with respect to "appropriate" prescribing practices, as well as efforts to help prevent misuse and diversion. (H-95.990, Drug Abuse Related to Prescribing Practices) Finally, the AMA does not have specific policy on what constitutes a "legitimate medical purpose," although AMA policy strongly supports state regulation of the practice of medicine. (H-275.978, Medical Licensure)

CONCLUSION

The AMA cannot prevent physicians from being investigated by law enforcement. Violations of the CSA for prescribing medication without a legitimate medical purpose, outside the usual course of professional practice, are not to be tolerated because such violations do not represent the practice of medicine. However, the AMA also does not support investigations that serve as so-called fishing expeditions that ensnare physicians—often those who provide care to the most vulnerable patients—in years of emotional, financial, and professional turmoil. The Board does not believe that law enforcement regularly engages in wanton or specious activities against physicians, but we do believe that increased guidance for law enforcement and physicians is warranted. Specifically, the Board recommends that federal law enforcement activities use state medical practice acts as their guide as to what is a "legitimate medical purpose." Every state defines the practice of medicine with greater clarity than federal regulations or statute. If a federal law enforcement agency seeks to investigate a physician in a particular state, the Board recommends that law enforcement start with understanding how a state defines the practice of medicine. This is not meant to hinder appropriate investigations, but to help guide law enforcement and physicians alike.

The Board, therefore, recommends that the HOD adopt new policy that advocates for the
U.S. Department of Justice (DOJ) to rely on state medical board definitions of "the practice of medicine" to guide investigations into whether a practitioner has acted without a "legitimate medical purpose." The Board also recommends that the HOD adopt policy directing the AMA and its interested medical association partners to work more closely with the DOJ to clearly identify the factors that the DOJ uses during an investigation. The Board further

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recommends that the HOD adopt policy directing the AMA to support the CDC's Opioid Rapid Response Program and similar state-based efforts to reduce disruptions to care caused by law enforcement or other actions.

RECOMMENDATIONS

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

1. That the referred clause from Resolution 209-A-25, "Reducing Risk of Federal Investigation or Prosecution for Prescribing Controlled Substances for Legitimate Medical Purposes," not be adopted.
2. That our American Medical Association advocate to the U.S. Department of Justice to rely on state medical board definitions of "the practice of medicine" to guide investigations into whether a practitioner has acted without a legitimate medical purpose. (Directive to Take Action)
3. That our AMA advocate to the U.S. Department of Justice to work more closely with the AMA and its interested medical association partners to more clearly identify the factors it uses during an investigation to minimize disruptions to patient care. (Directive to Take Action)
4. That our AMA support the U.S. Centers for Disease Control and Prevention Opioid Rapid Response Program and similar state-based efforts that seek to ensure continuity of care when patients lose access to care due to a law enforcement or other action that results in the closure of a physician's practice. (New AMA Policy)

Fiscal Note: Less than $500

APPENDIX A

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Practice of Medicine – Location Defined

Summary

- 44 states, DC, Guam, and the Northern Mariana Islands generally define the practice of medicine
- 6 states explicitly defines that the practice of medicine occurs where the patient is located
- 37 states, DC, and Guam are Members of the Interstate Medical Licensure Compact, which adopts the prevailing standard for licensure and affirms that the practice of medicine occurs where the patient is located at the time of the physician-patient encounter, and therefore, requires the physician to be under the jurisdiction of the state medical board where the patient is located.

	Statutes and/or regulations explicitly defines that the practice of medicine occurs where the patient is located	Member of IMLC and affirms practice of medicine occurs where the patient is located	Definition & Statute/Regulation Citation
AL		X	**Medical Practice Act Ala. Code 34-24-50, et. Seq. "Practice of medicine or osteopathy" defined.** "The 'practice of medicine or osteopathy' means: 1. To diagnose, treat, correct, advise, or prescribe for any human disease, ailment, injury, infirmity, deformity, pain, or other condition, physical or mental, real or imaginary, by any means or instrumentality; **2.** To maintain an office or place of business for the purpose of doing acts described in subdivision (1), whether for compensation or not…"
AK			**2011 Alaska Statutes Title 08. BUSINESS AND PROFESSIONS Chapter 08.64. MEDICNE Sec. 08.64.380. Definitions.**

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	Statutes and/or regulations explicitly defines that the practice of medicine occurs where the patient is located	Member of IMLC and affirms practice of medicine occurs where the patient is located	Definition & Statute/Regulation Citation
			"(5) 'practice of medicine' or 'practice of osteopathy' means: (a) For a fee, donation or other consideration, to diagnose, treat, operate on, prescribe for, or administer to, any human ailment, blemish, deformity, disease, disfigurement, disorder, injury, or other mental or physical condition; or to attempt to perform or represent that a person is authorized to perform any of the acts set out in this subparagraph;"
AZ		X	**Arizona Title 31 – Professions and Occupations, Chapter 13 – Medicine and Surgery, Article 1 – Arizona Medical Board 32-1401 Definitions.** "'Practice of medicine' means the diagnosis, the treatment or the correction of or the attempt or claim to be able to diagnose, treat or correct any and all human diseases, injuries, ailments, infirmities or deformities, physical or mental, real or imaginary, by any means, methods, devices or instrumentalities, except as the same may be among the acts or persons not affected by this chapter. The practice of medicine includes the practice of medicine alone or the practice of surgery alone, or both."
AR			**Arkansas Medical Practices Act and Regulations. Sub-Chapter 2-General Provisions. 17.95.202. Definitions.** 3. "Practice of medicine' means: (a) Holding out one's self to the public within this state as being able to diagnose, treat, prescribe for, palliate, or prevent any human disease, ailment, injury, deformity, or physical or mental condition, whether by the use of drugs, surgery, manipulation, electricity, or any physical, mechanical, or other means whatsoever, (b) Suggesting, recommending, prescribing, or administering any form of treatment, operation, or healing for the intended palliation, relief, or cure of any physical or mental disease, ailment, injury, condition, or defect of any person with the intention of receiving, either directly r indirectly, any fee, gift, or compensation whatsoever; (c) Maintaining an office or other place to meet persons for the purpose of examining or treating person afflicted with disease, injury, or defect of body or mind; (d) Using the title "M.D.", "M.B.", "D.O.", "physician", "surgeon", or any other word or abbreviation to indicate or induce others to believe that one is engaged in the diagnosis or treatment of persons afflicted with disease, injury, or defect of body or mind, except as otherwise expressly permitted by the laws of this state relating to the practice of any limited field of the healing arts; (e) Performing any kind of surgical operation upon a human being; or (f) Delegating certain medical practices to other personnel under rules adopted by the board (g)
CA			
CO	X	X	**The Colorado Medical Board Policies, 40-27, page 101. Guidelines for the Appropriate Use of Telehealth Technologies in the Practice of Medicine. 8/19/21.**

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	Statutes and/or regulations explicitly defines that the practice of medicine occurs where the patient is located	Member of IMLC and affirms practice of medicine occurs where the patient is located	Definition & Statute/Regulation Citation
			"Providers who evaluate, treat or prescribe through telehealth technologies are practicing medicine. The practice of medicine occurs where the patient is located at the time telehealth technologies are used."
CT		X	
DE	X	X	**2021 Delaware Code Title 24 – Professions and Occupations Chapter 17. Medical Practice Act Subchapter I. General Provisions Sect 1702. Definitions.** "For the purposes of this chapter, in order that the full resources of the State are available for the protection of persons using the services of physicians, the act of the practice of medicine occurs where a person is located at the time a physician practices medicine upon the person."
DC		X	**3 DMCR § 1201.02. Definitions of health occupations.** (7)(A) "Practice of medicine" means suggesting, recommending, prescribing, or administering, with or without compensation, any form of treatment, operation, drug, medicine, manipulation, electricity, or any physical, mechanical, or healing treatment by other means, for the prevention, diagnosis, correction, or treatment of a physical or mental disease, ailment, injury, condition, or defect of any person, including: (i) The management of pregnancy and parturition; (ii) The interpretation of tests, including primary diagnosis of pathology specimens, images, or photographs; (iii) Offering or performing a surgical operation upon another person; (iv) Offering or performing any type of invasive procedure of the body, whether through a body opening or a cutting of the skin, or otherwise affecting the layer of skin below the stratum corneum, for surgical, therapeutic, or cosmetic purposes, excluding procedures known as body tattooing or body piercing; (v) Rendering a written or otherwise documented medical opinion relating to the diagnosis and treatment of a person within the District, or the actual rendering of treatment to a person within the District, by a physician located outside the District as a result of transmission of the person's medical data by electronic or other means from within the District to the physician or to the physician's agent; (vi) Maintaining an office or other place for the purpose of examining persons afflicted with disease, injury, or defect of body or mind; (vii) Advertising or representing in any manner that one is authorized to practice medicine; or (viii) Using the designation "Doctor of Medicine," "Doctor of Osteopathy," "physician," "surgeon," "physician and surgeon," "M.D.," or "D.O.," or a similar designation, or any combination thereof, in the conduct of an occupation or profession pertaining to the prevention, diagnosis, or treatment of human disease or condition, unless the designation additionally contains the description of another branch of the healing arts for which one holds a valid license.
FL			**Title XXXII Regulation of Professions and Occupations, Chapter 458 Medical Practice, 458.305 Definitions** "'Practice of medicine' means the diagnosis, treatment, operation, or prescription for any human disease, pain, injury, deformity, or other physical or mental condition."

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GA		X	**2020 Georgia Code Title 43 – Professions and Businesses Chapter 34 – Physicians, Acupuncture, Physician Assistants, Cancer and Glaucoma Treatment, Respiratory Care, Clinical Perfusions, and Orthotics and Prosthetics Practice Article 2 – Medical Practice Sect 43-34-21. Definitions** "'To practice medicine,' 'the practice of medicine,' or 'practice medicine' means to hold oneself out to the public as being engaged in the diagnosis or treatment of disease, defects, or injuries of human beings; or the suggestion, recommendation, or prescribing of any form of treatment for the intended palliation, relief, or cure of any physical, mental, or functional ailment or defect of any person with the intention of receiving therefor, either directly or indirectly, any fee, gift, or compensation whatsoever; or the maintenance of an office for the reception, examination, and treatment of persons suffering from disease, defect, or injury of body or mind;…"
GU		X	**10 GCA Health and Safety. Ch. 12 Medical Practices** (b) The Healing Art means the art of prevention, detecting or attempting to detect the presence of any disease; of determining or attempting to determine the nature and state of any disease, if present; or preventing, relieving, correcting or curing of or attempting to prevent, relieve, correct or cure any disease; of safeguarding or attempting to safeguard the life of any woman or infant through pregnancy and parturition; and of doing or attempting to do any of the acts enumerated in this Subsection. The healing arts include, but are not limited to, optometry, nursing, chiropractic, dentistry, medicine and surgery, physician assistants, podiatry, psychology, osteopathic, pharmacy, physical therapy, acupuncture, speech language pathology, audiology, respiratory therapy, nutritionist/clinical dietician, cosmetology and veterinary medicine. (c) To Practice means to do or attempt to do, or to hold oneself out or to allow oneself to be held out as ready to do, any act enumerated in Subsection(b) of this Section as constituting a part of the healing art for a fee, gift, reward or in anticipation of any fee, gift or reward whether tangible or intangible.
HI			**Hawaii Revised Statues 453-1-Practice of medicine defined** "… the practice of medicine by a physician or an osteopathic physician includes the use of drugs and medicines; surgery; manual medicine; water; electricity; hypnotism; telehealth; the interpretation of tests, including primary diagnosis of pathology specimens, medical imaging, or any physical; osteopathic medicine; any means, method, or agent, either tangible or intangible, to diagnose, treat, prescribe for, palliate, or correct disease, or prevent any human disease, condition, ailment, pain, injury, deformity, illness, infirmity, defect, physical or mental condition in the human subject."
ID		X	**Idaho Title 54 Professions, Vocations and Businesses. Chapter 18 Physicians and Physician assistants. 54-1803. Definitions.** "'Practice of medicine' means: (a) The investigation, diagnosis, treatment, correction, or prevention of or prescription for any human disease, ailment, injury, infirmity, deformity or other condition, physical or mental, by any means or instrumentality that involves the application of principles or techniques of medical science; or

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			(b) Offering, undertaking, or holding oneself out as able to do any of the acts described in paragraph (a) of this subsection." **Idaho Title 54 Professions, Vocations and Businesses. Chapter 18 Physicians and Physician assistants. 54-1844. Definitions.** "'Practice of medicine' means the clinical prevention, diagnosis or treatment of human disease, injury, or condition requiring a physician to obtain and maintain a license in compliance with the medical practice act of a member state"
IL		X	**225 ILCS 60/49.5. From ch. 111, par 4400-38** (e) An out-of-state person providing a service listed in Section 49 to a patient residing in Illinois through the practice of telemedicine submits himself or herself to the jurisdiction of the courts of this State.
IN		X	**IC 25-22.5-1-1.1 Definitions.** "(a) 'practice of medicine or osteopathic medicine' means any one (1) or a combination of the following 2) The maintenance of an office or a place of business for the reception, examination, or treatment of persons suffering from disease, ailment, defect, injury, infirmity, deformity, pain, or other conditions of body or mind. 4) Providing diagnostic or treatment services to a person in Indiana when the diagnostic or treatment services: A) are transmitted through electronic communications; and B) are on a regular, routine, and nonepisodic basis or under an oral or written agreement to regularly provide medical services. In addition to the exceptions described of section 2 of this chapter, a nonresident physician who is located outside Indiana does not practice medicine or osteopathy in Indiana by providing a second opinion to a licensee or diagnostic or treatment services to a patient in Indiana following medical care originally provided to a patient while outside Indiana.
IA		X	**Chapter 148 Medicine and Surgery and Osteopathic Medicine and Surgery. 148.1 Persons engaged in practice.** 148.1 Persons engaged in practice. For the purpose of this subtitle, the following classes of persons shall be deemed to be engaged in the practice of medicine and surgery or osteopathic medicine and surgery: 1. Persons who publicly profess to be physicians and surgeons or osteopathic physicians and surgeons, or who publicly profess to assume the duties incident to the practice of medicine and surgery or osteopathic medicine and surgery. 2. Persons who prescribe, or prescribe and furnish, medicine for human ailments or treat the same by surgery
KS		X	**Healing Arts Act 65-2802. 65-2869. Persons deemed engaged in practice of medicine and surgery.** a. Persons who publicly profess to be physicians or surgeons, or publicly profess to assume the duties incident to the practice of medicine or surgery or any of their branches. b. Persons who prescribe, recommend or furnish medicine or drugs, or perform any surgical operation of the diagnosis, cure or relief of any wounds, fractures, bodily injury, infirmity, disease, physical or mental illness or psychological disorder, of human beings.
KY		X	**311.500 Definitions for KRS 311.530 to 311.620 and 311.990(4) to (6)**

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			Except as provided in subsection (11) of this section, the 'practice of medicine or osteopathy' means the diagnosis, treatment, or correction of any and all human conditions, ailments, diseases, injuries, or infirmities by any and all means, methods, devices, or instrumentalities;
LA		X	**2011 Louisiana Laws Revised Statutes TITLE 37 – Professions and occupations RS 37:1262 – Definitions.** "The practice of medicine," whether allopathic or osteopathic, means the holding out of one's self to the public as being engaged in the business of, or the actual engagement in, the diagnosing, treating, curing, or relieving of any bodily or mental disease, condition, infirmity, deformity, defect, ailment, or injury in any human being, other than himself, whether by the use of any drug, instrument or force, whether physical or psychic, or of what other nature, or any other agency or means; or the examining, either gratuitously or for compensation, of any person or material from any person for such purpose whether such drug, instrument, force, or other agency or means is applied to or used by the patient or by another person; or the attending of a woman in childbirth without the aid of a licensed physician or midwife.
ME		X	**2021 Maine Revised Statutes: Title 32: Processions and Occupations. Chapter 48: Board of Licensure in Medicine. Subchapter 3: General Provisions. Sect. 3300-D. Interstate practice of telemedicine.** 5. Jurisdiction. In registering to provide interstate telehealth services to residents of this State under this section, a physician agrees to be subject to the laws and judicial system of this State and board rules with respect to providing medical services to residents of this State.
MD		X	**Statutes Article – Health Occupations Sect. 14-101** (O) (1) "Practice medicine" means to engage, with or without compensation, in medical: (i) Diagnosis; (ii) Healing; (iii) Treatment; or (iv) Surgery. 2) "Practice medicine" includes doing, undertaking, professing to do, and attempting any of the following: (i) Diagnosing, healing, treating, preventing, prescribing for, or removing any physical, mental, or emotional ailment or supposed ailment of an individual: 1. By physical, mental, emotional, or other process that is exercised or invoked by the practitioner, the patient, or both; or 2. By appliance, test, operation, or treatment; (ii) Ending of a human pregnancy; and (iii) Performing acupuncture as provided under sec. 14-504 of this title.
MA			**243 CMR: Board of Registration In Medicine. 243 CMR 2.00: Licensing and the Practice of Medicine. 2.01: Scope and Construction** The Practice of Medicine means the following conduct, the purpose or reasonably foreseeable effect of which is to encourage the reliance of another person upon an individual's knowledge or skill in the maintenance of human health by the prevention, alleviation, or cure of disease, and involving or reasonably thought to involve an assumption of responsibility for the other person's physical or mental well being: diagnosis, treatment, use of instruments or other devices, or the

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			prescribing, administering, dispensing or distributing of drugs for the relief of diseases or adverse physical or mental conditions. (a) A person who holds himself or herself out to the public as a physician or surgeon, or with the initials "M.D." or "D.O." in connection with his or her name, and who also assumes responsibility for another person's physical or mental well being, is engaged in the practice of medicine (b) The Practice of Medicine includes the following: 1. Telemedicine, as defined in 243 CMR 2.01: Telemedicine; and 2. Providing an independent medical examination or a disability evaluation.
MI		X	**Mich. Comp. Laws § 333.17001 Definitions; principles of construction.** (j) "Practice of medicine" means the diagnosis, treatment, prevention, cure, or relieving of a human disease, ailment, defect, complaint, or other physical or mental condition, by attendance, advice, device, diagnostic test, or other means, or offering, undertaking, attempting to do, or holding oneself out as able to do, any of these acts.
MN		X	**147.081 PRACTICING WITHOUT LICENSE; PENALTY. Subd. 3.Practice of medicine defined.** For purposes of this chapter, a person not exempted under section 147.09 is "practicing medicine" or engaged in the "practice of medicine" if the person does any of the following: (1) advertises, holds out to the public, or represents in any manner that the person is authorized to practice medicine in this state; (2) offers or undertakes to prescribe, give, or administer any drug or medicine for the use of another; (3) offers or undertakes to prevent or to diagnose, correct, or treat in any manner or by any means, methods, devices, or instrumentalities, any disease, illness, pain, wound, fracture, infirmity, deformity or defect of any person; (4) offers or undertakes to perform any surgical operation including any invasive or noninvasive procedures involving the use of a laser or laser assisted device, upon any person; or (5) offers to undertake to use hypnosis for the treatment or relief of any wound, fracture, or bodily injury, infirmity, or disease.
MS	X	X	**MS Admin. Code Title 30, Part 2635, Rule 5.2.** "The practice of medicine is deemed to occur in the location of the patient."
MO			**Title XII Public Health and Welfare. Chapter 191. 191.1145. Definitions** 3. In order to treat patients in this state through the use of telemedicine or telehealth, health care providers shall be fully licensed to practice in this state and shall be subject to regulation by their respective professional boards.
MP			**Title 185: Commonwealth Health Care Professions Licensing Board. Chapter 185-10 Commonwealth Health Care Processions Licensing Board Regulations. Part 4200 – Physician – Doctor of Osteopathy. Sect 185-10-4201 Definitions** (dd) "Practice of Medicine" means: (1) Holding out one's self to the public as being able to diagnose, treat, prescribe for, palliate, or prevent any human disease, ailment, injury, deformity, or physical or mental condition, whether by the use of drugs, surgery, manipulation, electricity, or any physical, mechanical, or other means whatsoever;

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			(2) Suggesting, recommending, prescribing, or administering any form of treatment, operation, or healing for the intended palliation, relief, or cure of any physical or mental disease, ailment, injury, condition, or defect of any person with the intention of receiving, either directly or indirectly, any fee, gift or compensation whatsoever; (3) The maintenance of an office or other place to meet persons for the purpose of examining or treating persons afflicted with disease, injury, or clinical defect of the body or mind; (4) Using the title "Doctor," "Doctor of Medicine," "Doctor of Osteopathy," "Physician," "Surgeon," "Dr.," "M.D.," "D.O.," or any word or abbreviation to indicate or induce others to believe that one is engaged in the practice of medicine defined herein; (5) Performing any kind or surgical operation upon a human being.
MT		X	**Montana Code 2021 Title 37 Professions and Occupations Chapter 3. Medicine Part 1. General Definitions 31-3-102** "Practice of medicine" means the diagnosis, treatment, or correction of or the attempt to or the holding of oneself out as being able to diagnose, treat, or correct human conditions, ailments, diseases, injuries, or infirmities, whether physical or mental, by any means, methods, devices, or instrumentalities, including electronic and technological means such as telemedicine. If a person who does not possess a license to practice medicine in this state under this chapter and who is not exempt from the licensing requirements of this chapter performs acts constituting the practice of medicine, the person is practicing medicine in violation of this chapter.
NC			**Chapter 90 Medicine and Allied Occupations. Article 1. Practice of Medicine. Sect 90-1.1. Definitions.** The practice of medicine or surgery. - Except as otherwise provided by this subdivision, the practice of medicine or surgery, for purposes of this Article, includes any of the following acts: a. Advertising, holding out to the public, or representing in any manner that the individual is authorized to practice medicine in this State. b. Offering or undertaking to prescribe, order, give, or administer any drug or medicine for the use of any other individual. c. Offering or undertaking to prevent or diagnose, correct, prescribe for, administer to, or treat in any manner or by any means, methods, or devices any disease, illness, pain, wound, fracture, infirmity, defect, or abnormal physical or mental condition of any individual, including the management of pregnancy or parturition. d. Offering or undertaking to perform any surgical procedure on any individual. f. The performance of any act, within or without this State, described in this subdivision by use of any electronic or other means, including the Internet or telephone.
ND		X	**Chapter 43-17 Physicians and Surgeons. 43-17-01. Definitions.** 5. "Practice of medicine" includes the practice of medicine, surgery, and obstetrics. The following persons are regarded as practicing medicine: a. A person that holds out to the public as being engaged within this state in the diagnosis or treatment of diseases or injuries of human beings.

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			b. A person that suggests, recommends, or prescribes any form of treatment for the intended relief or cure of any physical or mental ailment of any individual, with the intention of receiving, directly or indirectly, any fee, gift, or compensation. c. A person that maintains an office for the examination or treatment of individuals afflicted with disease or injury of the body or mind.
NE		X	**Nebraska Revised Statute 38-2024 Practice of Medicine and Surgery, defined.** Persons who are physically located in another state but who, through the use of any medium, including an electronic medium, perform for compensation any service which constitutes the healing arts that would affect the diagnosis or treatment of an individual located in this state.
NH		X	**Title XXX Occupations and Professions. Chapter 329 Physicians and Surgeons. Section 329:1-d Telemedicine.** II. An out-of-state physician providing services by means of telemedicine shall be deemed to be in the practice of medicine and shall be required to be licensed under this chapter.
NJ		X	**NJ State Board of Medical Examiners Law. Article 1 Practice of Medicine and Surgery in General. 45:9-5.1. Definitions.** "the practice of medicine or surgery" and the phrase "the practice of medicine and surgery" shall include the practice of any branch of medicine and/or surgery, and any method of treatment of human ailment, disease, pain, injury, deformity, mental or physical condition
NM			**NM Statutes Annotated. Sec. 61-6-6-(K).** "The practice of medicine across state lines means the rendering of a written or otherwise documented medical opinion concerning diagnosis or treatment of a patient within this state, by a physician located outside this state, as a result of transmission of individual patient data by electronic, telephonic or other means from within this state, to the physician or the physician's agent, OR the rendering of treatment to a patient within this state, by a physician located outside this state, as a result of transmission of individual patient data by electronic, telephonic or other means from within this state to the physician or the physician's agent."
NV		X	**NRS 630.020 "Practice of medicine" defined.** "Practice of medicine" means: 1. To diagnose, treat, correct, prevent or prescribe for any human disease, ailment, injury, infirmity, deformity or other condition, physical or mental, by any means or instrumentality, including, but not limited to, the performance of an autopsy. 2. To apply principles or techniques of medical science in the diagnosis or the prevention of any such conditions. 3. To perform any of the acts described in subsections 1 and 2 by using equipment that transfers information concerning the medical condition of the patient electronically, telephonically or by fiber optics, including, without limitation, through telehealth, from within or outside this State or the United States. **NRS 629.515** Except as otherwise provided in this subsection, before a provider of health care who is located at a distant site may use telehealth to direct or manage the care or render a diagnosis of a patient who is located at an originating site in this State or

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			write a treatment order or prescription for such a patient, the provider must hold a valid license or certificate to practice his or her profession in this State
NY			**NY Education Law Article 131, Medicine. Sect 6521. Definition of practice of medicine.** The practice of the profession of medicine is defined as diagnosing, treating, operating or prescribing for any human disease, pain, injury, deformity or physical condition.
OH		X	**State medical Board of Ohio Position Statement on Telemedicine** The "practice of telemedicine" is defined in Ohio as the practice of medicine in this state through the use of any communication, including oral, written or electronic communication, by a physician located outside this state.
OK		X	**Oklahoma Allopathic Medical and Surgical Licensure and Supervision Act. Tite 59 O.S., Sect. 492. Practice of Medicine and Surgery – Title - Hospital** C. The definition of the practice of medicine and surgery shall include, but is not limited to: b. Except as provided in subsection D of this section, performance by a person within or outside of this state, through an ongoing regular arrangement, of diagnostic or treatment services, including but not limited to, stroke prevention and treatment, through electronic communications for any patient whose condition is being diagnosed or treated within this state. A person who performs any of the functions covered by this subparagraph submits himself or herself to the jurisdiction of the courts of this state for the purposes of any cause of action resulting from the functions performed.
OR			**Chapter 677 – Regulation of Medicine, Podiatry and Acupuncture. Sect. 677.085** What constitutes practice of medicine. A person is practicing medicine if the person does one or more of the following: (1) Advertise, hold out to the public or represent in any manner that the person is authorized to practice medicine in this state. (2) For compensation directly or indirectly received or to be received, offer or undertake to prescribe, give or administer any drug or medicine for the use of any other person. (3) Offer or undertake to perform any surgical operation upon any person. (4) Offer or undertake to diagnose, cure or treat in any manner, or by any means, methods, devices or instrumentalities, any disease, illness, pain, wound, fracture, infirmity, deformity, defect or abnormal physical or mental condition of any person. (5) Except as provided in ORS 677.060, append the letters "M.D." or "D.O." to the name of the person, or use the words "Doctor," "Physician," "Surgeon," or any abbreviation or combination thereof, or any letters or words of similar import in connection with the name of the person, or any trade name in which the person is interested, in the conduct of any occupation or profession pertaining to the diagnosis or treatment of human diseases or conditions mentioned in this section. **Chapter 677 – Regulation of Medicine, Podiatry and Acupuncture. Sect. 677.135** "Practice of medicine across state lines" defined (1) The rendering directly to a person of a written or otherwise documented medical opinion concerning the diagnosis or treatment of that person located within this state for the purpose of patient care by a physician or physician

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	Statutes and/or regulations explicitly defines that the practice of medicine occurs where the patient is located	Member of IMLC and affirms practice of medicine occurs where the patient is located	Definition & Statute/Regulation Citation
			assistant located outside this state as a result of the transmission of individual patient data by electronic or other means from within this state to that physician, the physician's agent or a physician assistant; or (2) The rendering of medical treatment directly to a person located within this state by a physician or a physician assistant located outside this state as a result of the outward transmission of individual patient data by electronic or other means from within this state to that physician, the physician's agent or a physician assistant.
PA		X	
PR			
RI		X	**Licensure and Discipline of Physicians (216-RICR-40-05-1) 1.2 Definitions.** "Practice of medicine" means the practice of allopathic and osteopathic medicine. Any person shall be regarded as practicing medicine within the meaning of the Act who holds himself or herself out as being able to diagnose, treat, perform surgery, use a laser/intense pulsed light, or prescribe for any person for disease, pain, injury, deformity or physical or mental condition or prescribe for any person ill or alleged to be ill with disease, pain, injury, deformity or abnormal physical or mental condition, or who shall either profess to heal, offer or undertake, by any means or method, to diagnose, treat, perform surgery, or prescribe for any person for disease, pain, injury, deformity or physical or mental condition. In addition, one who attaches the title M.D., physician, surgeon, D.O., osteopathic physician and surgeon, or any other similar word or words or abbreviation to his or her name indicating that he or she is engaged in the treatment or diagnosis of the diseases, injuries or conditions of persons shall be held to be engaged in the practice of medicine. Non-ablative treatment is part of the practice of medicine.
SC			**Title 40 – Professions and Occupations Chapter 47 Physicians and Miscellaneous Health Care Professionals. Article 1 General Provisions. Section 40-47-10. 36.** "Practice of Medicine" means: (a) Advertising, holding out to the public or representing in any manner that one is authorized to practice medicine in this State; (b) Offering or undertaking to prescribe, order, give, or administer any drug or medicine for the use of any other person; (c) Offering or undertaking to prevent or to diagnose, correct or treat in any manner, or by any means, methods, or devices, disease, illness, pan, wound, fracture, infirmity, defect, or abnormal physical or mental condition of a person, including the management of pregnancy and parturition; (d) Offering or undertaking to perform any surgical operation upon a person; (e) Rendering a written or otherwise documented medical option concerning the diagnosis or treatment of a patient or the actual rendering of treatment to a patient within this State by a physician located outside the state as a result of individual patient data by electronic or other means from within a state to such physician or his agent
SD		X	**Chapter 36-2 Practitioners of Healing Arts in General. 36-2-1. Definition of terms.** "Healing art," "healing," "art of healing," "practicing healing," "practicing of healing," any system, treatment, operation, diagnosis, prescription, or practice for the ascertainment, cure, relief, palliation, adjustment, or practice for the ascertainment, cure, relief, palliation, adjustment, or correction of any human

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	Statutes and/or regulations explicitly defines that the practice of medicine occurs where the patient is located	Member of IMLC and affirms practice of medicine occurs where the patient is located	Definition & Statute/Regulation Citation
			disease, ailment, deformity, injury, unhealthy or abnormal physical or mental condition;
TN		X	**2010 Tennessee Code Title 63 – Professions of the Healing Arts. Chapter 6 – Medicine and Surgery. Part 2 – General Provisions. 63-6-204 – Practice of medicine defined.** (a) (1) Any person shall be regarded as practicing medicine, within the meaning of this chapter, who treats, or professes to diagnose, treat, operates on or prescribes for any physical ailment or any physical injury to or deformity of another.
TX		X	**Occupations Code. Title 3. Health Professions. Subtitle B. Physicians. Chapter 151. General Provisions. Subchapter A. General Provisions. Sec. 151.002. Definitions.** (13) "Practicing medicine" means the diagnosis, treatment, or offer to treat a mental or physical disease or disorder or a physical deformity or injury by any system or method, or attempt to effect cures of those conditions…
UT		X	**Utah Medical Practice Act. Part 1 – General Provisions. 58-67-102. Definitions.** (12) (a) "Practice of medicine" means: (i) to diagnose, treat, correct, administer anesthesia or prescribe for any human disease, ailment, injury, infirmity, deformity, pain or other condition, physical or mental, real or imaginary, including to perform cosmetic medical procedures, or to attempt to do so, by any means or 2 instrumentality, and by an individual in Utah or outside the state upon or for any human within the state; (ii) when a person not licensed as a physician directs a licensee under this chapter to withhold or alter the health care services that the licensee has ordered; (iii) to maintain an office or place of business for the purpose of doing any of the acts described in Subsection (12)(a) whether or not for compensation;
VT		X	**26 V.S.A. Sect. 1311. Definitions.** (1) "Practice of medicine" means: (F) rendering a written or otherwise documented medical opinion concerning the diagnosis or treatment of a patient or the actual rendering of treatment to a patient within the State by a physician located outside the State as a result of the transmission of individual patient data by electronic or other means from within the State to the physician or his or her agent;
VI			**Title 27, Chapter 1, Subchapter IIa. Telehealth Act. Sect. 45d Telemedicine Licensure.** (b) No person shall practice or attempt to practice medicine at a distant site between the Virgin Islands and another United States jurisdiction without first complying with the provisions of this subchapter and without being a holder, of a Virgin Islands medical license.
VA	X		**Telemedicine Guidance. Doc. # 85-12. VA Board of Medicine. P. 2 & 4-5 (Aug. 19, 2021).** The practice of medicine occurs where the patient is located at the time telemedicine services are used, and insurers may issue reimbursements based on where the practitioner is located.
WA	X	X	**RCW 18.71.011 Definition of practice of medicine - Engaging in practice of chiropractic prohibited, when.**

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	Statutes and/or regulations explicitly defines that the practice of medicine occurs where the patient is located	Member of IMLC and affirms practice of medicine occurs where the patient is located	Definition & Statute/Regulation Citation
			A person is practicing medicine if he or she does one or more of the following: (1) Offers or undertakes to diagnose, cure, advise, or prescribe for any human disease, ailment, injury, infirmity, deformity, pain or other condition, physical or mental, real or imaginary, by any means or instrumentality; (2) Administers or prescribes drugs or medicinal preparations to be used by any other person; (3) Severs or penetrates the tissues of human beings; Telehealth in Washington State | Washington State Department of Health Telehealth care takes place where the patient is located at the time of the appointment.
WV	X	X	**§30-3-13a. Telemedicine practice; requirements; exceptions; definitions; rule-making.** (1) The practice of medicine occurs where the patient is located at the time the telemedicine technologies are used.
WI		X	**Chapter 448 Medical Practices. Subchapter I General Provisions. 448.01 Definitions.** "Practice of medicine and surgery" means: To examine into the fact, condition or cause of human health or disease, or to treat, operate, prescribe or advise for the same, by any means or instrumentality. To apply principles or techniques of medical sciences in the diagnosis or prevention of any of the conditions described in par. (a) and in sub. (2). To penetrate, pierce or sever the tissues of a human being. To offer, undertake, attempt or do or hold oneself out in any manner as able to do any of the acts described in this subsection.
WY		X	**Chapter 26 – Physicians and Surgeons. Article 1- General Provisions. 33-26-102. Definitions.** (xi) "Practicing medicine" means any person who in any manner: (A) Advertises, holds out, or represents to the public that he is authorized to practice medicine in this state; or (B) Offers or undertakes to prevent, diagnose, correct or treat, in any manner, by any means, method or device, any human disease, illness, pain, wound, fracture, infirmity, defect or abnormal physical or mental condition, injury, deformity or ailment, including the management of pregnancy and parturition; (E) Offers or undertakes to prescribe, order, give or administer drugs which can only be obtained by prescription according to law; or (F) Renders a determination of medical necessity or appropriateness of proposed treatment.

Last Updated: September 2022

For informational purposes only: This document is not intended as a comprehensive statement of the law on this topic, nor to be relied upon as authoritative. Non-cited laws, regulation, and/or policy could impact analysis on a case-by-case or state-by-state basis. All information should be verified independently.

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14. BINDING ARBITRATION IN HEALTH INSURANCE CONTRACTS

Reference committee hearing; see report of Reference Committee B.

HOD ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS
REMAINDER OF REPORT FILED
See Policy D-435.964

At the 2025 Annual Meeting of the American Medical Association (AMA) House of Delegates (HOD), the HOD adopted Policy D-435.967 "Binding Arbitration in Health Insurance Contracts," which directs the following:

> That our American Medical Association will study the effects of binding arbitration in health insurance contracts with physicians.

Testimony received by the HOD regarding Policy D-435-967expressed concerns that binding arbitration clauses in health insurance contracts limit physicians' legal recourse, reduce transparency, and can disproportionately favor insurers.

DISCUSSION

General Differences Between Binding Arbitration and Litigation

Binding arbitration is an alternative to litigation as a means of resolving disputes. Arbitration agreements are typically included in participation agreements between physicians and health insurers. Arbitration agreements usually state that proceedings will be conducted according to rules adopted by the American Arbitration Association, the American Health Law Association, or JAMS.

Arbitration is less formal than litigation, and the specific procedures of any given arbitration proceeding can vary widely based on the choices the parties make in their arbitration agreement. Arbitration agreements often forgo the application of the formal rules of civil procedure, discovery, and the admissibility of evidence that would otherwise apply in litigation.

Court proceedings are generally open to the public and court filings are usually publicly available. Arbitrations are typically private, where the parties agree to keep the proceedings and arbitration award confidential.

Court cases are often assigned at random to generalist judges, but in arbitration the parties may have a direct role in choosing the arbitrator who will adjudicate the dispute. Parties are often able to select experienced arbitrators with specialized knowledge.

Finally, while trial courts' judgments are subject to review by an appellate court with authority to correct erroneous rulings, arbitration awards are usually not reviewable by courts except on very narrow grounds that focus on arbitrator misconduct rather than legal or factual errors.

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Commonly Discussed Pros and Cons of Arbitration

The effects of binding arbitration in physician contracts with health insurers can be studied by examining the commonly discussed pros and cons of arbitration vis-à-vis litigation.

Potential Advantages of Arbitration

Arbitration may have several advantages when compared with litigation. However, some advantages may not be fully realized when the parties to arbitration agreements differ significantly in bargaining power, which can be the case when physicians and health insurers are the negotiating parties. Unequal bargaining power may enable health insurers to impose on physicians mandatory binding arbitration agreements that favor insurers.

As noted above, arbitration proceedings are usually less formal and complex than those involved in litigation, which can make arbitration less expensive and a faster way to resolve disputes. For example, physicians and health insurers may agree to limit discovery, e.g., restrict the number of depositions, interrogatories, document requests, etc. Arbitration may also settle disputes more efficiently because physicians and health insurers may be able to schedule hearings more quickly than in judicial proceedings, where a judge must fit hearing dates in among many other cases.

Another advantage frequently cited is the ability to retain arbitrators with specialized knowledge. If the dispute between a physician practice and a health insurer concerns reimbursement, the parties may be able to select an arbitrator who is familiar with coding, payment rules, fee schedules, etc., about which a judge may know very little. In such cases, the arbitrator's expertise could result in a fairer, timelier, and less costly resolution because the parties will not need to educate a judge and jury about the technical aspects of disputes that frequently occur between physicians and health insurers.

The finality of the arbitrator's decision may make arbitration cheaper and more efficient than judicial proceedings. Only in very limited circumstances may a party disagreeing with an arbitrator's decision appeal that decision to a court. Consequently, parties do not spend money or prolong the dispute process by subsequent appeals that are available in litigation.

Potential Disadvantages of Arbitration

Arbitration may not always be less expensive than litigation. Filing fees can be much higher than they are in judicial proceedings. Unlike judges, arbitrators charge hourly fees for their services, and it is not unusual for arbitration agreements between physicians and health insurers to call for three arbitrators to hear disputes above a specific threshold, e.g., $2,000,000. Thus, arbitrator fees can end up being quite costly. And physicians still must pay for attorneys just as they would in litigation.

The limited ability to appeal an arbitration decision is a potential drawback of arbitration just as it may potentially be advantageous, since a physician will not be able to have a court review an adverse arbitration decision.

Confidentiality may have its advantages, but it also may give rise to a lack of transparency that can be disadvantageous. If arbitration decisions are confidential, a physician will not be able to find out how an arbitrator has ruled in past disputes, e.g., whether the arbitrator has a reputation for competency and fairness. Not having this kind of information can make it more difficult for a physician to request, from his or her perspective, the best arbitrator to hear any given dispute.

Finally, in cases where a health insurer may have significantly more bargaining power than the physician, the arbitration agreement may require the physician to waive rights that would apply in litigation or otherwise agree to unfavorable terms. For example, the arbitration agreement may restrict the statute of limitations within which the physician must file a dispute, limit the damages that an arbitrator may award, waive pre-judgment interest, waive the right to join with other physicians to resolve similar disputes, including but not limited to class actions or class arbitrations. The arbitration agreement may require the physician to arbitrate the dispute in person at a location, e.g., the health insurer's offices, which may not be convenient. The agreement may state that the party losing the arbitration must pay the winner's costs, and it is highly likely that a physician cannot risk incurring such costs to the extent a health insurer can.

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The Federal Arbitration Act and State Arbitration Laws

Enacting legislation is the obvious strategy to address unfavorable aspects of binding arbitration agreements. State legislatures and state courts have attempted to place conditions on binding arbitration clauses to deal with situations where one party to the agreement may have more bargaining power than the other party. Such efforts are, however, usually preempted by the Federal Arbitration Act (FAA).

Congress passed the FAA in 1925 to ensure that arbitration agreements were enforced, in part to address growing concerns about the costliness and delays of litigation. Section 2 of the FAA states in part that:

> [a] written provision in any maritime transaction or a contract evidencing a transaction involving commerce to settle by arbitration a controversy thereafter arising out of such contract or transaction…shall be valid, irrevocable, and enforceable, save upon such grounds as exist at law or in equity for the revocation of any contract.

According to the U.S. Supreme Court (Court), in enacting Section 2 of the FAA Congress "declared a national policy favoring arbitration and withdrew the power of the states to require a judicial forum for the resolution of claims which the contracting parties agreed to resolve by arbitration."[1] The Court has also determined that the FAA preempts state laws that treat arbitration agreements differently than other contracts. So, state laws that "single out" arbitration agreements for special treatment are preempted by the FAA. Based on these and other pronouncements, courts regularly rule that the FAA preempts state laws that interfere with, or place conditions on, arbitration agreements.

The Court has in numerous cases decided that the FAA preempts a particular state statute or state court ruling. For example, in *Southland Corp. v. Keating*, 465 U.S. 1, 10 (1984), the Court held that the FAA preempted a state law that forced disputes to be heard in court. In *Doctor's Assocs., Inc. v. Casarotto*, 517 U.S. 681, 687 (1996), the FAA preempted a Montana law dictating that an arbitration agreement could only be enforced if the agreement on its first page stated that the agreement was subject to arbitration in underlined and capital letters. The *Court in Preston v. Ferrer*, 552 U.S. 346 (2008), ruled that the FAA preempted a state law that required disputes to be first heard by a state administrative agency before parties could arbitrate. *In Kindred Nursing Centers Limited Partnership v. Clark*, 581 U.S. 246 (2017) the FAA preempted a Kentucky rule stating that a person holding a power of attorney could not enter into an arbitration agreement for someone else unless the power of attorney specifically said so.[2] The Court found that the Kentucky rule failed "to put arbitration agreements on an equal plane with other contacts" and that the FAA also "displaces any rule that covertly accomplishes the same objective by disfavoring contracts that (oh so coincidentally) have the defining features of arbitration agreements."[3]

Thus, as things stand today, a state legislative strategy to place conditions on arbitration agreements between physicians and health insurers is not likely to be successful unless the FAA is significantly amended.

Amending the Federal Arbitration Act

The FAA would have to be amended so that conditions or restrictions could be placed on binding arbitration agreements between physicians and health insurers. Since its enactment over one hundred years ago, Congress has made only a few, very specific, amendments to the FAA.[4] Bills introduced in Congress proposing to make more significant changes to the FAA have not been successful. Presently, it is unlikely that Congress will make the kinds of changes to the FAA necessary to alter the current status of binding arbitration agreements between physicians and health insurers.

The AMA Should Provide Resources to Physicians

The Board of Trustees fully understands that unequal bargaining power between a health insurer and a physician may result in a physician being bound by an arbitration agreement that disproportionally favors the insurer, and that physicians need assistance. Even though a legislative approach to addressing concerns that physicians can have about binding arbitration is not likely to succeed at this time, the AMA can create resources to support physicians who are being asked to sign binding arbitration agreements. These resources could help physicians understand the possible advantages and disadvantages of binding arbitration and the extent to which those advantages and disadvantages are reflected in arbitration agreements offered to them. This information will be designed to help physicians negotiate more favorable arbitration agreements when they have the power to do so. But even if physicians cannot negotiate,

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resources will help physicians evaluate the arbitration agreements offered to them so that they can fully understand how to exercise the rights they do possess.

CONCLUSION

The Board, therefore, recommends that the HOD modify policy D-435.967, "Binding Arbitration in Health Insurance Contracts" by adding a new directive to D-435.967 requiring that our AMA create resources to help physicians evaluate binding arbitration agreements with health insurers so that physicians can identify the advantages and disadvantages that may be present in those agreements. The Board also recommends modifying D-435.967 by rescinding language calling on the American Medical Association to study the effects of binding arbitration in health insurance contracts with physicians, since this report constitutes the required study.

RECOMMENDATION

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

1. That our American Medical Association Policy D-435.967, "Binding Arbitration in Health Insurance Contracts," be rescinded having been accomplished by this report.
2. That our AMA create resources to help physicians evaluate binding arbitration agreements with health insurers so that physicians can identify the advantages and disadvantages that may be present in those agreements. Resources shall include, but not be limited to: (1) developing model arbitration language that protects physicians when such clauses are used; (2) establishing fairness principles or standards for arbitration provisions in physician-insurer contracts that include but are not limited to clear timelines, enforcement mechanisms, reasonable limits on arbitration costs, neutral arbitrator selection, and safeguards against venue manipulation; (3) identifying specific contract red flags such as venue restrictions that physicians should be aware of when reviewing arbitration clauses; and (4) encouraging greater transparency or reporting around arbitration outcomes.
3. That our AMA (1) opposes requiring mandatory binding arbitration as a condition of participation in an insurance company's provider network; (2) supports a physician's right to choose between arbitration and the public court system after a dispute arises, rather than being forced to waive their right to a jury trial; (3) believes that no physician should be required to participate in an arbitration or mediation process that is not the result of meaningful mutual agreement between the physician and health insurer; (4) advocates that all arbitration awards involving physician-payer disputes be reported to a centralized de-identified database to ensure transparency and to identify patterns of frequent bad-faith claims settlement practices by insurers.

Fiscal Note: Less than $500.

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2 *Kindred Nursing Centers Limited Partnership v. Clark*, 581 U.S. 246, 250 (2017)
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4 A recent example was the 2022 enactment of the Ending Forced Arbitration of Sexual Assault and Sexual Harassment Act (Act) which was first introduced in 2017. The Act prohibits employers from requiring employees or contractors to arbitrate sexual assault or sexual harassment claims.

15. PROTECTING THE PRESCRIPTIVE AUTHORITY OF PLENARY LICENSED PHYSICIANS

Reference committee hearing; see report of Reference Committee B.

HOD ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS
REMAINDER OF REPORT FILED
See Policies D-120.915, D-120.920 and H-120.947

At the 2025 Annual Meeting of the American Medical Association (AMA) House of Delegates (HOD), Resolution 204-A-25, "Protecting the Prescriptive Authority of Plenary Licensed Physicians," was adopted. This resolution resulted in Policy D-120.920, "Preserving Patients' Ability to Have Legally Valid Prescriptions Filled." Item one of this policy directs the AMA to do the following:

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1. Our AMA will 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.

Testimony universally acknowledged that pharmacists play an important role as part of a physician-led team. Testimony further highlighted physicians' appreciation for their pharmacy colleagues to assist with medication safety. Questions and concerns arise, however, when pharmacists make determinations that go beyond their education and training, including making decisions to withhold medication from patients after it has been prescribed by a physician for a legitimate medical purpose in the usual course of professional practice. This report studies the national prevalence and patterns of pharmacists refusing to fill valid prescriptions from plenary licensed physicians, including impact on patient outcomes and prescriber autonomy. It provides relevant background, discusses issues raised by the resolution, cites AMA policy, and makes recommendations.

BACKGROUND

In determining whether a prescription is "valid," there are multiple technical, clinical, and legal considerations that must be considered. These technical and legal considerations, which may vary slightly by state, generally require the physician to include multiple elements on the prescription, including:

- Name, address, phone number of the prescribing physician;
- Full name and address of the patient (also known as the "ultimate user");
- The drug name and strength;
- Specific directions for use, including number of times per day and number of days total;
- Quantity of the drug to be dispensed;
- Number of refills authorized by the prescriber;
- Whether the prescriber allows for substitutions, including generic versions, or whether the prescription shall be dispensed as written;
- The prescriber's signature, which may be required to be manually written, or for electronic prescriptions, additional requirements that help protect against fraud or forgery;
- Other information, such as diagnostic codes, may be required by a state;[1]
- Prescriptions for controlled substances have additional requirements, including the prescriber's DEA number;[2] and
- Electronic prescriptions for controlled substances also have additional requirements.[3]

For Medicaid claims, federal law requires physicians to include their National Provider Identifier (NPI) on the prescription.[4] It is important for the purposes of this report to note that the NPI, by itself, does not have information about a provider's specialty.[5] The NPI can be used, however, to identify a physician's specialty if a pharmacist, for example, used the National Plan and Provider Enumeration System to input a physician's name or NPI. A physician's specialty also may be evident from the name of the practice on the prescription (e.g., "John Smith, MD, Columbia Pediatric Associates," or a Google search.

In terms of the "clinical" or additional legal considerations for what constitutes a valid prescription, general guidance comes from the Controlled Substances Act (CSA). The CSA, which the Board of Trustees (the Board) acknowledges only technically applies to controlled substances, provides guidance that:

> A prescription for a controlled substance to be effective must be issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his professional practice. The responsibility for the proper prescribing and dispensing of controlled substances is upon the prescribing practitioner, but a corresponding responsibility rests with the pharmacist who fills the prescription. An order purporting to be a prescription issued not in the usual course of professional treatment or in legitimate and authorized research is not a prescription within the meaning and intent of section 309 of the Act (21 U.S.C. 829) and the person knowingly filling such a purported prescription, as well as the person issuing it, shall be subject to the penalties provided for violations of the provisions of law relating to controlled substances.

For the purposes of this report, the Board considers an "effective prescription" to carry equivalent weight and meaning as when discussing a "valid prescription." The CSA makes clear that there are mutual, complementary roles for the physician and the pharmacist. While the physician carries the primary responsibility for ensuring a prescription's validity, the pharmacist has a corresponding responsibility to ensure the prescription's validity. In fulfilling the

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corresponding responsibility, as physicians commonly experience, the pharmacist may ask questions of the patient and the physician to help ensure the medication prescribed meets the necessary safety requirements per the pharmacist's education and training. Per the CSA, the ultimate decision whether to fill and dispense a prescription, rests with the pharmacist.

DISCUSSION

The AMA believes that all qualified health care professionals play an integral role in the delivery of health care in the United States. Efficient delivery of care requires a team-based approach, which cannot exist without inter-professional collaboration between physicians, pharmacists, nurses, and other health care professionals. When each member of the health care team plays his or her optimal and unique role—a role that should be clearly defined by one's education and training, the AMA believes patients reap the benefits. The AMA defines "physician-led" in the context of team-based health care as the consistent use by a physician of the leadership knowledge, skills and expertise necessary to identify, engage and elicit from each team member the unique set of training, experience, and qualifications needed to help patients achieve their care goals, and to supervise the application of these skills.[6]

Potential Conflicts that Arise

If a pharmacist does not believe that a prescription presented by a patient or a patient surrogate has all the required technical information, the pharmacist has a professional and legal responsibility to not fill or dispense that prescription until the legal requirements are met. Similarly, if a pharmacist has cause to question other aspects about a prescription, the pharmacist generally has a legal and ethical obligation to resolve questions before filling or dispensing the prescription. There also are legal obligations put upon pharmacists who are employed by pharmacies subject to the national, multistate opioid litigation settlement agreements for pharmacists to resolve so-called "red flags."[7] Pharmacists who fill or dispense invalid prescriptions, or those for which all "red flags" have not been resolved, bear the professional and legal penalties that result. Despite this pressure, the Board continues to encourage cordial, professional interactions between physicians and pharmacists to resolve any outstanding questions and to help ensure the physician-pharmacist-patient therapeutic triad works for the benefit of patients' health and safety.[8]

The Board acknowledges that conflicts may arise, however, when a pharmacist determines that it is not within a physician's scope of practice to treat a particular medical condition. The AMA is aware of many examples of this happening across different medical specialties, including ophthalmology, dermatology, oncology, physiatry, hospice and palliative medicine, addiction medicine, obstetrics and gynecology, and surgery, to name a few. While the Board will not go into the unique circumstances of each situation, the Board remains steadfast in its support of patients retaining the ability to have legitimate prescriptions filled and dispensed. The AMA opposes pharmacists deciding on their own, to invalidate a prescription solely because of a determination that it is outside the prescribing physician's scope of practice. The AMA also opposes actions by corporations to issue corporate blocks on physicians without due process or an understanding of the unique situation/circumstances of the physician's practice.[9]

When a pharmacist refuses to fill a legitimate prescription issued in the usual course of professional practice, there is the potential for multiple negative outcomes. For a patient with an irritating skin condition, for example, the result could be worsening of symptoms and an increased chance of debilitation. For a patient with opioid use disorder (OUD), the result could be relapse and return to use of illegally made fentanyl or other substances.[10] For a patient with cancer or chronic pain, the result could be increased suffering and seeking out illicit, toxic forms of pain relief.[11,12] These are but a few examples where a pharmacist's refusal could lead to unnecessary pain and suffering.

At the same time, if a pharmacist identifies a potential drug safety issue, the outreach to the prescribing physician can be the difference between life and death. The Board does not want to put a chill into the pharmacist's essential role to help ensure drug safety and education by suggesting—let alone demanding—that a pharmacist fill and dispense any prescription transmitted by a physician. In such cases where a medication dosage was inadvertently transcribed as 100mg 2x/day instead of 10mg 2x/day, for example, ensuring the correct dose is essential. Physicians value pharmacists acting as a secondary check for technical errors, typos or potentially harmful drug-drug interactions. A resilient, productive relationship with pharmacists should be thought of as a key component of the "Swiss cheese model" of adverse event prevention.[13] This might also include automated pharmacy system alerts when certain medications are prescribed or ordered for concurrent administration.

Similarly, if a pharmacist contacts the physician to alert the physician that the patient has multiple prescriptions for the same medication from different prescribers, the Board sees this as an opportunity to improve continuity of care

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and support patient safety. Even though the Board opposes inappropriate pharmacy intrusions into the practice of medicine, we also know that beneficial physician-pharmacist communication occurs on a regular basis. Moreover, if a pharmacist determines—based on the pharmacist's education and training, combined with additional information from the prescriber and patient—that the prescription is not for a legitimate medical purpose issued in the usual course of professional practice, the Board acknowledges that the pharmacist may legally refuse to dispense that medication.

Satisfactorily determining legitimacy of the prescription from the pharmacist's point of view raises other issues, as well. As noted above, communicating with prescribers can be essential in ascertaining the legitimacy of a controlled substance prescription, although simply phoning a prescriber and inquiring if the prescription is legitimate may not be satisfactory. In the case of prescribers who may be involved in illicit prescribing practices, for example, it is highly unlikely that the response to an inquiry from the pharmacist concerning the legitimacy of the prescription would be for the prescriber to affirm that the prescription is not legitimate. This is clearly different from a situation where, for example, pharmacists refuse to fill and dispense a prescription for an eye rash because they believe only dermatologists are trained to know when it is safe to prescribe a cream for an eye rash.

A different issue arises, however, when the pharmacist's own professional judgment is effectively made null and void by an employer's policy. This may occur when a payor, pharmacy corporation, or pharmacy benefit manager impose policies that either directly or effectively force the pharmacist to refuse to fill and dispense a prescription. This is common for opioid prescriptions or treatment of OUD but also arises with stimulants and other controlled substances. In many cases, the corporate entity has essentially told their state-licensed pharmacists that any prescriptions written by specific health care professionals shall not be filled under any circumstance. The AMA would like to believe that a pharmacist's professional and ethical obligations would rise past the boundaries of a corporate edict, but we believe that it must be acknowledged that that has not been the case in far too many situations. While these situations are not those that gave rise to the underpinnings of this report, the Board would be remiss to ignore the conflicts that pharmacists often face.

National Prevalence and Patterns of Pharmacists Refusing to Fill Valid Prescriptions

How often does a pharmacist's inquiry about a patient's prescription or decision to reject a physician's prescription occur? Data regarding national prevalence or patterns is sparse, but there are a limited number of studies providing at least some insight. In one study,[14] researchers found that pharmacists were willing to refuse to dispense prescriptions that were deemed unsafe, even if they contacted the prescriber. The same study found that in other situations, even if the prescription was deemed unsafe, 75 percent of pharmacists responding said that they filled the prescription because they "felt the prescriber knew the medical history or clinical situation better than they did." The study also presented respondents with five hypothetical medication scenarios to test pharmacists' decision-making. The researchers concluded that, "Pharmacists appeared more aligned with a patient counseling and prescriber consulting role than with withholding likely dangerous prescriptions which have been verified by the prescriber."

There also is limited data with respect to specific medical conditions. A 2022 American Society of Addiction Medicine study, for example, found that 45 percent of respondents said that a "pharmacy or pharmacist declined to fill the prescription for buprenorphine."[15] Among the reasons given for the denial: (1) concern that the prescription was clinically inappropriate; (2) corporate policy limiting or prohibiting dispensing of medication; or (3) belief that the Drug Enforcement Administration (DEA) has a cap on the quantity of buprenorphine that can be dispensed. While most patients were able to ultimately have their prescription filled at a different pharmacy, 14 percent could not get their prescription filled. The outcome for those patients is unclear.

This issue has been particularly nettlesome with respect to filling and dispensing prescriptions for opioid analgesics. The Board will not delve too deeply into this issue as it has been covered many times before, but for the purposes of this report, there are several relevant points that we would like to make. First, as detailed above, there are studies showing that patients with cancer and/or chronic pain have been denied access to the medication recommended by their physician. Even Walmart, which operates more than 5,000 pharmacies[16] at its Walmart and Sam's Club locations, acknowledges that complaints have been filed against it for refusing to dispense medication in 40 states.[17] Further, a small Texas study found that, "Patients with cancer perceived difficulties when filling their opioid prescriptions, and the results suggest that negative interactions with the pharmacy and/or pharmacist contribute to their perceived difficulty."[18]

While these studies show that inappropriate actions by pharmacists do occur, the limited number makes it challenging to identify specific patterns or national prevalence of such actions. There is certainly anecdotal information concerning

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refusals to fill medications for pain or OUD because of a physician's scope of practice—and the AMA has been clear in its opposition, including drafting model state legislation to help prevent corporate pharmacy interference in the practice of medicine. The AMA has shared this model state legislation with multiple medical societies, and the AMA Advocacy Resource Center is available to support any state interested in pursuing such legislation.

To effectively identify national patterns and prevalence, however, we believe that we need more than anecdotes or secret shopper surveys. At a minimum, we need specific data sources of refusals, and reasons for such refusals. One place where such data might exist is from the parties subject to the national opioid litigation settlement agreement.[19] Provisions within the agreement require pharmacies, wholesalers, and distributors to create processes to monitor such occurrences and document actions when a prescription is "rejected pursuant to Red Flags identified by the pharmacist."[20] It is not clear, however, whether this data is publicly accessible. The Board believes that a review of such data would help illuminate the issues raised by the resolution and identified in this report.

A brief review of prominent data sources highlights other challenges with identifying relevant data. Prescription drug monitoring programs (PDMPs) are a comprehensive source of data for the prescribing and dispensing of controlled substances, but they only contain information about prescriptions dispensed. Specifically, they do not capture data on prescriptions refused. Electronic health records also would have information about patients' prescription history, but it is not likely such history includes refusals to fill. This is to say that while the Board agrees that knowing national patterns and prevalence of pharmacists refusing to fill valid prescriptions could provide actionable insight, the challenges in creating such a data set and performing the necessary retrospective analysis would be considerable. The Board, therefore, recommends that the AMA Advocacy team continue to strongly support physician-led teams, work with national pharmacy organizations in support of those teams, and encourage physicians and pharmacists to rely on each other's unique education and training to the benefit of their patients.

The Board also notes the related, but distinct issue of pharmacist refusals to dispense valid prescriptions based on personal belief. Reports of refusals to dispense contraception, emergency contraception, abortifacients, or other reproductive health medications have surfaced in at least 26 states, indicating that the issue is geographically widespread.[21] Survey data also suggest that conscience-based refusals, while not predominant, are not negligible. In one survey of community pharmacists conducted in 2010, nearly six percent indicated they would refuse to dispense and decline to transfer at least one controversial medication, including emergency contraception or abortifacients.[22] These refusals can delay or foreclose timely access to prescribed care, particularly in rural or underserved areas where alternative pharmacies may not be readily available.

Additionally, conscience refusals have been bolstered in recent years by a growing number of state legislatures that have enacted statutory "conscience clause" protections allowing pharmacists and other healthcare professionals to decline to provide certain healthcare services on moral or religious grounds.

AMA POLICY

AMA policy supports developing and building strong relationships with our pharmacy colleagues while simultaneously "protect[ing] patients' ability to have valid prescriptions filled."
(D-120.975, "Preserving Patients' Ability to Have Legally Valid Prescriptions Filled"). AMA policy also guides the AMA in efforts at the state and federal levels "to protect the authority of plenary licensed physicians to prescribe all legal medications in accordance with their training and medical judgment." (D-120.920, "Protecting the Prescriptive Authority of Plenary Licensed Physicians"). AMA policy further "opposes pharmacists being given the authority to initiate or modify prescription drug treatment except on a case-by-case basis at the specific direction of a physician." (H-160.928, "Drug Initiation or Modification by Pharmacists").

AMA policy recognizes "the contribution of pharmacy as an independent profession in assisting physicians toward the constant goal of improved patient care is recognized and commended."
(H-35.999, "Medicine and Pharmacy Relations"). The AMA "urges physicians to encourage and support the continued growth of pharmacy as a valuable and necessary member of the health team. (H-35.999, "Medicine and Pharmacy Relations"). AMA policy strongly supports a physician-led health care team that includes pharmacists for their role in support of preventing medication errors (H-120.965, "Medication Errors"), as well as for consultations with patients. (H-120.932, "Pharmacy Review of First Dose Medication").

Finally, while the AMA strongly supports pharmacists playing an integral role as part of a physician-led health care team, AMA policy "deems inappropriate inquiries from pharmacies to verify the medical rationale behind

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prescriptions, diagnoses, and treatment plans to be an interference with the practice of medicine and unwarranted. (H-35.961, "AMA Response to Pharmacy Intrusion into Medical Practice").

CONCLUSION

Refusing to fill a valid prescription issued in the usual course of professional practice for a legitimate medical purpose risks patient harm. If a pharmacist has a question to help ensure the accuracy and safety of a prescription, it is important for pharmacists to feel confident in reaching out to the prescribing physician. This does not mean, however, that pharmacists should seek information that is beyond their education and training. Nor does it mean that pharmacists have a right to refuse to fill and dispense a prescription solely because pharmacists do not agree that a physician's specialty matches what the pharmacist expects for a given prescription. Physician-pharmacist conflicts are rare, but the Board understands that they occur—and that it is incumbent upon all of us to work together for our patients' health and safety.

Given the high degree of interprofessional respect that occurs daily between physicians and pharmacists—combined with the clarity of AMA policy that simultaneously highlights the benefits of pharmacists on the health care team while opposing interference in medical practice—the Board does not believe that additional policy is required. Rather, the Board supports renewed efforts to proactively engage with our pharmacy colleagues to explore additional avenues in which the issues raised in this report might be addressed in a collaborative fashion between the two professions.

The Board, therefore, recommends that the HOD adopt new policy that focuses on convening national pharmacy organizations to identify solutions to address the issues raised in this report and to urge pharmacies subject to the national opioid litigation settlements to provide data on refusals to fill and dispense medications, including the reasons for such refusals. The Board also recommends the HOD reaffirm of Policy H-120.947, "Preserving Patients' Ability to Have Legally Valid Prescriptions Filled" as it is directly on point in terms of the issues raised by this report. Finally, the Board recommends that the HOD rescind the first item of Policy D-120.920 as this report has accomplished the directive to 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.

RECOMMENDATIONS

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

1. That our American Medical Association convene a meeting with the National Association of Boards of Pharmacy and other national pharmacy organizations to identify ways to improve communications between physicians and pharmacists about physicians' and pharmacists' corresponding responsibility and related areas, with report back at A-27.
2. That our AMA work with pharmacies subject to the national opioid litigation settlements to provide data on refusals to fill and dispense medications, including the reasons for such refusals.
3. That our AMA Policy H-120.947, "Preserving Patients' Ability to Have Legally Valid Prescriptions Filled," be reaffirmed.
4. That Policy D-120.920 "Preserving Patients' Ability to Have Legally Valid Prescriptions Filled," be amended by deletion of the first item to read as follows:

~~1. Our American Medical Association will 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.~~

1.1. Our AMA will 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.

~~3.~~2. Our AMA will reaffirm and publicize existing policy opposing unauthorized medication substitution, inappropriate pharmacy inquiries, and unauthorized treatment modification by pharmacists.

4.3. Our AMA supports 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.

~~5.~~4. Our AMA encourages interprofessional collaboration to clarify scope-of-practice boundaries, educate interested parties on the legal authority of plenary licensure, and promote policies that ensure timely patient access to physician led care.

Fiscal note: Less than $500.

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16. DEMOGRAPHIC REPORT OF THE HOUSE OF DELEGATES AND AMA MEMBERSHIP

Informational report; no reference committee hearing.

HOD ACTION: FILED

This informational report, "Demographic Report of the House of Delegates and AMA Membership," is prepared pursuant to Policy G-600.035, "House of Delegates Demographic Report," which states:

> A report on the demographics of our AMA House of Delegates will be issued annually and include information regarding age, gender, race/ethnicity, education, life stage, present employment, and self-designated specialty.

In addition, this report includes information pursuant to Policy G-635.125, "AMA Membership Demographics," which states:

> Stratified demographics of our AMA membership will be reported annually and include information regarding age, gender, race/ethnicity, education, life stage, present employment, and self-designated specialty.

This document compares the House of Delegates (HOD) with the entire American Medical Association (AMA) membership and with the overall United States physician and medical student population. Medical students are included in all references to the total physician population throughout this report to remain consistent with the bi-annual Council on Long Range Planning and Development report. In addition, residents and fellows endorsed by their states to serve as sectional delegates and alternate delegates are included in the appropriate comparisons for the state and specialty societies. For the purposes of this report, AMA-HOD includes both delegates and alternate delegates.

DATA SOURCES

Lists of delegates and alternate delegates are maintained in the Office of House of Delegates Affairs and are based on official rosters provided by the relevant society. The lists used in this report reflect 2025 year-end delegation rosters.

Data on individual demographic characteristics are taken from the AMA Physician Professional Data, which provides comprehensive demographic, medical education, and other information on all United States and international medical graduates (IMGs) who have undertaken residency training in the United States. Data on AMA membership and the total physician and medical student population are taken from the Masterfile and are based on 2025 year-end information.

Some key considerations must be kept in mind regarding the information captured in this report. Vacancies in delegation rosters mean that the total number of delegates credentialed for the November 2025 Interim Meeting is less than the 733 allocated and the number of alternate delegates credentialed is nearly always less than the full allocation. As such, the total number of delegates and alternate delegates credentialed for the 2025 Interim Meeting is 1186 rather than the 1466 allotted. Race and ethnicity information, which is provided directly by physicians, is missing for approximately 10 percent of AMA members and approximately 22 percent of the total United States physician and medical student population, limiting the ability to draw firm conclusions. Efforts to improve AMA data on race and ethnicity are part of Policy D-630.972. Improvements have been made in collecting data on race and ethnicity, resulting in a decline in reporting race/ethnicity as unknown in the HOD and the overall AMA membership.

CHARACTERISTICS OF AMA MEMBERSHIP AND DELEGATES

Table 1 presents basic demographic characteristics of AMA membership and HOD Delegates & Alternates along with corresponding figures for the entire physician and medical student population.

Data on physicians' and students' current activities appear in Table 2. This includes life stage as well as present employment and self-designated specialty.

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Table 1: Basic Demographic Characteristics of AMA Members & HOD Delegates & Alternates, December 2025

	AMA Members	All Physicians and Medical Students	HOD Delegates & Alternates (credentialed)
Total	322,123	1,612,618	1,186
Mean age (years)	46.6	52.7	53.9
Age distribution			
Under age 40	51.12%	31.52%	20.07%
40-49 years	13.31%	16.92%	19.14%
50-59 years	10.82%	15.10%	19.90%
60-69 years	8.62%	14.51%	22.93%
70 or more	16.13%	21.95%	17.96%
Gender			
Male	57.23%	60.74%	57.59%
Female	41.98%	38.57%	42.24%
Unknown	0.79%	0.69%	0.17%
Race/ethnicity			
American Indian or Alaskan Native	0.15%	0.17%	0.59%
Asian	17.50%	16.04%	16.10%
Black or African American	4.96%	4.36%	5.99%
Hispanic, Latino, or Spanish Origin	4.22%	4.31%	3.29%
Middle Eastern or North African	0.08	0.02%	0.00%
Multi-Race/Ethnicity	6,87%	5.19%	3.37%
Native Hawaiian or Other Pacific Islander	0.04%	0.03%	0.00%
White	45.08%	47.11%	58.77%
Other	1.64%	1.64%	1.60%
Unknown	19.47%	21.14%	10.29%
Education			
US or Canada	80.47%	77.49%	90.47%
IMG	19.53%	22.51%	9.53%
Life Stage			
Student2	17.18%	9.08%	5.73%
Resident2	26.61%	11.09%	8.09%
Young (under 40 or first 8 years in practice)	12.01%	15.53%	8.52%
Established (40-64)	24.01%	35.05%	48.82%
Senior (65+)	20.20%	29.25%	28.84%
Present Employment			
Self-employed solo practice	4.97%	6.40%	9.19%
Two physician practice	1.22%	1.67%	1.60%
Group practice	28.61%	39.91%	41.57%
HMO	0.25%	0.13%	0.76%
Medical school	0.74%	1.18%	3.12%
Non-government hospital	3.58%	4.55%	7.67%
State or local government hospital	3.28%	5.04%	9.95%
US government	0.69%	1.30%	2.28%
Locum Tenens	0.12%	0.16%	0.34%
Retired/Inactive	9.77%	13.16%	7.93%
Resident/Intern/Fellow	26.61%	11.09%	8.09%
Student	17.18%	9.08%	5.73%
Other/Unknown	2.97%	6.32%	1.77%
Specialty			
Family Medicine	9.21%	11.12%	11.64%
Internal Medicine	22.18%	22.67%	20.49%

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	AMA Members	All Physicians and Medical Students	HOD Delegates & Alternates (credentialed)
Surgery	12.36%	12.47%	18.72%
Pediatrics	5.93%	8.45%	4.22%
OB/GYN	4.88%	4.32%	6.91%
Radiology	3.32%	4.14%	4.89%
Psychiatry	4.28%	5.04%	4.22%
Anesthesiology	3.62%	4.27%	2.95%
Pathology	1.61%	2.02%	2.28%
Other specialty	15.41%	16.42%	17.96%
Students	17.18%	9.08%	5.73%

Appendix

Specialty classification using physician's self-designated specialties.

Major Specialty Classification	AMA Physician Masterfile Classification
Family Practice	General Practice, Family Practice
Internal Medicine	Internal Medicine, Allergy, Allergy and Immunology, Cardiovascular Diseases, Diabetes, Diagnostic Laboratory Immunology, Endocrinology, Gastroenterology, Geriatrics, Hematology, Immunology, Infectious Diseases, Nephrology, Nutrition, Medical Oncology, Pulmonary Disease, Rheumatology
Surgery	General Surgery, Otolaryngology, Ophthalmology, Neurological Surgery, Orthopedic Surgery, Plastic Surgery, Colon and Rectal Surgery, Thoracic Surgery, Urological Surgery
Pediatrics	Pediatrics, Pediatric Allergy, Pediatric Cardiology
Obstetrics/Gynecology	Obstetrics and Gynecology
Radiology	Diagnostic Radiology, Radiology, Radiation Oncology
Psychiatry	Psychiatry, Child Psychiatry
Anesthesiology	Anesthesiology
Pathology	Forensic Pathology, Pathology
Other Specialty	Aerospace Medicine, Dermatology, Emergency Medicine, General Preventive Medicine, Neurology, Nuclear Medicine, Occupational Medicine, Physical Medicine and Rehabilitation, Public Health, Other Specialty, Unspecified

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17. SUPPORTING THE INTEGRATION OF BLOOD PRESSURE VARIABILITY DATA IN ELECTRONIC MEDICAL RECORDS REPORT

Reference committee hearing; see report of Reference Committee D.

HOD ACTION: **RECOMMENDATIONS ADOPTED**
REMAINDER OF REPORT FILED
See Policy H-425.961

BACKGROUND

At the 2025 Annual Meeting, resolution 424, "Supporting the Integration of Blood Pressure Variability Date in Electronic Medical Records," was introduced by the Ohio delegation and was referred. It asks the following:

> RESOLVED that our AMA support the integration of blood pressure variability data into electronic medical records, emphasizing automated calculation capabilities similar to those established for body mass index; and be it further

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RESOLVED that our AMA support research efforts to establish pathological Blood Pressure Variability thresholds to guide dietary and exercise recommendations, sleep evaluation, risk stratification, and other evidence-based interventions by healthcare providers.

DISCUSSION

Blood pressure (BP) measurement is one of the most common procedures performed in the clinical setting and accurate BP measurement is essential to assess, diagnose, and treat hypertension. Hypertension is the most prevalent, modifiable cardiovascular disease risk factor and is the leading cause of death and disability worldwide.[1] According to the 2026 Heart Disease and Stroke Statistics, the prevalence of hypertension among US adults was 47.3 percent in 2021 to 2023.[2]

Blood pressure naturally varies throughout the day, from the time a person wakes up in the morning through sleeping overnight, due to factors including environmental circumstances, physical activity, and emotional stress. Blood pressure variability (BPV) refers to these changes in blood pressure that occur over different time periods.[3,4] Excessive long-term blood pressure variability is suggested to be defined as variation in measurements greater than 12 mm Hg, determined by deriving the standard deviation of ideally 6-7 or more clinic-based BP measurements, but this has been debated among scientific scholars.[5,6] Long term variability has been defined as clinic visit-to-visit variability, over months or years, and can be influenced by factors such as time of year (seasonal variability) and vascular stiffness. Very short-term variability occurs beat-to-beat, short-term variability occurs over a 24-hour period, and mid-term variability is defined as variability seen day-to-day (or between days).[7,8] Blood pressure variability can be calculated using standard deviation, the coefficient of variation, or variance, independent of the mean. The coefficient of the mean can be calculated by dividing the standard deviation by the mean blood pressure.[9]

Multiple studies have shown that long term BPV is associated with cardiovascular events (including stroke, myocardial infarction, coronary heart disease, and heart failure) and mortality outcomes, independent of mean blood pressure. Both mid-term and short-term BPV are associated with mortality outcomes and with poor cardiovascular outcomes (noting the link to cardiovascular outcomes is suggested to be supported by limited data).[10]

There is growing recognition of blood pressure variability as an important cardiovascular risk factor and BPV can act as a predictor of cardiovascular risk independent of average blood pressure, however it is not currently included in

[1] 2025 AHA/ACC/AANP/AAPA/ABC/ACCP/ACPM/AGS/AMA/ASPC/NMA/PCNA/SGIM Guideline for the Prevention, Detection, Evaluation and Management of High Blood Pressure in Adults: A Report of the American College of Cardiology/American Heart Association Joint Committee on Clinical Practice Guidelines. *Circulation*. 2025;152(11):e114-e218. https://doi.org/10.1161/CIR.0000000000001356

[2] 2026 Heart Disease and Stroke Statistics: A Report of US and Global Data from the American Heart Association. *Circulation*. 2026;153(9):e275-e906. https://doi.org/10.1161/CIR.0000000000001412

[3] Parati G, Stergiou GS, Dolan E, Bilo G. Blood pressure variability: clinical relevance and application. *J Clin Hypertension* (Greenwich). 2018;20(7):1133-1137.doi10.1111/jch.13304

[4] Pugalenthi, LS, Senapati, SG, Gohri, J, et al. Blood Pressure Variability (BPV) as a Novel Digital Biomarker of Multisystem Risk and Diagnostic Insight: Measurement, Mechanisms, and Emerging Artificial Intelligence Methods. Biomedicines. 2026;14(2):317. https://doi.org/10.3390/biomedicines14020317

[5] Dasa O, Smith SM, Howard G, et al. Association of 1-Year Blood Pressure Variability with Long-term Mortality Among Adults with Coronary Artery Disease: A Post Hoc Analysis of a Randomized Clinical Trial. *JAMA Network Open*. 2021;4(4):e218418.doi:10.1001/jamanetworkopen.2021.8418

[6] Lai A, Lam L, Raminemi A, Sonecha A, Sever P. Long-term blood pressure variability: an emerging cardiovascular risk factor. Br J Cardiol. 2024;31:155-9. doi:10.5837/bjc.2024.043

[7] Parati G, Stergiou GS, Dolan E, Bilo G. Blood pressure variability: clinical relevance and application. *J Clin Hypertension* (Greenwich). 2018;20(7):1133-1137.doi10.1111/jch.13304

[8] Pugalenthi, LS, Senapati, SG, Gohri, J, et al. Blood Pressure Variability (BPV) as a Novel Digital Biomarker of Multisystem Risk and Diagnostic Insight: Measurement, Mechanisms, and Emerging Artificial Intelligence Methods. Biomedicines. 2026;14(2):317. https://doi.org/10.3390/biomedicines14020317

[9] Pugalenthi, LS, Senapati, SG, Gohri, J, et al. Blood Pressure Variability (BPV) as a Novel Digital Biomarker of Multisystem Risk and Diagnostic Insight: Measurement, Mechanisms, and Emerging Artificial Intelligence Methods. Biomedicines. 2026;14(2):317. https://doi.org/10.3390/biomedicines14020317

[10] Stevens S L, Wood S, Koshiaris C, Law K, et al. Blood pressure variability and cardiovascular disease: systematic review and meta-analysis. *BMJ* 2016;354:i4098.doi10.1136/bmj.i4098

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standardized management guidelines as a therapeutic target.[11] It has been suggested that future research is needed to better understand the pathophysiology of target-organ damage and to define the physiological and pathological ranges of BPV.[12]

Electronic Health Record Integration of Blood Pressure Variability

Integration of blood pressure variability data into electronic health records would provide physicians and clinical teams with additional data to assess visit-to-visit BPV risk.[13] Automated calculation capabilities in the electronic health record (EHR) takes the burden off clinical teams to manually calculate and enter data into the system. Currently, there is no diagnosis code (ICD-10-CM) for blood pressure variability.

Lifestyle Approaches to Reduce Blood Pressure Variability

It has been proven that lifestyle modifications are critically important strategies to prevent or manage high blood pressure and hypertension. A meta-analysis conducted to assess the effectiveness of lifestyle and stress-reduction strategies for lowering BP found that the Dietary Approach to Stop Hypertension (DASH) eating plan was the most effective intervention followed by aerobic exercise, isometric resistance training, and low-sodium/high potassium salt interventions. The 2025 Guideline for the Prevention, Detection, Evaluation and Management of Hypertension outlines the approximate reduction in systolic blood pressure (SBP) for proven interventions for people with and without hypertension; for example, the DASH diet lowers SBP in patients with hypertension by approximately 5 to 8 mm Hg.[14]

The risk of adverse blood pressure variability-related outcomes may be reduced through lifestyle changes. The DASH diet, potassium supplements, reducing salt intake, engaging in moderate intensity and isometric exercises, managing stress, and quality sleep are associated with reducing BPV.[15]

Medication

As a note, several anti-hypertensive medication classes have been shown in trials to reduce blood pressure variability, such as angiotensin-converting enzyme inhibitors (ACEi) and angiotensin receptor blockers (ARBs) compared to other anti-hypertensive medications.[16]

AMA Commitment to Reducing the Burden of Chronic Diseases

The AMA MAP™ Hypertension clinical quality improvement program was designed to improve blood pressure control rates by addressing barriers to blood pressure measurement, treatment intensification, and patient engagement. The program is offered at no cost and has demonstrated effectiveness in a variety of health care settings from large health care organizations (HCO) to community health centers.

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[11] Pugalenthi, LS, Senapati, SG, Gohri, J, et al. Blood Pressure Variability (BPV) as a Novel Digital Biomarker of Multisystem Risk and Diagnostic Insight: Measurement, Mechanisms, and Emerging Artificial Intelligence Methods. Biomedicines. 2026;14(2):317. https://doi.org/10.3390/biomedicines14020317

[12] Sheikh AB, Sobotka PA, Garg I, et al. Blood Pressure Variability in Clinical Practice: Past Present, and the Future. *Journal of the American Heart Association*. 2023;12(9):e029297.doi10.1161/JAHA.122.029297

[13] Dasa O, Smith SM, Howard G, et al. Association of 1-Year Blood Pressure Variability with Long-term Mortality Among Adults with Coronary Artery Disease: A Post Hoc Analysis of a Randomized Clinical Trial. *JAMA Network Open*. 2021;4(4):e218418.doi:10.1001/jamanetworkopen.2021.8418

[14] 2025 AHA/ACC/AANP/AAPA/ABC/ACCP/ACPM/AGS/AMA/ASPC/NMA/PCNA/SGIM Guideline for the Prevention, Detection, Evaluation and Management of High Blood Pressure in Adults: A Report of the American College of Cardiology/American Heart Association Joint Committee on Clinical Practice Guidelines. *Circulation*. 2025;152(11):e114-e218. https://doi.org/10.1161/CIR.0000000000001356

[15] Pugalenthi, LS, Senapati, SG, Gohri, J, et al. Blood Pressure Variability (BPV) as a Novel Digital Biomarker of Multisystem Risk and Diagnostic Insight: Measurement, Mechanisms, and Emerging Artificial Intelligence Methods. Biomedicines. 2026;14(2):317. https://doi.org/10.3390/biomedicines14020317

[16] Pugalenthi, LS, Senapati, SG, Gohri, J, et al. Blood Pressure Variability (BPV) as a Novel Digital Biomarker of Multisystem Risk and Diagnostic Insight: Measurement, Mechanisms, and Emerging Artificial Intelligence Methods. Biomedicines. 2026;14(2):317. https://doi.org/10.3390/biomedicines14020317

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In 2024, the AMA was awarded multi-year funding as part of the Centers for Disease Control and Prevention's National Partners Cooperative Agreement. One of the initiatives is to prevent heart attacks and strokes, via improvement in blood pressure control and cholesterol management, in populations served by Community Health Centers/Federally Qualified Health Centers.

The AMA endorsed and participated in the writing and evidence-review committees for the 2025 Guideline for the Prevention, Detection, Evaluation and Management of High Blood Pressure in Adults: A Report of the American College of Cardiology/American Heart Association Joint Committee on Clinical Practice Guidelines. This guideline provides clinical teams with recommendations for patients who have or are at risk for developing cardiovascular disease.

The AMA currently devotes resources towards advancing the functionality of health information technology (HIT), including (EHRs, to support the use of average blood pressure, self-monitoring, and remote patient monitoring. In 2023, the AMA was successful in getting average blood pressure included in the US Core for Data Interoperability (USCDI). The USCDI is a federally mandated data set that EHR systems are required to support. The USCDI contains over 100 elements including patient demographic information, vital signs, problems, and procedures. The USCDI enables EHRs and other certified HIT to capture, exchange, and use standardized medical information. The Centers for Medicare and Medicaid Services also recognizes the USCDI in its physician and hospital reporting programs, e.g., the Quality Payment Program.

The examples above are not inclusive of all the work the AMA has done to improve hypertension control and reduce the burden of chronic disease. AMA's continued work and commitment support ongoing research and policy development to provide physicians and clinical teams with guidance to address BPV and improve patient outcomes.

Existing AMA Policy

Pharmacist in Hypertension Screening H-425.998
(1) Physicians should encourage the establishment of adequate training programs in blood pressure measurement, under the supervision of qualified physicians or other qualified personnel, for pharmacists and other non-physicians in order to assure adequate personnel for hypertension screening programs. (2) The medical profession should participate in the development of programs which ensure an adequate system for monitoring blood pressure measurement and referring patients when indicated to physicians. (3) Community programs should be established to educate the public on the importance of participation in screening programs and adherence to subsequently prescribed courses of therapy, with periodic blood pressure measurement and evaluation of the effectiveness of the therapeutic regimen by licensed physicians. (4) The particular program to be implemented in any community should receive the full support of the medical profession and be built upon the existing community facilities and health personnel resources, taking into consideration applicable state legal restriction or requirements.

Genomics in Hypertension: Risk Prediction and Treatment H-460.901
Our American Medical Association encourages continued research on the genetic control of blood pressure, including in pediatric populations, and the development of genomic-based tools that may assist health professionals in better predicting risk and targeting therapy for hypertension, and supports the view that hypertension clinical trial designs should attempt to reduce phenotypic heterogeneity in order to improve the quality and interpretation of results.

Non-Physician Measurement of Body Functions H-35.990
In the public interest, the AMA recommends that non-physicians who perform tests such as blood pressure or blood sugar measurements advise the examinee to communicate these findings to their personal physician.

Medical Evaluation of Healthy Persons H-425.994
The AMA supports the following principles of healthful living and proper medical care: (1) The periodic evaluation of healthy individuals is important for the early detection of disease and for the recognition and correction of certain risk factors that may presage disease. (2) The optimal frequency of the periodic evaluation and the procedures to be performed vary with the patient's age, socioeconomic status, heredity, and other individual factors. Nevertheless, the evaluation of a healthy person by a physician can serve as a convenient reference point for preventive services and for counseling about healthful living and known risk factors. (3) These recommendations should be modified as appropriate in terms of each person's age, sex, occupation and other characteristics. All recommendations are subject to modification, depending upon factors such as the sensitivity and specificity of available tests and the prevalence of the diseases being sought in the particular population group from which the person comes. (4) The testing of

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individuals and of population groups should be pursued only when adequate treatment and follow-up can be arranged for the abnormal conditions and risk factors that are identified. (5) Physicians need to improve their skills in fostering patients' good health, and in dealing with long recognized problems such as hypertension, obesity, anxiety and depression, to which could be added the excessive use of alcohol, tobacco and drugs. (6) Continued investigation is required to determine the usefulness of test procedures that may be of value in detecting disease among asymptomatic populations.

CONCLUSION

This report highlights the current known association of blood pressure variability with cardiovascular events and mortality outcomes. Future research is needed to standardize definitions, e.g. excessive BPV, measurement protocols, and establish pathological BPV thresholds and clinical pathways/protocols to guide physicians and clinical teams in providing evidence-based interventions to improve patient outcomes. AMA has existing policy on the importance of blood pressure measurement in multiple settings but currently has nothing specific to blood pressure variability.

RECOMMENDATION

The Board of Trustees recommends that Resolution 424-A-25 be amended by addition and the remainder of the report be filed.

> That our AMA support additional research efforts to establish pathological Blood Pressure Variability thresholds to guide dietary and exercise recommendations, sleep evaluation, risk stratification, and other evidence-based interventions by healthcare providers.
>
> That our American Medical Association support the integration of blood pressure variability data into electronic medical records, emphasizing automated calculation capabilities similar to those established for body mass index once additional research has been published on this topic, including peer-reviewed evidence establishing clinical utility, reproducibility of blood pressure variability metrics, and such research has informed recommendations or guidance from relevant clinical and public health authorities.

Fiscal Note: Significant Fiscal Impact

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18. REPORT ON THE PRESERVATION OF INDEPENDENT MEDICAL PRACTICE

Informational report; no reference committee hearing.

HOD ACTION: FILED

At its 2022 Annual Meeting, the House of Delegates (HOD) adopted Policy D-405.988, “The Preservation of Independent Medical Practice,” directing the American Medical Association (AMA) to issue a report every two years describing AMA efforts to support independent physician practice.

The policy affirms the AMA’s support for private practice, recognizes its importance to physician autonomy and professional sustainability, and acknowledges the value independent practices provide to patients and communities.

This report details AMA activities since the 2024 Annual Meeting to preserve and strengthen independent medical practice. It reflects both the governance structures established to ensure durable representation of independent physicians within the AMA and the specific policy, advocacy, and programmatic outcomes advanced through those structures.

DISCUSSION

During this reporting period, AMA’s support for independent medical practice has focused on three interrelated areas of work:

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- ensuring independent physicians have an organized, durable voice in AMA policy development;
- creating consistent, direct engagement channels through which independent physicians can surface operational challenges and share practice-level strategies; and
- delivering tools, education, structured advocacy, and practice resources that address the day-to-day realities of operating an independent practice.

Providing a voice for independent physicians in AMA policy development

The Private Practice Physicians Section (PPPS) remains the primary mechanism through which independent physicians engage in the AMA policymaking process. Established by action of the HOD in 2020 and operational since 2021, the Section functions as a stable governance unit with defined leadership roles, regular business meetings, and repeatable policy workflows aligned with the HOD policymaking cycle.

As of March 2026, PPPS includes approximately 425 certified members representing a broad range of specialties, practice sizes, and geographic regions. Continued membership growth reflects sustained demand for a forum focused on the policy and operational concerns of independent physicians.

PPPS convenes formal business meetings in conjunction with each AMA Annual and Interim Meeting of the HOD to:

- surface practice-level issues identified by members;
- review emerging regulatory, payer, and market developments affecting independent practices;
- draft and refine policy proposals; and
- coordinate Section positions on HOD items of business.

Since the 2024 Annual Meeting, the HOD has adopted 15 PPPS-originated resolutions in some manner. This record reflects sustained policy engagement by independent physicians and substantive consideration of those issues by the HOD. Several adopted resolutions illustrate the tangible impact of PPPS-driven advocacy:

- Resolution 229-I-24, Supporting Penalties on Insurers Who Fail to Pay Doctors, directed the AMA to advocate for penalties against insurers that fail to pay physicians within required timeframes after physicians prevail in the federal Independent Dispute Resolution process, addressing delayed payment practices that create financial strain for independent practices.
- Resolution 714-A-25, Root Cause Analysis of the Causes of the Decline of Private Medical Practice, directed the AMA to conduct a comprehensive analysis of the economic, regulatory, educational, and market forces contributing to the decline of private practice, formally committing the AMA to evidence-based examination of consolidation and practice closure trends.
- Resolution 715-A-25, Grace Period for Timely Filing Due to Technology Failures Regardless of Cause, directed the AMA to advocate for relief from timely filing limits when claims processing failures occur due to large-scale technology disruptions, protecting practices from denials caused by circumstances beyond physician control.
- Resolution 810-I-25, Opposing Unilateral Downcoding of Physician Services by Insurance Companies, directed the AMA to oppose insurer-initiated downcoding of evaluation and management services, reaffirm CPT® and E/M guidelines as the national standard, and pursue regulatory, legislative, educational, and, where appropriate, legal strategies to address such practices.

Together, these policies reflect a consistent focus on insurer accountability, payment fairness, administrative due process, and the structural sustainability of independent medical practice.

Outreach and engagement with independent physicians

Beyond formal HOD activity, PPPS convenes recurring engagement forums intentionally aligned with the HOD policymaking cycle to support timely policy development and review.

Each year, the Section hosts two primary engagement events:

- a spring virtual Town Hall meeting aligned with preparations for the AMA Annual Meeting; and
- a fall engagement and policy discussion aligned with the AMA Interim Meeting.

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The PPPS Town Hall meeting has become a signature engagement forum for independent physicians. It provides a regularly occurring venue for peer-to-peer exchange on business operations, payer and contracting challenges, regulatory compliance, staffing, and practice sustainability. These sessions also function as an early signal-gathering mechanism, informing PPPS policy priorities and resolution development.

Issues surfaced through these engagement forums are carried forward into PPPS business meetings, translated into policy proposals where appropriate, and used to shape educational programming and resource referrals. Additionally, PPPS is developing member committees focused on practice sustainability and advocacy to extend engagement between meetings and provide additional opportunities for member input and collaboration.

Advocacy in support of independent practice

In parallel with PPPS contributions to AMA policy development and practice support initiatives, the AMA has continued to engage in advocacy actions that directly affect independent physicians. Prime examples of these efforts include:

- Fixing our nation's unsustainable Medicare payment system will remain a top AMA advocacy priority until meaningful reform is achieved. Physicians are urged to join the fight for reform by visiting FixMedicareNow.org which coordinates grassroots action on AMA priority Medicare Payment Reform bills. The campaign has generated more than 103 million earned media and ad impressions, 3.9+ million media and ad engagements, and 100,000+ contacts to Congress, as well as a combined 235+ third-party media placements and grasstops contacts made in key Congressional districts in 2025 alone.
- AMA submitted comment letters to the Centers for Medicare & Medicaid Services on the CY 2025 Medicare Physician Fee Schedule Proposed Rule and the CY 2026 Medicare Physician Fee Schedule Proposed Rule, addressing physician payment adequacy, proposed conversion factor reductions, and administrative burden associated with Medicare participation.
- AMA engaged in federal advocacy related to prior authorization reform, including physician-facing implementation issues arising from the CMS Interoperability and Prior Authorization Final Rule (CMS-0057-F). Advocacy focused on prior authorization timelines, transparency requirements, and payer compliance obligations with implications for independent practice operations. Further AMA advocacy to reform prior authorization includes supporting federal legislation; collaborating with influential policy organizations such as the National Conference of Insurance Legislators and the National Association of Insurance Commissioners; and partnering with patient advocacy groups to advance key measures. The AMA also provided testimony and influenced recommendations from an advisory council convened by the Department of Labor to consider regulatory changes to how employer-sponsored health plans governed by ERISA use prior authorization and manage claims and appeals procedures. AMA also worked closely with over 20 states that enacted prior authorization reform legislation in 2025.
- Following the February 2024 Change Healthcare cyber-event, the AMA issued public statements and advocacy communications and engaged with federal agencies and payers regarding widespread claims processing disruptions, timely filing requirements, and payment relief for affected physician practices. These efforts sought to mitigate financial harm to independent practices caused by large-scale system failures beyond physician control.
- AMA has advocated for fair contracting and out-of-network payments including engaging in litigation to force implementation of the No Surprises Act (NSA) as Congress intended, advocating to regulators and Congress to ensure independent dispute resolution awards under the NSA are paid, and in the required timely manner, by insurers to physicians, and sounding the alarms on health insurer practices that bypass the NSA and threaten the sustainability of independent practices. AMA has also supported the No Surprises Act Enforcement Act in the House and Senate.
- The AMA has continued federal and state legislative advocacy on insurer administrative practices, and accountability measures including releasing a state model bill on insurer downcoding practices, physician-led team-based care, physician wellness, advancing technology including augmented intelligence, access to care, and medical liability consistent with adopted House of Delegates policy. In addition, AMA has participated in legal advocacy, including amicus curiae activity, in matters affecting physician reimbursement and practice viability.

Collectively, these advocacy efforts reflect the execution of AMA policy positions through regulatory, legislative, communication, and legal channels that shape the operating environment for independent medical practices.

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Promoting resources for the advancement of independent practice

The AMA has continued to invest in practical resources designed to support the operational and financial sustainability of independent medical practices.

The AMA STEPS Forward® initiative remains a central platform for this work, offering open-access, practice-focused tools through the AMA Ed Hub™. These resources include implementation guides, templates, webinars, podcasts, and continuing medical education opportunities addressing staffing, workflow design, regulatory compliance, patient engagement, and practice operations. Independent practice-specific offerings include the 7 STEPS to Starting a Private Practice guide and the Private Practice Playbook, which provides adaptable templates such as patient intake forms, administrative policies, and employee documentation.

Building on these resources, in 2025 the AMA launched the Independent Practice Incubator through the STEPS Forward® Innovation Academy. The incubator is a structured, cohort-based program designed for physicians planning to establish office-based, physician-owned independent practices. The program integrates asynchronous learning, live virtual sessions with subject-matter experts, and peer collaboration, covering business planning, legal and regulatory considerations, credentialing and contracting, staffing and human resources, revenue fundamentals, and patient acquisition and retention. The incubator spanned approximately 12 months and culminated in the development of a comprehensive business proposal, providing participants with a structured pathway from early concept through implementation readiness. Learning and content from the incubator will inform more structured, more widely available AMA Private Practice Accelerator events in the future.

PPPS also uses its Annual and Interim Meeting convenings to provide issue-focused education and operational peer exchange. Programming is member-informed and aligned with the same pipeline that drives PPPS policy development, ensuring that issues raised by members translate into both policy action and practical guidance supported by existing AMA resources.

Finally, the AMA has published a curated collection of education modules, "Thriving in Private Practice," to help physicians effectively build and manage a private medical practice. The collection includes 7.5 hours of learning content on topics including payer contracting and audits, human resources, marketing and branding, and revenue cycle management.

CONCLUSION

The AMA remains attentive to ongoing changes in the physician practice environment, including consolidation pressures, workforce instability, and increasing administrative complexity that disproportionately affect independent practices.

Through durable representation in the AMA policymaking process, measurable policy outcomes driven by independent physicians, documented regulatory, legislative, and legal advocacy, recurring engagement aligned with the AMA meeting cycle, and sustained investment in practical tools and programs, the AMA has continued to provide tangible support for independent medical practice. These efforts establish a strong foundation for continued work to ensure that independent physicians remain a viable and integral part of the nation's health care system.

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19. ROOT CAUSE ANALYSIS OF THE CAUSES OF THE DECLINE OF PRIVATE MEDICAL PRACTICE

Reference committee hearing; see report of Reference Committee B.

HOD ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS
REMAINDER OF REPORT FILED
See Policies D-160.906, D-160.907, D-160.908, D-160.909, D-215.984, D-225.995, D-240.994, D-330-902, D-330.909, D-330.997, D-385.940, D-400.990, D-405.962, D-405.988, H-110.985, H-155.976, H-160.885, H-160.960, H-180.947, H-215.960, H-215.969, H-240.958, H-330.932, H-383.988, H-385.921, H-390.879 and H-400.957

At the 2025 Annual Meeting, Policy D-405.965, "Root Cause Analysis of the Causes of the Decline of Private Medical Practice," was adopted by the House of Delegates (HOD). This policy directs the American Medical Association (AMA) to do the following:

Our AMA will study and report back on the root cause of the decline in private practice to include consideration of at least the following factors:

1. The declining inflation-adjusted Medicare rates.
2. Stark laws, which allow hospitals, but not private physicians, to self-refer.
3. The development of insurance plans that had no out-of-network benefits.
4. The permitted consolidation of insurers and hospitals.
5. Hospital-insurer agreements with minimal in-network fee requirement and other conditions such as the requirement for high hospital technical fees.
6. Increased government influence by insurers and hospitals and decreased influence by doctors.
7. Inadequate formal education on the business of medicine.
8. Educational debt of early career physicians.
9. Evolving lifestyle preference of early career physicians.
10. Overhead expenditures such as Electronic Health Records (EHRs), personnel, and administrative costs.
11. Provider based facility fees charged by hospital employers but not by private practitioners.

This report includes detailed information about the root causes of the decline of private medical practice, organizing contributing factors into four categories—economic pressures, market consolidation, administrative and regulatory burden, and generational workforce factors—to better contextualize and understand their interaction. It also highlights the AMA's efforts to address these issues and recommends strengthened communication and engagement so that available AMA resources and solutions more effectively reach physicians in private practice and those considering transitioning to private practice.

BACKGROUND

Private practice can be defined as a medical practice wholly owned by one or more physicians. There has been an overall decline in physician ownership of medical practices over the past four decades, dropping especially precipitously from 61 percent physician owners in 2008 to 35.4 percent in 2024. Similarly, the proportion of physicians working in private practice as employees or owners has fallen from 60.1 percent in 2012 to 42.2 percent in 2024, as described in the AMA Physician Practice Benchmark Surveys.[1]

Private practice was a cornerstone of American medicine in the 20th century, representing a distinct health care delivery model with specific advantages and disadvantages. Despite evidence that suggests physician-owned practices are slower to adopt innovations such as health information technology[2] and care management processes[3], they are equivalent or better than other models of practice in total spending and quality measures such as preventable hospital admissions, readmissions, and emergency department visits.[4] Additionally, the autonomy associated with being a practice owner may contribute to physician well-being.[5]

The U.S. health care system overall has undergone significant change in the last several decades, including rising health care costs, continued downward pressure on payment, wide adoption of EHRs and other technology, the rise of chronic disease burden and more complex care, and more recently, the downstream effects of a global pandemic. During this period, many private practices have been acquired by hospitals and health systems. Drivers of this shift were recorded by the 2022 AMA Physician Practice Benchmark Survey, where 80 percent of physicians whose

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practices were acquired indicated that the need to better negotiate favorable (higher) payment rates with payers was a very important (46.1 percent) or important (33.4 percent) reason as to why their practice was sold to or acquired by a hospital or health system. The need to better manage payers' regulatory and administrative requirements and improve access to costly resources were both reported by approximately 70 percent of physicians as a very important or important reason for selling their practice.[6]

While it is difficult to establish clear causal relationships between the factors delineated in the resolution and the decrease of the number of physicians in private practice, this report will use the general framework of a root cause analysis and describe the role that each factor plays, discuss the interrelations between the factors, and summarize relevant AMA policy and activity.

DISCUSSION

For the purpose of this discussion, a basic root cause analysis fishbone diagram[7] was used to categorize the delineated factors in Policy D-405.965 into overarching themes. This diagram can be viewed in the appendix section at the end of this report (Figure 1). Although other potential factors were not included in the analysis, this categorical framework can be used to include other causes in the future.

Each category will be discussed in turn, including the associated potentially causative factors. Understanding that potential causes may overlap categories, they are discussed with the most pertinent themes.

Economic Pressures

Economic pressures may be divided into two main forces: (1) those which decrease practice revenues typified by the decrease in inflation-adjusted Medicare reimbursement rates, and (2) those that increase practice costs. The convergence of these forces contributes to the compression of the margin required to operate all medical practices. However, increasing overhead costs can have amplified consequences for private medical practices since they are typically small and unable to gain economies of scale or the leverage to negotiate for better payment rates. Asymmetries in federal payment systems and misaligned regulatory incentives, such as the Medicare Outpatient Prospective Payment System (OPPS) which tends to favor hospital-based ambulatory services, can also disadvantage physicians in private practice compared to their system-employed colleagues.

Declining Inflation-Adjusted Medicare Rates

Adjusted for inflation in practice costs, Medicare physician payment declined 33 percent from 2001 to 2026.[8] Furthermore, reimbursement systems for commercial health insurance plans tend to be based upon the Medicare system, albeit generally at higher rates. While the decline in these rates affect physicians in all practice settings, it may disproportionately affect those in private practice given that a larger percentage of revenue may be generated through the fee-for-service payments driven by the Medicare Physician Fee Schedule (MPFS).

Overhead Expenditures such as EHRs, Personnel, and Administrative Costs

During the same time period from 2001 to 2026, practice expenditures rose by 63 percent, with rapid acceleration beginning in 2021.[8] In addition to inflationary pressures on rents, personnel, and supplies, medical practices were also subject to increased costs associated with the acquisition of technology (e.g., EHRs to fulfill meaningful-use requirements, telehealth during the Covid-19 pandemic, digital systems to fulfill quality reporting requirements).[9] These practice costs can potentially be mitigated through economies of scale, which small private practices may not have.

Provider-Based Facility Fees Charged by Hospital Employers but not by Private Practitioners

Under the standard reimbursement system for traditional fee-for-service Medicare, in addition to physician payment through the MPFS "facility" rates, hospital outpatient departments (HOPDs) (with some exclusions) receive payment for ambulatory services under the OPPS. Clinicians rendering services in freestanding physician-owned offices receive payment through the MPFS "non-facility" rates, and the private practices do not receive payment through OPPS. This is the so-called "site-of-service differential." For example, in 2023, an initial preventative exam was reimbursed at a 51 percent higher rate in an existing HOPD than in a freestanding physician-owned office.[10] Another study addressing the commercial insurance market in 2022 found that on average, total payment for an ambulatory service in a HOPD

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was 145 percent more than in a physician office.[11] The "site-of-service differential" can advantage hospital-based outpatient services compared to those in free-standing physician offices.

Additionally, current implementation of the 340B Drug Pricing Program has been criticized for advantaging hospitals because it allows them to buy drugs at discounted rates while receiving full reimbursement—creating revenue streams unavailable to many private practice physicians—contributing to hospital acquisition of physician practices and care consolidation.[12] This has especially impacted private practice physicians in the oncology, rheumatology, and gastroenterology specialties.[13,14] The program has also been critiqued for incentivizing hospitals to shift care from underserved areas to wealthier communities to increase revenue.[12] AMA Policy H-110.985, "340B Drug Discount Program" recognizes that the 340B program does not support the extent of care provided by ineligible physician practices to the medically indigent or underserved, and commits to working with HRSA to establish 340B eligibility for all practices demonstrating a commitment to serving low-income and underserved patients.

Market Consolidation

Horizontal consolidation pertains to the situation when organizations in a common market, delivering the same services, combine. For example, this happens when two hospitals in the same city merge, or when one large health insurer buys out a smaller insurer that covers the same population. This type of consolidation decreases competition and leads to the increased pricing power of the dominant entities.

Vertical consolidation happens when organizations in a common market, contributing different services along the delivery chain, combine. The classic example is a health system buying one or more physician practices. While this type of integration may have benefits in streamlining care coordination, there may also be the downside consequence of decreasing competition. Both situations can adversely affect the financial sustainability of physicians in private practice as their market power diminishes.

The Permitted Consolidation of Insurers and Hospitals

There has been continued consolidation in the health care market as it pertains to both hospitals and commercial insurers. For instance in 2023, one or two health systems controlled the entire market for inpatient hospital care in almost half of metropolitan statistical areas (MSAs), and nearly all (97 percent) had highly concentrated markets for inpatient hospital care.[15] Similarly, the insurers are also consolidating, leading to a highly concentrated health insurance market. A recent study from the AMA reveals that 97 percent of MSA-level commercial markets in 2023 were highly concentrated according to the Herfindal-Hirschman Indices (HHI) and Department of Justice (DOJ)/Federal Trade Commission (FTC) merger guidelines.[16]

There are many detrimental effects of health care consolidation on the sustainability of smaller independent physician-owned practices. In highly concentrated markets, small independent practices do not have much leverage in negotiations of reimbursement rates from commercial payers. Smaller independent practices may also have a difficult time negotiating competitive pricing for resources and human capital if located in a market with a dominant hospital/health system with similar needs. Smaller practices are also disproportionately impacted when payors or hospitals/health systems enter exclusivity contracts. In a consolidated market, practices excluded from these agreements lose access to most patients and are unable to survive. These effects are further magnified when payors or health systems directly or indirectly employ physicians.

Hospital-Insurer Agreements with Minimal In-Network Fee Requirement and Other Conditions Such as the Requirement for High Hospital Technical Fees

Given the market leverage that dominant health systems possess, they can negotiate terms with commercial payers which allow them to gain advantage. The so-called "anti-steering clause" (or "anti-incentive clause") is a requirement that the insurer places the health system at the lowest cost-sharing rate to avoid steering patients away from the health system's network. Other contract clauses which insurers and some hospital systems can employ to gain advantage are the following[17]:

- Most Favored Nation (MFN) Clause
- Non-compete Clause
- All-or-nothing Clause

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- Anti-tiering/Anti-steering Clause
- Gag Clause (Price Secrecy Provision)
- Exclusive Contracting Clause[17]

While each contracting strategy will not be detailed in this report, any or all the above may be used by payers or health systems to disadvantage small private practice.

The Development of Insurance Plans That had No Out-of-Network Benefits

Traditionally, preferred provider organization (PPO) and point of service health plans have out-of-network benefits, while health maintenance organization (HMO) and exclusive provider organization (EPO) plans do not. While all these health plan types have existed for decades, the relative adoption of these plans has changed with time. PPO plans remain common in employer-sponsored plans. However, the individual marketplace has shifted dramatically in favor of HMO and EPO plans, with some states having no PPO plans in the marketplace.[18] Given the transition to these options, the negotiating power of dominant health systems to include all-or-nothing clauses in their payer contracts can amplify exclusion of private practices in payer networks.

Increased Government Influence by Insurers and Hospitals and Decreased Influence by Doctors

As health care markets continue to consolidate, it follows that these larger entities may exert increased influence on local, state and federal governments, both directly and through affiliated societies and umbrella organizations. Physicians continue to have a strong voice through organized medicine. However, as ever more complex organizations are formed, there are new shifts in alignment and influence that may dilute the voice of physicians in private practice.

Administrative & Regulatory Burdens

Burdens related to compliance are felt by physicians in all practice settings. However, physicians affiliated with larger systems may be more sheltered from these burdens as they may have dedicated compliance infrastructures in place. Furthermore, additional regulations regarding physician ownership, including Stark and anti-kickback laws, may disadvantage physicians in private practice.

The Physician Self-Referral (Stark) Law

In Policy D-385.940, "Stark Law Self-Referral Ban", the AMA recognizes the challenges the Stark law may pose to many physician practices and that restrictions on self-referral may be a contributing factor to market consolidation. However, the Stark law does not provide a blanket ban on self-referral practices. Rather, it contains numerous exceptions, which if met, allow physicians to self-refer (e.g., when physicians self-refer to risk bearing arrangements). Most importantly for the purposes of this report, the Stark law has a broad exception for both ownership interests and compensation arrangements that applies specifically to physician practices—the in-office ancillary services exception. That said, the increased costs of legal and administrative work required to form and maintain the structures necessary to comply with these Stark law exceptions may be significant.

Administrative Burdens

Private practice physicians face substantial administrative and regulatory burdens, often exceeding those experienced by physicians employed by larger systems with dedicated compliance infrastructure. These burdens include requirements for quality reporting, prior authorizations, payer contracting and credentialing, regulatory compliance for privacy and security (e.g., HIPAA), and maintenance of licensure and certification.

The cumulative time devoted to administrative tasks not directly related to patient care has been a major contributor to physician dissatisfaction and burnout.[19] In smaller practices, physicians often personally handle or oversee these requirements, whereas larger organizations are able to delegate to specialized administrative personnel. The increasing complexity of federal, state, and payer requirements—especially regarding EHR interoperability, value-based payment reporting[20], and frequent changes to billing codes—has raised the cost of compliance and further strained private practice viability.

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Generational Workforce Factors

As the "baby-boom" generation continues to age out of the physician workforce, factors affecting the younger generations, including lifestyle preferences, personal finances, and lack of business education, may contribute significantly to decreasing numbers of graduating trainees and early career physicians choosing to enter private practice. Trainees' limited exposure to the professional satisfaction associated with private practice may also lead them to select other models of practice.

Inadequate Formal Education on Business Skills

In 2023, the AMA conducted a study investigating physician career transitions in which 35 physicians who changed jobs between health care organization employment, private practice, or non-clinical roles were interviewed. Although the main objective of this research was to identify drivers of these transitions, the potential avenues of support for the physician career journey were also studied. One of the key unmet needs that these physicians identified was that "physicians across experience levels benefit from exposure to business and other skills." These skills are not typically taught in medical education and training due to the time and rigor necessary to achieve clinical competence. However, business knowledge is vitally important to the sustainability of a private medical practice given the necessary decisions which need to be made by the physician owners. Young physicians who feel uncomfortable due to poor exposure to the basic skills necessary to run an independent practice may perceive employment as a more stable alternative.

Evolving Lifestyle Preference of Early Career Physicians

A 2017 AMA and M3 Global Research survey found that 92 percent of physicians aged 35 and younger rated work-life balance as a priority. Nearly four out of five said they eventually hoped to seek out fields beyond patient care, including entrepreneurship, health care consultancy, hospital/health system executive management, and academic research.[21] These findings were echoed by the younger physicians in the 2023 AMA "Illuminating the Physician Practice Transition Journey" study, wherein participants reported that "being a physician is no longer the only way they define themselves." Although private practice is constantly evolving, the perception that private practice offers "little separation between work and life" and no opportunities beyond patient care persists. These changing life priorities and fixed perception of private practice may contribute to younger physicians choosing employment.

Educational Debt of Early Career Physicians

The average medical school debt balance rose from about $180,000 in 2015 to $216,659 in 2025, with 70 percent of 2025 graduates taking on student loan debt.[22] While there is more extensive literature describing the amount of educational debt driving decisions regarding specialty and location (i.e., rural practices), it logically follows that an increased debt load may drive a physician to the perceived relative financial stability of a salaried employment arrangement and away from the potential financial instability of private practice. Additionally, some larger organizations offer loan repayment as a potential recruiting tool to make employment more attractive.

Another concrete decision point of physicians with education debt was the opportunity to pursue debt forgiveness through the federal public service loan forgiveness program, which is only available to those employed by not-for-profit, government, or public health care organizations. This serves as an additional deterrent to those who would otherwise have chosen to pursue private practice.

Interplay of Factors

The factors discussed likely do not affect the decline of private medical practice independently. Rather, the factors most likely interact in a dynamic fashion. It is important that policymakers and stakeholders understand the interplay between these factors to identify and prioritize effective interventions such as AMA-recommended reforms to promote site-neutral payment policies that base reimbursement on the cost of a service rather than its location, modernize physician payment through increased rates and inflation-based annual updates, and greater transparency of facility fees at HOPDs. The following discussion outlines how most of the factors may contribute to a reinforcing feedback loop, either directly, or as an accelerant.

Private Practice Margins are Compressed by Economic Pressures

Most private, independent physician-owned practices are small, so efficiencies gained from economies of scale are not available to decrease overhead costs. Therefore, the effects of decreasing reimbursement rates and loss of revenue

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streams to larger consolidated health care organizations are causing a continued loss of the margin required to financially sustain practice.

Innovative mitigation of financial risk is hindered by regulatory burdens as costs associated with compliance are significant and burdensome. In addition, the lack of formal business education also hampers physicians from finding solutions to these economic stressors although even formal business education would not negate the realities of the economic imbalance, decreasing revenues, increasing costs, and restrictive structural barriers (e.g., increasing administrative and regulatory burdens).

Physicians' Concern about Private Practice Viability Accelerates the Move to Employment or Retirement

These unmitigated economic pressures coupled with increasing administrative burdens decrease the attractiveness of private practice to physicians as compared to the perceived economic stability (including additional revenue generated from the site-of-service differential) and decreased administrative burden promised by other practice modes. This is accentuated by limited exposure to private practice in training and the changes in generational preferences in lifestyle as well as a high educational debt load. Many physicians have sought financial stability and decreased administrative burden by retiring or becoming employed by—or selling their practices to—large health systems.

Health Care Market Becomes More Consolidated, Exacerbating and Compounding the Cycle

As health care delivery and payment policy has become more complex, consolidation among hospitals, health systems and physician practices has occurred. Dominant health insurers also limit independent physicians' ability to negotiate, furthering a relative decrease in reimbursement rates and loss of revenue streams as compared to health systems in dominant positions. This exacerbates financial pressures on independent practices, further compounding the cycle that drives consolidation.

AMA RESOURCES AND ACTIVITIES

With all the above factors, the AMA has made significant efforts to address the issues called out in Policy D-405.965 regarding education, advocacy, and other activities.

Medicare payment reform advocacy

The AMA has identified Medicare physician payment reform as a top advocacy priority.[23] Through sustained advocacy such as the "Fix Medicare Now" campaign—which in 2025 generated over 100,000 contacts to Congress and experienced a 36 percent increase in visitors to the site—AMA and its partners have raised awareness among policymakers about the growing gap between the cost of delivering care and Medicare reimbursement. Federal advisory bodies have echoed these concerns. For instance, in its June 2025 report to Congress, MedPAC warned that the gap between what Medicare pays and physicians' practice costs could threaten patient access to care, and the Medicare Trustees similarly projected that access to Medicare-participating physicians could become a significant long-term issue if this gap persists. In response to these pressures, Congress recently provided a one-time 2.5 percent Medicare payment update for 2026 in the One Big Beautiful Bill Act (H.R. 1), while MedPAC recommended an additional 0.5 percent payment update for 2027 on top of updates already specified in law.[24]

Recent AMA efforts also comprise several advocacy measures concerning the site-of-service differential. For example, in 2024, AMA authored an issue brief on this payment differential between physician offices and ambulatory surgical centers versus HOPDs. The brief highlighted that while physician Medicare pay rose eight percent (declined 29 percent when adjusted for inflation) between 2001 and 2024, hospital Medicare pay rose over 70 percent over that same period—despite CMS attempts at site neutrality since 2017. The brief presented several key points for reform including payment based on the cost of a service rather than its location, increasing physician payments (as opposed to just cutting hospital payment), adding inflation-based annual updates, and encouraging care in lower-cost settings.[25]

Additionally, in Section 6225 of the Consolidated Appropriations Act, 2026—a government bill recently signed into law—Congress included a provision that's consistent with AMA Policy D-330.891, "Transparency of Facility Fees for Hospital Outpatient Department Visits" which advocates for (1) legislation or regulation that mandates the proactive transparency of the added costs to the consumer for health care services rendered at HOPD designated clinics and (2) the additional costs of facility fees over professional services be stated upon scheduling of such services, noting the two are separate and additive charges, as well as prominently displayed at the point of service. Section 6225

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requires all off-campus outpatient departments to obtain separate, unique National Provider Identifiers and submit an attestation confirming compliance with provider-based regulations by January 1st, 2028, or otherwise face the loss of OPPS payments.[26]

Further, in 2025, CMS proposed and finalized the expansion of its policy of paying the MPFS equivalent site neutral rate (40 percent of the OPPS rate) for drug administration services furnished in excepted, off-campus HOPDs. The AMA provided their comments to CMS in September 2025, supporting site-neutral outpatient policies in principle, but not if they reduce total Medicare funding or ignore inadequate physician payment and resulting patient access risks. Rather, the AMA clarified its support of competition in health care so patients have choices for where to receive care but argued that true site neutrality requires raising and modernizing physician payment, not cutting payments overall or shifting financial and other access-related burdens onto patients and physicians.[27]

Monitoring of market dynamics

At the 2024 Annual meeting, Council on Medical Service Report 4: "Health System Consolidation" summarized main findings from the AMA's Policy Research Perspective, "Competition in Hospital Markets, 2013–2021", developed in response to Policy D-160.907 which directed the AMA to assess nationwide health system consolidation. Overall, the findings indicated that nearly all U.S. hospital markets are highly concentrated, with consolidation trends continuing to increase market concentration.[28]

Additionally, the AMA's Division of Economic and Health Policy Research conducts independent analyses of competition in health insurance, pharmacy benefit manager, and hospital markets. One of the Division's most significant efforts is its annually updated Competition in Health Insurance (CHI) study—the only publication of its kind. This study uses comprehensive national enrollment data to assess insurer market dynamics.[29] The 2025 update of this study examined market concentration across 384 MSAs, all 50 states, and the District of Columbia using 2024 enrollment data and the HHI. The study found that U.S. health insurance markets remain overwhelmingly concentrated—97 percent of MSA-level commercial markets were highly concentrated in 2024, with an average HHI of 3486, and in nearly half of markets a single insurer held at least a 50 percent market share. Market concentration has generally increased between 2014 and 2024, and Medicare Advantage markets also remain highly concentrated.[16]

Decreasing administrative and regulatory burdens

The AMA also provides physicians, care teams and health care leadership with resources designed to promote professional satisfaction, efficient use of digital health technology, practice sustainability, and quality patient care through its STEPS Forward® Innovation Academy. Resources are offered in the form of playbooks, toolkits, webinars, podcasts, and bootcamps on topics such as private practice, physician burnout, and time-saving strategies.[30]

Further, the AMA's Debunking Regulatory Myths series provides physicians and care teams with regulatory clarification to reduce guesswork and administrative burden in their day-to-day practice, helping streamline clinical workflows, improve patient outcomes, and enhance physician satisfaction. The series focuses on topics such as billing/coding, documentation, EHR interoperability, Joint Commission and CMS guidance, and scope of practice laws.[31]

Support of Private Practice

The High-Performing Private Practice Initiative launched in 2021 to enhance the AMA's efforts to address a concerning trend—a decline in physician practice ownership from 54 percent in 2018 to 49.1 percent in 2020.[32] A 2021 AMA-Mathematica study of 25 high-performing practices identified critical barriers, including professional isolation and insufficient business management education among recent graduates.[33]

The AMA initiative created essential resources to support private practice. Between 2021 and 2022, the team developed the Private Practice web toolkit, the Simple Solutions educational series, the Thriving in Private Practice podcast, and the Private Practice Playbook. The Navigating Practice series introduced medical students to independent practice as a viable career path. By 2023-2024, programming expanded with the STEPS Forward Attending to Business podcast. The June 2024 workshop addressing business skills in private practice represented a pivotal evolution from passive resources to active business education. As part of this program, educational modules were curated so physicians could become exposed to introductory level business skills and concepts. These efforts were

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guided by an Advisory Council consisting of physician leaders and directors of physician-specific MBA programs at well-known business schools. A more formal curriculum is currently under development.

These early efforts revealed that physicians lacked comprehensive support for launching independent practices. The Independent Practice Incubator pilot filled this gap as a first-of-its-kind 12-month immersion program covering essential competencies for independent practice. The first cohort received education to adopt innovative private practice models, including several that were designed to serve underrepresented and underserved communities.

Based on learnings from the Incubator pilot, the AMA is now scaling this program and, in the fall of 2026, the Independent Practice Forum—a two-day intensive workshop distilling essential competencies through expert sessions, case studies, and peer networking—will launch. This accessible format will provide physicians exploring or beginning independent practice with foundational knowledge in strategic planning, obtaining capital, business fundamentals, revenue cycle management, operations, leadership, and marketing.

The AMA will now offer a complete ecosystem—foundational resources, community building, and education spanning from medical school through practice launch. This multi-tiered approach—combining ongoing education, immersion programs, and intensive workshops—establishes the AMA as the primary resource for independent practice physicians. By preserving physician choice and practice model diversity, the program ensures that AMA's core mission of removing obstacles to patient care and ensuring high-quality care delivery remains accessible despite increasing health care consolidation.

AMA POLICY

The following emphasizes the breadth of AMA policies aimed at addressing the factors contributing to the decline of private practice including: Medicare reimbursement, the site-of-service differential, inflation-based physician payment, health system and insurance consolidation, the preservation of private practice, and administrative burden.

Medicare Reimbursement

Regarding the importance of improved Medicare and Medicaid reimbursement, the AMA (1) 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) 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) aggressively encourages CMS to affirm the patient's and the physician's constitutional right to privately contract for medical services; notes that (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; and (5) 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 (Policy H-330.932, “Cuts in Medicare and Medicaid Reimbursement”).

The AMA will also (1) encourage CMS to expand the extent and amount of reimbursement for procedures performed in the physician's office, to shift more procedures from the hospital to the office setting, which is more cost effective; (2) seek to have the RBRVS practice expense RVUs reflect the true cost of performing office procedures; (3) work with CMS to develop consistent regulations to be followed by carriers that include reimbursement for the costs of disposable supplies and surgical tray fees incurred with office-based procedures and surgery; (4) support the Current Procedural Terminology (CPT®) Editorial Panel / RVS Update Committee (RUC) recommendation to the Centers for Medicare & Medicaid Services (CMS) to separately pay for high-cost supplies priced more than $500; and (5) work with the federal government to address flaws in the Medicare Physician Fee Schedule practice expense methodology resulting in reimbursement being less than direct costs for hundreds of services in the office-based setting (Policy H-400.957, “Medicare Reimbursement of Office-Based Procedures”).

Further, the AMA urges CMS to permit separate reimbursement for medically necessary multiple visit services rendered to Medicare patients on the same day by the same physician regardless of the setting in which those services were provided (Policy H-390.879, “Medicare Reimbursement for Multiple Physician's Visits on the Same Day Regardless of the Place of Service”).

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Site-of-Service Differential

Concerning the site-of-service differential, AMA (1) supports Medicare payment policies for outpatient services that are site-neutral without lowering total Medicare payments and Medicare payments for the same service routinely and safely provided in multiple outpatient settings (e.g., physician offices, HOPDs, and ASCs) that are based on sufficient and accurate data regarding the actual costs of providing the service in each setting; (2) will urge the CMS to update the data used to calculate the practice expense component of the Medicare physician fee schedule by administering a physician practice survey (similar to the Physician Practice Information Survey administered in 2007-2008) every five years, and that this survey collect data to ensure that all physician practice costs are captured; (3) encourages CMS to both: base disproportionate share hospital payments and uncompensated care payments to hospitals on actual uncompensated care data; and study the costs to independent physician practices of providing uncompensated care; (4) will collect data and conduct research to both: document the role that physicians have played in reducing Medicare spending; and facilitate adjustments to the portion of the Medicare budget allocated to physician services that more accurately reflects practice costs and changes in health care delivery; and (5) will disseminate educational materials and graphics and promote awareness that the site-of-service payment differential is not based on the quality of care provided across outpatient care settings (Policy D-330.902, "The Site-of-Service Differential").

Further, AMA will advocate to prohibit insurers from denying or reducing payment for a procedure based solely on the site of service in which was performed, provided that the procedure is medically necessary and can safely be performed in that location (Policy H-240.958, "Prohibiting Insurers from Denying Payment for Procedures Based on Site of Service").

AMA will also work with states to advocate that third party payers be required to: a. Assess equal or lower facility coinsurance for lower-cost sites of service (hospital outpatient department, ambulatory surgical center, or office-based facility); b. Publish and routinely update pertinent information related to patient cost-sharing; and c. Allow their plan's participating physicians to perform outpatient procedures at an appropriate site of service as chosen by the physician and the patient (Policy D-240.994, "Payment Variations Across Outpatient Sites of Service").

Further, the AMA encourages CMS to: (A) define Medicare services consistently across settings and, in particular, to avoid the use of diagnosis codes in determining Medicare payments to hospital outpatient departments and other ambulatory settings; and (B) adopt payment methodology for hospital outpatient departments and ambulatory surgical centers that will assist in leveling the playing field across all sites-of-service. If necessary, the AMA should consider seeking a legislative remedy to the payment disparities between hospital outpatient departments and ambulatory surgical centers. AMA will continue to encourage the CMS to collect data on the frequency, type and cost of services furnished in off-campus, provider-based departments (Policy D-330.997, "Appropriate Payment Level Differences by Place and Type of Service").

Inflation-Based Physician Payment

On the topic of inflation-adjusted physician payment rates, AMA policy states that it shall use every means available to convince health insurance companies and managed care organizations to immediately uncouple fee schedules from the Medicare Physician Payment Schedule and to maintain a level of payment that is sustainable, reflects the full cost of practice, and the value of the care provided, and includes inflation-based updates; and AMA will seek legislation and/or regulation to prevent managed care companies from utilizing a physician payment schedule below the updated Medicare Physician Payment Schedule (Policy D-400.990, "Uncoupling Commercial Fee Schedules from the Medicare Physician Payment Schedule").
Additionally, AMA supports policy that increases and maintains access to health care for all, payment for physicians under Medicaid, TRICARE, and any other publicly funded insurance plan must be sustainable, reflect the full cost of practice and the value of the care provided, include inflation-based updates, and pay no less than 100 percent of RBRVS Medicare allowable (Policy H-385.921, "Health Care Access for Medicaid Patients).

Health System & Insurance Consolidation

AMA has numerous policies regarding health system and insurance consolidation. For instance, the AMA (1) will assess and report annually on nationwide health system and hospital consolidation, as well as payer consolidation, to assist policymakers and the federal government; and this AMA annual report on nationwide hospital consolidation will be modeled after the "Competition in health insurance: A comprehensive study of U.S. Markets" in its thoroughness to include for example data and analyses as: (a) a review of the current level of hospital and/or health

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system consolidation at the level of all metropolitan statistical areas, state, and national markets; (b) a list of all mergers and acquisition transactions valued above a set threshold amount resulting in hospital and/or health system consolidation; (c) analyses of how each transaction has changed or is expected to change the level of competition in the affected service and geographic markets; and (d) analyses of healthcare costs and prices have changes in affected markets after a large consolidation transaction has taken place. AMA will report the initial findings of this study to the House of Delegates by Annual 2024 and the findings of this study to its members and stakeholders, including policymakers and legislators, to inform future healthcare policy (Policy D-160.907, "Health System Consolidation").

The AMA will also study nationwide health system and hospital consolidation in order to assist policymakers and the federal government in assessing healthcare consolidation for the benefit of patients and physicians who face an existential threat from healthcare consolidation; and will regularly review and report back on these issues to keep the House of Delegates apprised on relevant changes that may impact the practice of medicine, with the first report no later than the 2023 Annual Meeting (Policy D-215.984, "Health System Consolidation").

Further, the AMA opposes consolidation in the health insurance industry that may result in anticompetitive markets (Policy H-180.947, "Maintaining Freedom of Choice with Insurance Products).

Furthermore, AMA advocates to adequately resource competition policy authorities such as the FTC and DOJ Antitrust Division to perform oversight of health care markets (Policy D-160.906, "Strengthening Efforts Against Horizontal & Vertical Consolidation").

Likewise, the AMA advocates against anticompetitive business practices that have the potential to adversely affect the physician patient relationship, to result in higher costs or decreased quality of care, or are not in the best interest of patients, the public and/or physicians; and also supports efforts to increase transparency, review, and enforcement of laws with respect to vertical mergers that have the potential to negatively impact the health care industry. AMA will work with all appropriate stakeholders to create model legislation to prohibit anticompetitive business practices within the health care sector (Policy D-160.908, "Vertical Consolidation in Health Care – Markets or Monopolies").

The AMA also (1) recognizes the substantial impact of the Stark law's unequal restrictions on independent physicians, contributing to the growing trend of hospital consolidation, which has led to negative consequences of restricted access to care and inflated costs; (2) supports comprehensive Stark law reform aimed at rectifying the disparities that disadvantage independent physician practices while preserving the intent of AMA Code of Ethics Policy 9.6.9, "Physician Self-Referral"; and (3) supports equitable and balanced Stark law reform that fosters fair competition, incentivizes innovation, and facilitates the delivery of high-quality, patient-centered care (Policy D-385.940, "Stark Law Self-Referral Ban").

Further, the AMA affirms that: (a) health care entity mergers should be examined individually, taking into account case-specific variables of market power and patient needs; (b) strongly supports and encourages competition in all health care markets; (c) supports rigorous review and scrutiny of proposed mergers to determine their effects on patients and providers; and antitrust relief for physicians remains a top AMA priority. AMA will continue to support actions that promote competition and choice, including: (a) eliminating state certificate of need laws; (b) repealing the ban on physician-owned hospitals; (c) reducing administrative burdens that make it difficult for physician practices to compete; and (d) achieving meaningful price transparency. AMA will work with interested state medical associations to monitor hospital markets, including rural, state, and regional markets, and review the impact of horizontal and vertical health system integration on patients, physicians and hospital prices (Policy H-215.960, "Hospital Consolidation").
It is the policy of the AMA that, in the event of a hospital merger, acquisition, consolidation, or affiliation, a joint committee with merging medical staffs should be established to resolve at least the following issues: (a) medical staff representation on the board of directors; (b)clinical services to be offered by the institutions; (c) process for approving and amending medical staff bylaws; (d) selection of the medical staff officers, medical executive committee, and clinical department chairs; (e) credentialing and recredentialing of physicians and limited licensed providers; (f) quality improvement; (g) utilization and peer review activities; (h) presence of exclusive contracts for physician services and their impact on physicians' clinical privileges; (i) conflict resolution mechanisms; (j) the role, if any, of medical directors and physicians in joint ventures; (k) control of medical staff funds; (l) successor-in-interest rights; and (m) that the medical staff bylaws be viewed as binding contracts between the medical staffs and the hospitals. AMA will also work to ensure, through appropriate state oversight agencies, that where hospital mergers and acquisitions may lead to restrictions on reproductive health care services, the merging entity shall be responsible for ensuring continuing community access to these services (Policy H-215.969, "Hospital Merger Study").

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Similarly, AMA will: (1) urge its AMA Commissioners to The Joint Commission to seek the inclusion of a standard in The Joint Commission hospital accreditation program requiring a medical staff successor-in-interest standard in the hospital medical staff bylaws; (2) seek inclusion of medical staff bylaw successor-in-interest provisions in the Medicare Conditions of Participation and in the rules and regulations of other public and private hospital accreditation agencies; and (3) continue to monitor and report on current numbers of mergers and break-ups of mergers of hospitals in this country (Policy D-225.995, "Hospital Merger Study").

Further, AMA will: (1) pursue the elimination of or physician exemption from anti-trust provisions that serve as a barrier to negotiating adequate physician payment; (2) work to establish tools to enable physicians to consolidate in a manner to insure a viable governance structure and equitable distribution of equity, as well as pursuing the elimination of anti-trust provisions that inhibited collective bargaining; and (3) find and improve business models for physicians to improve their ability to maintain a viable economic environment to support community access to high quality comprehensive healthcare (Policy H-383.988, "Physicians' Ability to Negotiate and Undergo Practice Consolidation").

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

It is also AMA policy that when a private medical practice is purchased by corporate entities, patients going to that practice shall be informed of this ownership arrangement by the corporate entities and/or by the physician (Policy H-160.960, "Corporate Ownership of Established Private Medical Practices").

Preservation of Private Practices

Concerning the preservation of private practice, AMA policy states that the AMA (1) supports preserving the value of the private practice of medicine and its benefit to patients; (2) will utilize its resources to protect and support the continued existence of solo and small group medical practice, and to protect and support the ability of these practices to provide quality care; (3) will advocate in Congress to ensure adequate payment for services rendered by private practicing physicians; (4) will work through the appropriate channels to preserve choices and opportunities, including the private practice of medicine, for new physicians whose choices and opportunities may be limited due to their significant medical education debt; (5) will work through the appropriate channels to ensure that medical students and residents during their training are educated in all of medicine's career choices, including the private practice of medicine; (6) will create, maintain, and make accessible to medical students, residents and fellows, and physicians, resources to enhance satisfaction and practice sustainability for physicians in private practice; (7) will create and maintain a reference document establishing principles for entering into and sustaining a private practice, and encourage medical schools and residency programs to present physicians in training with information regarding private practice as a viable option; and (8) will issue a report in collaboration with the Private Practice Physicians Section at least every two years communicating their efforts to support independent medical practices (Policy D-405.988, "The Preservation of the Private Practice of Medicine").

Additionally, our AMA will (1) inform corporate efforts about the value of private practices to successfully participate in new "value-based" models; (2) identify and work with a corporate entity that is advancing these models to explore a two year pilot among independent private practices in which our AMA will: (a) convene physician practices in a community; (b) provide educational resources and technical assistance to practices to support their participation with the corporate entity; (c) formally evaluate the pilot for outcomes; and (3) will advocate with commercial payers and health plans and federal and state payers and policymakers to support private practice through policies and models that provide adequate payment, infrastructure and data to succeed in "value-based" models (Policy D-160.909, "Advocacy of Private Practice Options for Healthcare Operations in Large Corporations").

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Administrative Burdens

Also of importance to discuss are AMA policies on administrative burden. Such policy states that the AMA will perform or commission an analysis of the direct and indirect costs and documented benefits associated with significant administrative and regulatory requirements imposed by the CMS, including but not limited to face-to-face documentation requirements, the Physician Quality Reporting System, and the Meaningful Use program (Policy D-330.909, "Study the Costs of Administrative and Regulatory Burdens").

Furthermore, AMA supports accurate calculations of the administrative costs of government programs (Medicare, Medicaid, TRICARE, etc.) and private health insurance plans. It is the policy of the AMA: (1) to begin immediately to seek comprehensive reforms to reduce the administrative inefficiencies, burdens and expenses involved in paying for health care services and to urge that proposals to increase access to health care also address the need to reduce administrative costs and burdens; (2) that state and county medical societies and national medical specialty societies be urged to utilize the joint Guidelines for Health Benefits Administration in discussions with health care payers directed toward improving the efficiency of utilization management programs and minimizing the administrative burdens they impose on physicians and hospitals; (3) that the AMA strongly encourage further study of the cost-effectiveness of all types of utilization management systems and programs and report further results of such study to the Federation as they become available; (4) that state medical societies be urged to work for enactment of the AMA model state legislation governing: (a) clarity and readability of contract language and uniform policy provisions; (b) liability of review entities for injury to beneficiaries; (c) physician involvement in the review process; and (d) confidentiality of medical information requested by review entities; and (5) that this information be conveyed to the American public through appropriate mechanisms (Policy H-155.976, "Administrative Costs and Access to Health Care").

CONCLUSION

This root cause analysis concerning the causes of the decline of private medical practice is a helpful reexamination that can serve as a catalyst for continued and enhanced action. The framing of potential causes into the four categories of economic pressures, market consolidation, administrative and regulatory burden, and generational workforce factors can help contextualize the factors delineated in the resolution as well as any other newly identified potential factors. Understanding the interplay between the factors is also helpful in identifying and prioritizing effective interventions.

The AMA has dedicated significant resources and other efforts in this area as specified in this report. To more effectively leverage this body of work, AMA should enhance its communication and engagement efforts to ensure private practice and AMA solutions are widely available to all physicians. The findings of this report can potentially guide a more comprehensive strategy in this communication and engagement so that these resources and efforts are not implemented in silos but are mutually reinforcing to produce a more effective result.

RECOMMENDATIONS

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

1. That our AMA reaffirm the following policies:
    a. H-330.932, "Cuts in Medicare and Medicaid Reimbursement";
    b. H-400.957, "Medicare Reimbursement of Office-Based Procedures";
    c. H-390.879, "Medicare Reimbursement for Multiple Physician's Visits on the Same Day Regardless of the Place of Service";
    d. D-330.902, "The Site-of-Service Differential";
    e. H-240.958, "Prohibiting Insurers from Denying Payment for Procedures Based on Site of Service";
    f. D-240.994, "Payment Variations Across Outpatient Sites of Service"; D-330.997, "Appropriate Payment Level Differences by Place and Type of Service";
    g. D-400.990, "Uncoupling Commercial Fee Schedules from the Medicare Physician Payment Schedule";
    h. H-385.921, "Health Care Access for Medicaid Patients";
    i. D-160.907, "Health System Consolidation";
    j. D-215.984, "Health System Consolidation";
    k. H-180.947, "Maintaining Freedom of Choice with Insurance Products";
    l. D-160.906, "Strengthening Efforts Against Horizontal & Vertical Consolidation";

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m. D-160.908, “Vertical Consolidation in Health Care – Markets or Monopolies”;
n. D-385.940, “Stark Law Self-Referral Ban”;
o. H-215.960, “Hospital Consolidation”;
p. H-215.969, “Hospital Merger Study”;
q. D-225.995, “Hospital Merger Study”;
r. H-383.988, “Physicians' Ability to Negotiate and Undergo Practice Consolidation”;
s. H-160.885, “Impact of Integration and Consolidation on Patients and Physicians”;
t. H-160.960, “Corporate Ownership of Established Private Medical Practices”;
u. D-405.988, “The Preservation of the Private Practice of Medicine”;
v. D-160.909, “Advocacy of Private Practice Options for Healthcare Operations in Large Corporations”;
w. D-330.909, “Study the Costs of Administrative and Regulatory Burdens”;
x. H-110.985, "340B Drug Discount Program"; and
y. H-155.976, “Administrative Costs and Access to Health Care” (Reaffirm HOD Policy)

2. Our AMA will identify stakeholders to expand physician awareness of and engagement with AMA private practice resources and solutions.
3. That consistent with Policy D-405.965, “Root Cause Analysis of the Causes of the Decline of Private Medical Practice,” our AMA further study and report back on the role of physician non-compete agreements and other physician employment restrictions as potential contributors to the decline of private medical practice, including their impact on physician mobility, the ability of physicians to establish or re-establish independent practices, patient access and continuity of care, and the maintenance of market power by dominant health systems.

Fiscal Note: Minimal

APPENDIX:

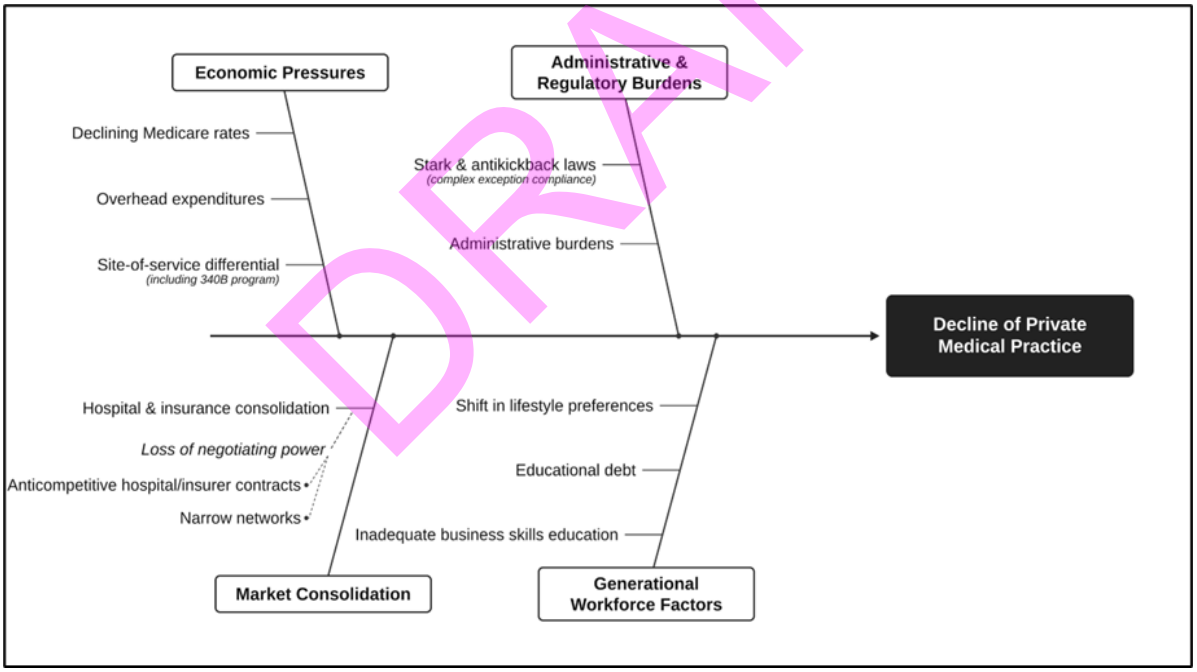


Figure 1: Basic root cause analysis fishbone diagram[7] used by report authors to organize the factors outlined in Policy D-405.965 into overarching thematic categories.

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20. MITIGATING THE IMPACT OF EXCESSIVE PRIOR AUTHORIZATION PROCESSES

Reference committee hearing: see report of Reference Committee G.

HOD ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS
REMAINDER OF REPORT FILED
See Policies D-320.974, H-320.934, H-320.939 and H-320.950

At the 2025 Annual Meeting, Resolution 704-A-25 was introduced by the Florida delegation. The House of Delegates adopted two of the resolve statements of the resolution resulting in Policy D-320.971, "Mitigating the Impact of Excessive Prior Authorization Processes", which states:

1. Our AMA will actively and urgently generate a prior authorization database collecting and analyzing data including metrics reflecting denial rates, care delays, impact on patient care, and associated cost adversely affecting patients and physicians across major health care insurers.
2. Our AMA will strengthen and expand the existing public awareness campaign including but not limited to social media, print media, and editorials to highlight the negative impacts of abusive and obstructive prior-authorization requirements on patient care, and educate physicians AND patients on their rights and available resources.

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An additional resolve statement was referred and is the subject of this report. The referred resolve reads as follows:

> RESOLVED, That our American Medical Association working with legal experts, determine whether and to what extent it may be appropriate to initiate and/or support a class action lawsuit against insurance companies based on the identified prior authorization data, and if so appropriate, collaborate with patient advocacy groups to support potential lawsuits.

BACKGROUND

Prior authorization is a process used by health insurers requiring physicians to receive approval from plans before certain prescribed medications, procedures, or treatments can be provided to patients. While intended to control costs and ensure medical necessity, prior authorization has become a significant administrative burden for physicians. Per the American Medical Association ("AMA") Prior Authorization Survey conducted in 2024[18], ninety-three percent of physicians report that prior authorization leads to delays in patient care, and eighty-two percent say it results in patients abandoning treatment due to these barriers.[19] Most alarmingly, more than one-quarter of physicians report that such delays have resulted in serious adverse events for patients—including hospitalization or death.[20] In addition, the average weekly prior authorization workload for a single physician consumes 13 hours of physician and staff time, with 89 percent of physicians saying that prior authorization increases burnout. These findings underscore the urgent need for reform to reduce administrative friction and protect patient access to timely care.

Relevant Current AMA Policy

AMA Policy H-320.939, "Prior Authorization and Utilization Management Reform," supports the overall effort to mitigate the impact of prior authorization on patient care.

AMA Policy H-320.950, "Eliminating Precertification," advocates for utilization review efforts and preauthorization request to focus on statistical outliers and physicians whose claims have shown to be statistical outliers, respectively, rather than the physician population at large.

AMA Policy D-320.974, "Insurer Accountability When Prior Authorization Harms Patients," calls for increased legal accountability of insurers via (i) private right of action for patients to sue insurers that supersedes any other contractual provision, and (ii) the prohibition of mandatory pre-dispute arbitration clauses.

DISCUSSION

The referred Resolve clause, which is the subject of this report, calls for a possible class action lawsuit against insurance companies "based on the identified prior authorization data" collected pursuant to the now adopted policy. The AMA has not yet created the prior authorization database mandated under the new policy, as funding for this project was not available until January 2026. The Advocacy Group is issuing a request for proposal (RFP) for a feasibility study to assess the logistics, costs (both initial and long term), and overall return on investment in creating such a database. The vendor selected from the RFP process would prepare a robust report to inform the AMA's future decisions on the direction of this project. Given the current status of the database, the condition precedent to implementation of the class action under the Second Resolve has not transpired, and so the AMA lacks the necessary data to evaluate the suggested lawsuit.

While the lack of the prior authorization database is a barrier to assessing potential lawsuits, disregarding that obstacle the proposed class action would be a steep uphill climb. The AMA has long been and remains a staunch advocate for physicians and that includes, where appropriate, taking necessary legal action or submitting an *amicus curiae* ("a friend of the court") non-party brief in on-going legal matters. These briefs help inform courts and judges of points of information in lawsuits involving the healthcare industry and the wider, real-world impact of legal decisions. The AMA has, for years, searched for meritorious class action lawsuits against managed care companies; however, to bring such a case remains challenging – the reasons include:

[18] 2024 AMA Prior Authorization Physician Survey *located at:*https://www.ama-assn.org/system/files/prior-authorization-survey.pdf
[19] https://www.ama-assn.org/system/files/prior-authorization-survey.pdf
[20] https://www.ama-assn.org/system/files/prior-authorization-survey.pdf

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Class Actions are Difficult to Bring

Class actions are inherently difficult to bring successfully. Rule 23 of the Federal Rule of Civil Procedure imposes multiple, demanding procedural and substantive requirements that plaintiffs must satisfy at an early stage of litigation. Proposed class representatives must establish all four prerequisites of Rule 23(a) – numerosity, commonality, typicality, and adequacy – each of which is technically complicated, closely scrutinized by courts,[21] and often contested by defendants. These prerequisites are defined as follows:

- Numerosity: the class is so numerous that joinder of all members is impracticable.[22]
- Commonality: there are questions of law or fact common to the case.[23]
- Typicality: the claims or defenses of the representative parties are typical of the claims or defenses of the class.[24]
- Adequacy: the representative parties will fairly and adequately protect the interest of the class.[25]
- Prior authorization disputes can be heavily individualized due to varied patient conditions, differing practices based on specialty, and varied insurance contracts, all of which undermine the "commonality" and "typicality" requirements for class certification.[26]

Restrictions on Prior Authorization are Intended to Protect Patients

Restrictions on insurance companies' use of prior authorization are generally focused on protecting patients – not physicians. While physicians may incur harm because of prior authorization abuse, such harm could be considered only incidental to the harm caused to patients. Most of the prior authorization legislation enacted to date is intended to protect patients' access to care – addressing items such as response times, retrospective denial, clinical criteria, medical necessity, qualifications of reviewers, peer-to-peer review/appeals processes, and physician "gold carding" (a process where physicians with a proven track record of prior authorization approvals – often over 90 percent – are exempted from prior authorizations, and one of the few remedies that has a *direct* impact on physicians). [27] [28] Similarly, the Centers for Medicare & Medicaid Services cited the barrier for care and disproportionate impact prior authorization may have on certain patient demographics for adopting rules requiring faster determinations and greater transparency in Medicare Advantage and Medicaid programs.[29]

Most law and policy remedies are directed at enforcement by public officials—not at empowering physicians or their organizations to bring class actions. Physicians do not generally have a private right of action to bring a lawsuit under laws on prior authorization.[30] [31]

Other Considerations

Proving prior authorization abuse to sustain a class action suit would be difficult. An isolated case of abuse would be insufficient – a class action suit would need to rely on systematic abuse. Indirect and anecdotal evidence would be only a start. Prior authorization decisions are likely to vary, based on insurers, physicians, patients, and treatment settings. These variations can make it difficult to substantiate uniform, class-wide harm.

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[21] Wal-Mart Stores, Inc. v. Dukes, 564 U.S. 147, 161 (2011) (holding that Rule 23(a)'s requirements "are not mere pleading standards" and must be proven with evidentiary support at certification).
[22] Fed R. Civ. P. 23(a)(1).
[23] Fed R. Civ. P. 23(a)(2).
[24] Fed R. Civ. P. 23(a)(3)
[25] Fed R. Civ. P. 23(a)(4)
[26] "Doctors Target Insurers' Prior Authorization Policies in Legislative Push," MedPage Today, March 2023 *located at*: https://www.medpagetoday.com/special-reports/features/98337.
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[29] 89 Fed. Reg. 8,759-60 (Feb. 08, 2024).
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Further, physician network contracts almost always include provisions that (a) require pre-dispute arbitrations and (b) prohibit consolidation of claims, of which a class action would be an extreme example. Courts have routinely upheld network contract arbitration clauses in disputes between healthcare providers and payors.[32]

CONCLUSION

This report does not conclusively determine that the contemplated class action would be impossible – only that it would be difficult. The AMA has searched for meritorious class actions against managed care organizations, and that effort continues.

RECOMMENDATIONS

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

1. That the referred resolve clause of Resolution 704-A-25 not be adopted.
2. That our AMA continue to actively monitor prior authorization legislation and litigation on a state and federal level and, where appropriate, take action to advance legislation and support litigation, respectively, that have a direct impact on reducing the burdens of prior authorization for physicians including, if feasible, a potential class action lawsuit.
3. That existing AMA policies H-320.939, "Prior Authorization and Utilization Management Reform", D-320.974, "Insurer Accountability When Prior Authorization Harms Patients", and H-320.950, "Eliminating Precertification" be reaffirmed.

Fiscal Note: No Significant Fiscal Impact

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[32] Infectious Disease Doctors, P.A. v. Bluecross Blueshield of Texas, No. 3:13-CV-02920-L, 2015 WL 4992964 (N.D. Tex. Aug. 21, 2015). *See also.* Klay v. United Healthgroup, Inc., 376 F.3d 1092 (11th Cir. 2004).

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21. ABOLISHING VENUE SHOPPING

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: RECOMMENDATIONS ADOPTED
REMAINDER OF REPORT FILED
See Policy D-435.968

At the 2025 Annual Meeting of the American Medical Association (AMA) House of Delegates (HOD), the HOD adopted Policy D-435.968, "Abolishing Venue Shopping" which asked the following:

1. That our American Medical Association oppose venue shopping in medical professional liability actions; and be it further
2. 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.

Policy D-435.968 was adopted following mixed testimony. Testimony noted that venue shopping was a complicated issue involving varying state and federal rules, statutes, cases, and constitutional issues. Testimony also noted that having the AMA advocate for specific venue requirements may have unintended consequences for physicians who are defending allegations of medical liability. Significant testimony was offered highlighting the problems that can arise for physicians when venue shopping is utilized in medical liability cases. During testimony, the authors of the original resolutions offered alternative language which the HOD adopted. It is noteworthy that while Policy D-435.968 called for a study, overwhelming testimony supported action being taken on venue shopping immediately.

BACKGROUND

Medical liability reform has long been one of the AMA's advocacy priorities. Although physicians and patients are not yet experiencing the kind of national medical liability insurance crisis that occurred in the early 2000s, over the last few years there has been a significant increase in the size of medical liability awards. In fact, the U.S. has seen an increase of "nuclear verdicts" in medical liability cases, i.e., cases where the jury awarded $10 million or more, some exceeding $25 million. This is worrisome to the Board of Trustees (the Board) because such awards are often influenced by factors that have nothing to do with a physician's alleged negligence or patient injury. Oftentimes they are the product of "social inflation," such as eroding trust in the U.S. health care system and the perceived corporatization of medicine. There also appears to be a return of hard medical liability insurance markets in parts of the country.
In addition to what has been described above, the Board knows that venue shopping, also known as forum shopping, can be a major contributor to increasing medical liability exposure. Venue shopping occurs when a plaintiff's attorney can file medical liability lawsuits in a county where juries are known for awarding large medical liability awards, even if the county has no connection to underlying facts of the lawsuit. Venue shopping is an abuse of the judicial process, as it leads to outsized awards that must be absorbed by physicians in the form of increased medical liability insurance premiums, ultimately to the detriment of patient access.

Based on the above, the Board understands that the need to enact medical liability reform is urgent in some states.

State Medical Liability Lawsuits and Forum Shopping: The Pennsylvania Example

After evaluating state environments across the country, it is clear that Pennsylvania physicians have suffered the most harm from venue shopping in medical liability cases. Notably, in the early 2000s, Pennsylvania experienced a severe medical liability crisis. Much of the crisis was the result of plaintiffs' attorneys filing medical liability cases in Philadelphia County and Allegheny County, where juries were notoriously plaintiff friendly.

Because Pennsylvania has been ground zero of venue shopping abuse and has led the way in efforts to combat venue shopping, the Board believes that closely analyzing the Pennsylvania experience is the best way to conduct the study called for by Policy D-435.968.

During its medical liability crisis, Pennsylvania pursued at least two strategies to combat venue shopping. First, Pennsylvania enacted 42 Pa.C.S.A. § 5101.1. This statute required medical liability cases to be filed "only in a county in which the cause of action arose." This statute was, however, declared unconstitutional in *North-Central*

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Pennsylvania Trial Lawyers Association v. Weaver, 827 A.2d 550 (Pa. Cmmwth. 2003) on the grounds that Pennsylvania's judicial branch of government, rather than the Pennsylvania General Assembly, was constitutionally authorized to set venue rules.

Second, in 2002, Pennsylvania enacted the Medical Care Availability and Reduction of Error Act (the MCARE Act). The MCARE Act established the Interbranch Commission on Venue (the Commission), comprised of representatives from the legislative, judicial, and executive branches of the Commonwealth of Pennsylvania, and others. In 2003, on recommendations from the Commission, the Supreme Court of Pennsylvania adopted a civil procedure rule, Rule 1006(a)(1), requiring medical liability cases to be filed in the county in which the cause of action arose. Rule 1006(a)(1) was instrumental in stabilizing the medical liability insurance market in Pennsylvania.

Notably, on August 25, 2022, however, the Supreme Court of Pennsylvania, following recommendations of the Civil Procedural Rules Committee (Civil Rules Committee), whose members are appointed by the Supreme Court of Pennsylvania, issued an order amending Rule 1006. The amendments eliminated the requirement that medical liability lawsuits had to be filed in the county where the cause of action arose. Due to this decision, like other lawsuits, medical liability lawsuits in Pennsylvania may now, once again, be forum shopped since lawsuits may be filed where a defendant may be served, the cause of action arose, or a transaction or occurrence took place out of which the cause of action arose. After the amendments to Rule 1006 were adopted, the Board would like to note that there was a four-fold increase in the number of malpractice lawsuits filed in Philadelphia County. Moreover, between January 2023 and April 2023, 43 percent of 657 medical malpractice complaints that were initiated in Philadelphia County were based on care provided outside the city.[1]

The Board believes that it is likely that restoring plaintiffs' attorneys' ability to venue shop medical liability cases in Pennsylvania will undermine the stability of the medical liability insurance market in the state.

Venue Shopping and Resourced-Based Standards of Care

Venue shopping may hit physicians that practice in rural or underserved communities and their patients particularly hard, since these physicians often have fewer resources, limited staff, and less advanced medical equipment compared to those within larger health care systems. It may be logistically impossible for rural physicians to perform certain procedures or make needed referrals due to lack of availability within the community. These and similar resource constraints must be considered when determining the standard of care relevant to any medical liability allegations. Juries in some parts of a state, e.g., a well-resourced city with four Level-1 trauma centers, may know nothing about the resource limitations under which rural physicians must practice, and thus apply a standard of care that is appropriate to physicians practicing in that city but wholly inappropriate to a rural practice setting. Rural physicians whose liability is determined by juries having no appreciation for their unique practice environments are likely to be held responsible for harm resulting from factors far outstripping their control or even influence. To ensure fairness, AMA policy should state that the AMA opposes venue shopping resulting in the application of a standard of care that is not specifically linked to the physical resources, technology and specialty support available at the site of patient care delivery.

Federal Medical Professional Liability Actions and Venue Shopping

Federal medical professional liability actions are brought under the Federal Tort Claims Act (FTCA).[2] A medical liability lawsuit under the FTCA may be commenced only in the judicial district where the plaintiff resides or wherein the act or omission complained of occurred.[3] Thus, it does not appear that federal medical professional liability actions raise the kinds of venue shopping concerns that may exist in state law. This does not mean, however, that attempts might be made in the future to alter the FTCA to permit venue shopping. The AMA would vehemently oppose such efforts.

Given that current venues for federal medical professional liability actions under the FTCA appear to provide little opportunity for venue shopping, the remainder of this report will focus on state venue issues.

[1] Venue Shopping Brings a Flood of Medical Liability Lawsuits to Philadelphia, ISMIE Mutual Insurance Company, October 8, 2024. https://www.ismie.com/Articles/Legal-Cases/Oct-8-2024-Venue-Shopping-Brings-a-Flood-of-Medica.
[2] U. S. Code 28 U.S.C. §§ 1346(b), 2671-2680
[3] 28 U.S. Code § 1402(b); §§ 2671-2680

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DISCUSSION

Policy D-435.968 asks that the AMA study avenues to most effectively combat venue shopping in state and federal medical professional liability actions. At this point there appear to be at least three strategies that might be used to combat venue shopping in states, all based on knowledge of and insights taken from the Pennsylvania experience.

First, enacting a statute that restricts where medical professional liability lawsuits may be filed is one strategy to combat venue shopping. As the *Weaver* case illustrates, however, such statutes may be subject to constitutional challenges. Importantly, the Board notes that while this is what happened to Pennsylvania's statute, the situation may be different in other states. For example, in 2005, Missouri enacted R.S,Mo. § 508.010, as part of a comprehensive medical liability reform package. Section 508.010 establishes venue under different scenarios for both non-tort and tort claims (e.g., medical professional liability lawsuits). Section 508.010 states in part that, "Notwithstanding any other provision of law, in all actions in which there is any count alleging a tort and in which the plaintiff was first injured in the state of Missouri, venue shall be in the county where the plaintiff was first injured by the acts or conduct alleged in the action."

In Missouri, venue is fixed in the county where the plaintiff was first injured by the alleged negligence. While the meaning and application of § 508.010 has been litigated many times, there appear to be no reported cases ruling that § 508.010 is unconstitutional. One cannot simply assume that the courts of any given state would decide that a statute like 42 Pa.C.S.A. § 5101.1 would be unconstitutional. In fact, in some states, enacting state laws prohibiting venue shopping might be a viable option to combat venue shopping.

Second, if there are concerns about the constitutionality of a statutory approach, one could follow the Pennsylvania example and advocate for a law that would convene members of the legislative, judicial, and executive branches of government and other interested parties to see if the judicial branch would address venue shopping through court rules. While this approach succeeded in Pennsylvania, the Board warns that this strategy might not be as promising as a legislative solution since the decision of whether to implement (or implement and then repeal) such rules would lie entirely within the judicial branch's discretion.

A recent Pennsylvania court decision, *Somerlot v. Jung*, 343 A.3d 324, 333 (Pa. Super. 2025), suggests a third way to combat venue shopping. In this case, the plaintiff, Ms. Somerlot fell and injured one of her fingers. Due to pain and decreased range of motion she sought pain treatment from the defendant, Dr. Jung, whose office was in Bucks County Pennsylvania. Dr. Jung ultimately determined that Ms. Somerlot needed spinal cord surgery. Ms. Somerlot alleged to have received injuries during the surgery and filed a medical liability lawsuit against Dr. Jung in Philadelphia County, notwithstanding the fact that the Court of Common Pleas of Bucks County was less than two miles from Ms. Somerlot's home.

Notably, the facts showed that prior to surgery, Ms. Somerlot signed a "Consent to Operate, Administration of Anesthetics and Rendering of Medical Services." This document included a venue selection clause stating in part that, "Any legal claims or civil actions, including, but not limited to, a claim for medical malpractice in any way related to this admission/procedure, and medical services shall be brought solely in the Courts of Bucks County, in the Commonwealth of Pennsylvania."

Because Ms. Somerlot signed the venue selection clause, Dr. Jung argued that Ms. Somerlot had to file her lawsuit in Bucks County, not Philadelphia County. Ultimately, the court agreed with Dr. Jung, stating that:

> Critically, the Civil Rules Committee omitted language or a Note to Rule 1006 reflecting the fact that Pennsylvania law has long recognized a contract-based exception to all Rule 1006 on venue. The Supreme Court of Pennsylvania has made clear that parties may freely contract to limit venue to one of several available venues. The Supreme Court first recognized such an exception in *Central Contracting Co. v. C. E. Youngdahl & Co*., 418 Pa. 122, 209 A.2d 810 (Pa. 1965).

Thus, based on Pennsylvania Supreme Court precedent and the fact that Ms. Somerlot consented to venue in Bucks County by signing the venue selection clause, the court transferred the case from Philadelphia County to Bucks County. Based on this case, the Board believes that this contractual approach is a strategy to combat venue shopping that may also be available in other states.

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CONCLUSION

The Board is greatly concerned about recent, disturbing trends in medical liability, and this includes venue shopping. The Board recognizes that advocacy efforts to combat venue shopping may raise complicated issues. Regardless of issues raised, the Board believes that the AMA, alongside its medical society partners, must do everything it can to enact effective medical liability reforms at the state level, and this includes combating venue shopping.

The Board, therefore, recommends that the HOD modify existing policy D-435.968, "Abolishing Venue Shopping," and by adopting new policy focused on the AMA working with interested medical societies in combating venue shopping in medical liability lawsuits. The Board also recommends that the HOD modify D-435.968 "Abolishing Venue Shopping" by rescinding language in the second resolve requiring that the AMA study avenues to most effectively combat venue shopping in state and federal medical professional liability actions with report back at A-26, since this report constitutes the required study.

RECOMMENDATION

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 amend Policy D-438.968, "Abolishing Venue Shopping" by deletion of clause 2 as it has been accomplished by this report:
    1. Our American Medical Association (AMA) opposes venue shopping in medical professional liability actions.
    2. ~~Our AMA will study avenues to most effectively combat venue shopping in state and federal medical professional liability actions with report back at A-26.~~
2. That our AMA will work with interested medical society partners, to combat venue shopping in medical liability lawsuits.
3. That our AMA opposes any efforts to move venue to jurisdictions that may apply a standard of care not reflecting specific resource constraints, available technology/equipment and community standards of the location where the patient's clinical care was actually delivered.

Fiscal Note: Less than $500.

22. COMPREHENSIVE AMA POLICY PUBLICATION REGARDING EMPLOYED PHYSICIANS

Reference committee hearing: see report of Reference Committee G.

HOD ACTION: RECOMMENDATIONS ADOPTED
REMAINDER OF REPORT FILED

At the 2025 American Medical Association (AMA) Annual Meeting, the House of Delegates (HOD) adopted Policy D-225.971 "Comprehensive AMA Policy Publication Regarding Employed Physicians," which directs the AMA to "comprehensively review the current landscape of the employment of physicians for report back to the House of Delegates at Annual 2026, including but not limited to:

1. The changing context and expectations of different practice models;
2. Factors which have led to physicians increasingly choosing an employment practice model over independent practice;
3. The employed physician relationship with healthcare organizations, including those controlled by private equity; and
4. The evolution of collective bargaining by, and unionization of, physicians."

The policy separately directs the AMA to create a policy publication addressing various matters of relevance to employed physicians, such as employment contracting, compensation models, and maintaining professionalism and the primacy of the physician-patient relationship in an employment relationship. While that policy publication is not the subject of this informational report, this report additionally highlights various AMA resources that are responsive to the needs of employed physicians.

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BACKGROUND

Practice model options

From an ownership and employment perspective, physicians have a range of practice models to choose from, each offering different levels of autonomy, financial opportunity, and administrative responsibility. At the most generalized level, these models include:

- Solo practice: Physicians have complete control and autonomy over their practice but bear all administrative duties and financial risk.

- Group practice partnership: Multiple physicians share ownership, distributing risks and workloads and providing a balance between independence and collaboration.

- Third-party-owned practice (including hospital, health system, private equity, or other corporate ownership): Physicians are employed, with reduced administrative burden but also often less autonomy.

While the term "physician employment" most commonly refers to working for an entity owned by a third party, physicians may also be employed by group practices (sometimes on a partnership track), governmental agencies, or non-profit organizations.

Trends in practice ownership and physician employment

The AMA's Physician Practice Benchmark Survey, conducted on a biennial basis since 2012, provides insight into trends in practice ownership and physician employment and factors driving these trends. Since the early 1980s, the share of physicians with an ownership share in their practice decreased from approximately 76 percent to 53.2 percent in 2012 to just 35.4 percent in 2024. Similarly, the share of physicians who worked in a practice that was owned by a hospital, hospital system, or health system, or were directly employed by or contracted with a hospital, increased from 29 percent in 2012 to 47 percent in 2024. An additional 6.5 percent of physicians reported practicing in settings owned by private equity groups in 2024, an increase from approximately 4.5 percent in both 2020 and 2022.[1]

AMA research highlights three key factors driving physicians to sell their independent practices or seek employment relationships:[2]

- Financial pressures: Large organizations are able to negotiate higher payment rates with insurers compared to smaller, independent practices. Lower reimbursements make it more difficult for private practices to remain sustainable, while employment offers greater financial stability.

- Access to resources: Hospitals and health systems can afford to invest in expensive medical equipment and advanced technology, often giving employed physicians better access to these resources than those in small independent practices.

- Administrative burden: The growing complexity of healthcare regulations and administrative requirements makes independent practice increasingly challenging. Employed settings provide administrative and regulatory support, alleviating some of this burden for physicians.

Members are encouraged to review the AMA's most recent Physician Practice Benchmark Survey for a comprehensive discussion of these and other practice trends.

Trends in physician unionization

While the number of physicians who are members of unions is small compared to the size of the profession, that share is growing. The AMA has estimated that between 2014 and 2019 the share of physicians who were union members increased from 5.7 percent to 7.2 percent.[3] This trend appears to be accelerating, as highlighted by a *JAMA* study analyzing trends in the number of petitions filed with the National Labor Relations Board to form unions with physician members; there were 44 such petitions filed between 2000 and 2022 – and an additional 33 filed in 2023-

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2024 alone.[4] The same study found that physicians are motivated to organize unions primarily due to "concerns about working conditions, physicians' autonomy, and voice in management, and the quality of patient care."[5]

Members are encouraged to review the AMA issue brief, Collective bargaining for physicians and physicians-in-training, for a comprehensive discussion of the topic. Members may also wish to review CLRPD Report 2-A-24, Scenarios on Collective Action and Physician Unions, which examined trends and factors in collective bargaining and physician unionization and implications for the AMA. Finally, see AMA ethical opinion 1.2.10, Political Action by Physicians, which addresses the ethical implications of unionization and collective bargaining.

DISCUSSION

Challenges of physician employment

Employment and practice ownership status do not change a physician's professional or ethical obligations. However, shifts in practice ownership, especially employment by third-party entities in which a physician has no ownership interest, introduce unique challenges and create complicated relationships between physicians and their employers. Notable challenges that may arise with physician employment include:

- Decreased clinical autonomy: Physicians may have less control over clinical decisions and daily operations due to complex leadership structures in larger organizations.
- Reduced influence in decision-making: Employment in larger organizations can limit opportunities for physicians to participate in high-level decisions affecting clinical practice or workplace operations.
- Alignment with organizational goals: Physicians must adapt to employer-set policies and values, which may differ from their own practice philosophies.
- Performance metrics and targets: Physicians may feel pressured to meet benchmarks set by employers, which can at times be perceived as emphasizing productivity or administrative tasks over individualized patient care.
- New administrative demands: Employment structures may simply replace the administrative demands of independent practice with a new set of administrative demands, adding to workload and impacting job satisfaction.
- Potential for burnout: These challenges can affect physician professional satisfaction and lead to burnout.[6]

Addressing the challenges of physician employment

While employment relationships often provide financial stability, access to resources, and operational advantages, they may also introduce challenges that affect satisfaction and well-being. These challenges can be reduced significantly in organizations that prioritize physician well-being. Therefore, when evaluating potential employers, physicians should look beyond compensation to consider an organization's commitment to physician well-being. Two key indicators of such commitment include:

- Has the organization conducted an AMA Organizational Biopsy®, or other biopsy assessment, to measure and take action to improve the health of the organization in areas critical to physician well-being, such as organizational culture, practice efficiency, self-care, and retention?
- Has the organization applied for or received recognition through the AMA Joy in Medicine™ Health System Recognition Program for its efforts to combat burnout and promote a culture of wellness at the organizational level?

Weighing these factors carefully will help ensure physicians select a workplace that respects their professionalism while supporting their well-being, job satisfaction, and lasting career fulfillment. Members are encouraged to review the AMA STEPS Forward® module, What to Look for in Your First or Next Practice, to learn more.

Other AMA resources for employed physicians

The AMA offers a suite of practical tools and support to help employed physicians and health care organizations navigate challenges associated with physician employment:

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- The AMA Annotated Model Physician-Group Practice Employment Agreement and the AMA Physicians' Guide to Hospital Employment Contracts provide comprehensive guidance for understanding, evaluating, and negotiating key terms and implications of physician employment contracts. Additionally, the AMA has published a six-part podcast series exploring contract negotiation.
- As a benefit of membership, AMA members receive a 20 percent discount on contract review packages and salary data from Resolve, an industry leader in physician employment contract review.
- The AMA Principles for Physician Employment, codified as AMA policy H-225.950, provide guidance to help physicians and their employers navigate unique challenges to professionalism and patient care arising from employment relationships, addressing issues such as conflicts of interest, advocacy for patients and the profession, contracting, medical staff relations, peer review, and payment agreements.
- The AMA Physician's Guide to Medical Staff Organization Bylaws is designed to assist medical staffs with drafting or amending medical staff bylaws and understanding how emerging issues in health care impact medical staff. Notably, the Guide addresses issues specific to employed physicians within the context of the medical staff, such as hearing rights for employed physicians.
- AMA STEPS Forward® is a collection of resources covering everything from time-saving strategies and preventing physician burnout to improving practice workflows, building a supportive organizational culture, and implementing digital health solutions that reduce technology-associated administrative burdens.
- The AMA Joy in Medicine® Health System Recognition Program is a prestigious AMA-granted distinction in recognition of an organization's demonstrated efforts to enhance physician well-being by resolving the root causes of work-related burnout.
- The AMA Organizational Biopsy® is an assessment tool and set of services developed by the AMA to assesses burnout levels within health care organizations to provide metrics that can guide solutions and interventions that mitigate system-level burnout rates and improve physician well-being.
- The AMA issue brief, Collective bargaining for physicians and physicians-in-training, provides an overview of trends in physician unionization, examines the factors driving physicians to join unions, and discusses the implications of union membership for physicians and the broader healthcare system.
- The AMA Organized Medical Staff Section (OMSS) has convened an employed physician caucus to amplify the voice and issues of employed physicians in AMA policy development. Members may contact the OMSS (omss@ama-assn.org) to learn more.

The AMA is currently evaluating the most effective ways to organize its diverse and comprehensive resources for use by employed physicians and those considering employment opportunities. This curated collection ultimately will serve as the policy publication designated by Policy D-225.971, offering practical, real-time guidance for physicians as they navigate employment relationships and decisions.

CONCLUSION

The landscape of physician employment and practice ownership continues to change, with physicians increasingly employed by hospitals, health systems, and corporate-owned practices. As traditional practice ownership declines and trends toward employment and unionization increase, physicians are encountering new challenges related to clinical autonomy, professional identity, and workplace dynamics. The AMA remains committed to supporting employed physicians by providing educational resources, advocacy, and practical tools to successfully navigate these evolving environments.

RECOMMENDATION

The Board of Trustees recommends that the first directive of Policy D-225.971, Comprehensive AMA Policy Publication Regarding Employed Physicians, be rescinded as having been accomplished by this report and that the remainder of the report be filed.

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RELEVANT AMA POLICY

D-225.971 Comprehensive AMA Policy Publication Regarding Employed Physicians

1. Our AMA will comprehensively review the current landscape of the employment of physicians for report back to the House of Delegates at Annual 2026, including but not limited to:
    a. The changing context and expectations of different practice models;
    b. Factors which have led to physicians increasingly choosing an employment practice model over independent practice;
    c. The employed physician relationship with healthcare organizations, including those controlled by private equity; and
    d. The evolution of collective bargaining by, and unionization of, physicians.
2. Our AMA will create a comprehensive policy publication, which will be an essential tool for employed physicians with guiding principles, rights, and responsibilities regarding, but not limited to, the following:
    a. Employment contracting;
    b. Different compensation models;
    c. Professional accountability to, and as a member of, the medical staff; and
    d. Primacy of the doctor-patient relationship within the context of employment.
3. Our AMA will have a comprehensive policy publication regarding employed physicians available to all physicians, in any employment model, and to all healthcare collaborators with the AMA who directly employ and/or have contracting arrangements with physicians.

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23. LIBERALIZED REMORSE PERIOD FOR MEDICARE ADVANTAGE PLAN INSUREDS

Reference committee hearing: see report of Reference Committee A.

HOD ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS
REMAINDER OF REPORT FILED
See Policies H-330.861 and H-330.866

Resolution 117-A-25, "Liberalized Remorse Period for Medicare Advantage Plan Insureds," was introduced by the Mississippi delegation and was referred. It asked the following:

> RESOLVED, that our American Medical Association advocate for the Centers for Medicare Services to expand the period that Medicare Advantage (MA) plan insureds can leave their MA plan and obtain coverage by traditional Medicare part B and D plans from the current policy of January through March to any month for any reason with plan changes becoming effective on the first day of the next month (Directive to Take Action); and be it further
> RESOLVED, that our AMA prepare a "tool-kit" for both patients and physicians to help patients make an informed choice regarding their Medicare coverage options.

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The rationale that the sponsors provided for changing Medicare policy on MA disenrollment is that the health care system is increasingly complicated, expensive, and difficult for the average adult to navigate, and that health insurance costs and coverage options vary greatly, even within the same company. Patients covered by MA plans often experience "buyer's remorse" after March of each year due to unanticipated health crises that increase their need for health care resources and make traditional Medicare a better option for their care. Testimony on the resolution supported its intent but expressed concern about the complexity of the issue, particularly that allowing people to disenroll from their MA plan at any time for any reason could disrupt the stability of medical groups and health plans, with negative impacts for both patients and physicians.

BACKGROUND

There are two standard Medicare enrollment periods annually. From October 15 to December 7, beneficiaries can switch from traditional Medicare to an MA plan, change from one MA plan to another, change from MA to traditional Medicare, and/or change or drop their Part D prescription drug plan. Changes made during this Medicare Annual Enrollment Period take effect on January 1 of the subsequent year. Then, during the MA Open Enrollment Period from January 1 to March 31, beneficiaries enrolled in MA can switch to a different MA plan or to traditional Medicare, with changes taking effect on the first of the month following receipt of the change request.

In addition to these two standard enrollment periods, there are Special Enrollment Periods for which beneficiaries can become eligible due to many reasons. These include whether the beneficiary moves or their circumstances change, such as admission to or discharge from a nursing facility. They also include coverage changes such as losing Medicaid eligibility or being offered coverage from a union or employer, as well as plan changes such as the plan ending its Medicare contract or CMS ending its contract with the plan or sanctioning the plan. Other factors that make beneficiaries eligible for a Special Enrollment Period are if they are in an MA plan with a relatively low star rating and/or want to enroll in a five-star plan, as well as if their choice was based on bad information. Other important reasons that beneficiaries can change their Medicare coverage are if there is a significant change in the plan's provider network or if they chose their MA plan based on incorrect information about the network. For example, CMS recently adopted an AMA recommendation that MA plans include their physician directories on the Medicare Plan Finder. The agency then determined that beneficiaries who choose a plan based on incorrect information in the Medicare Plan Finder about their physician being in-network are eligible for a Special Enrollment Period.

There is also a Special Enrollment Period for beneficiaries who previously had traditional Medicare and a Medigap supplemental plan but later decide to enroll in MA. Medigap plans cannot be used with MA, and beneficiaries only have a guaranteed right to reenroll in their Medigap plan for 12 months after they disenroll and join MA. Beneficiaries have up to 12 months, therefore, after enrolling in an MA plan, to switch back to traditional Medicare, reenroll in Medigap, and choose a Medicare Part D prescription drug plan. Also, any Medicare beneficiary who enrolls in MA when they first become eligible for Medicare can switch from MA to traditional Medicare during the 12-month period following their initial enrollment in MA and have a right to enroll in a Medigap plan.

AMA POLICY

Three existing AMA policies are most relevant to the issues raised in Resolution 117-A-25. Policy H-330.866 supports annual open enrollment periods and guaranteed lifetime enrollment eligibility for Medigap plans, as well as advocating for federal "guaranteed issue" protections, allowing beneficiaries the freedom to switch from MA to traditional Medicare without facing prohibitive barriers. Policy H-285.982 includes the recommendation discussed above that MA plans be required to update their physician network directories and make them accessible on the Medicare Plan Finder. This policy also calls for CMS to develop a plan to effectively communicate with patients about network access and any changes to the network that may directly or indirectly impact patients, including updating the Medicare Plan Finder website. To improve beneficiaries' understanding of the differences between MA and traditional Medicare, Policy H-330.867 required the AMA to create educational materials such as an infographic to compare the two types of health care coverage.

DISCUSSION

Beneficiaries do not receive clear and objective information about the Medicare program and how to choose their Medicare coverage, either when they initially become eligible for the program or during the Medicare Annual Enrollment Period. They may choose to enroll in an MA plan without knowing what it means to have a network, whether their physician(s) is in the plan's network, or whether the network will be able to offer the types of care they

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may need at a location and cost that is accessible to them. Many beneficiaries who choose MA believe they will have lower out-of-pocket costs in MA. Although this is possible as MA plans have out-of-pocket spending limits that traditional Medicare does not, the limits can be as high as $9,250 for in-network services and $13,900 for combined in- and out-of-network services. Beneficiaries with a Medigap supplemental policy may not understand that they cannot use their Medigap coverage for copayments once they enroll in MA, nor that the MA cost-sharing for services like chemotherapy could be just as expensive in MA as in regular Medicare Part B. Most tests, referrals, admissions, procedures, and therapies are available in traditional Medicare without prior authorization, but prior authorization requirements are pervasive in MA. (There is prior authorization for many medications whether patients are in MA or in traditional Medicare with a standalone Part D prescription drug plan.)

Besides not being familiar with how MA plans work and how they differ from traditional Medicare, beneficiaries are highly unlikely to be fully informed about their options for disenrolling from MA and switching to traditional Medicare, changing MA plans, reenrolling in a Medigap policy, or the many circumstances that qualify them for a Special Enrollment Period. The Board of Trustees (Board) believes that this information gap is a serious problem and agrees with the sponsors of Resolution 117-A-25 that certain barriers to disenrolling from MA should be removed. Ideally, beneficiaries should be able to obtain good information about MA plans before they enroll in them. Providing good information beforehand may lessen the number of beneficiaries who later need to find a way to disenroll from an MA plan. It is important to ensure that beneficiaries can make fully informed decisions about their Medicare enrollment from the beginning. They should not have to contend with the disruption involved in changing plans and likely finding a new physician multiple times because they were not educated about access to care, potential cost-sharing liability, and the implications for their Medigap policy before they signed up.

Most discussions of the information people receive as they approach the age of Medicare eligibility and around the annual enrollment periods focus on the information that is provided through marketing representatives or the online Medicare Plan Finder. The Board believes that the federal government should take a stronger role in educating people about Medicare and the complex decisions involved in choosing the type of Medicare Part A, B, C, and D coverage that will best meet their needs. The current CMS Administrator took an important step in this direction when he made a video about these choices as he approached 65 himself, but CMS needs to do more.

Your Board also agrees with the testimony on Resolution 117-A-25 that allowing everyone with Medicare to disenroll from MA at any time and return to traditional Medicare would be complex and could have unintended adverse consequences for medical groups and patients. Although many people are likely unaware of it, as noted above Medicare policy already allows two categories of beneficiaries who want to disenroll from MA and switch to traditional Medicare to do so during their first 12 months in the MA plan: those who signed up for MA when they first enrolled in Medicare and those who disenrolled from their Medigap plan and want to return to it. It would be better if all beneficiaries could disenroll from MA and switch to traditional Medicare during the first 12 months they are in MA, even if they did not have a Medigap plan. We believe this would fill a gap in current Medicare policy without causing as much disruption as would the policy proposed in Resolution 117-A-25.

RECOMMENDATIONS

The Board of Trustees recommends that the following be adopted in lieu of Resolution 117-A-25 and the remainder of the report be filed:

1) That our American Medical Association (AMA) urge the Centers for Medicare & Medicaid Services to create a comprehensive strategy to educate people approaching the age of Medicare eligibility and for annual enrollment periods about key aspects of Medicare affecting choices between traditional Medicare and Medicare Advantage (MA) plans.
2) That our AMA support a Medicare policy that allows beneficiaries who enroll in MA for the first time to disenroll for any reason and return to traditional Medicare within the first 12 months of enrollment in the plan.
3) That our AMA reaffirm Policy H-330.866, “Medigap Patient Protections.”

Fiscal note: Less than $500

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24. AMA ADVOCACY TO MITIGATE MEDICAID CUTS

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS
REMAINDER OF REPORT FILED
See Policies D-290.970, H-285.898, H-290.951 and H-290.961

At the 2025 Interim Meeting, the American Medical Association (AMA) House of Delegates adopted Policy D-290-970, "Call for Action by the AMA to Reverse or Mitigate Medicaid Cuts," which directs the AMA to:

1. Publicly denounce cuts to Medicaid in Public Law 119-21 (known as the "One Big Beautiful Bill Act of 2025");
2. Through, but not limited to, press releases, position statements, op-eds in major outlets, press conferences and lobbying, work to reverse or mitigate Public Law 119-21 as it relates to Medicaid;
3. Continue working with state medical societies, specialty societies, patient advocacy groups, hospital systems and safety net organizations to advocate for the reversal or mitigation of Medicaid-related cuts in Public Law 119-21;
4. Report back to the AMA's House of Delegates at A-26.

The Board of Trustees is pleased to report that the AMA has taken prompt and sustained action consistent with this directive, including public condemnation of the Medicaid cuts, extensive collaboration with Federation partners and other stakeholders, and ongoing policy, advocacy, and technical assistance to the Federation of Medicine in an effort to mitigate the impact of these changes on patients and physicians. (Note: Because of approval deadlines, this informational report was prepared in February 2026 and does not include more recent developments. For more information on the AMA's up-to-date advocacy to mitigate or reverse the Medicaid cuts, please visit www.ama-assn.org/OB3.)

BACKGROUND

Summary of Medicaid Cuts

The One Big Beautiful Bill Act of 2025 (Public Law 119-21 or OBBBA) enacted sweeping changes to the Medicaid program and broader federal health care financing. The legislation reduced federal Medicaid spending through a combination of structural financing changes, new eligibility and administrative requirements, and limits on other long-standing program features. Collectively, these provisions represent one of the most significant retrenchments of Medicaid funding in the program's history.

Key Medicaid-related provisions of the law include reductions to allowable Medicaid provider taxes and state-directed payments, new Medicaid work requirements for certain adult beneficiaries, and more frequent eligibility checks, among other things. These changes shift increased financial and administrative responsibility to states while constraining their ability to generate non-federal Medicaid revenue, placing pressure on state budgets, provider reimbursement, and patient access to care.

The law's rollback of provider tax arrangements has particular implications for state Medicaid programs, as these mechanisms have long been used, within federal parameters, to support states' share of Medicaid financing and stabilize physician and hospital payment rates. Reductions in provider tax authority may require states to reduce Medicaid expenditures, including eligibility, benefits, or provider payments, absent alternative revenue sources.

In addition, the law authorizes Medicaid work requirements and requires more frequent eligibility verification processes, which introduce new administrative barriers for beneficiaries and state agencies. Past experience with similar policies has demonstrated a high risk of coverage loss among eligible individuals due to reporting burdens, confusion, and administrative churn. These provisions also increase administrative complexity for physicians and health care systems caring for patients on Medicaid.

The law also established a new source of federal funding, the Rural Health Transformation Program, intended to offset impacts of reduced Medicaid spending in rural areas. However, the

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$50 billion program is time limited and falls short of fully replacing lost funding from OBBBA. As a result, many states will still face significant challenges maintaining access to care, supporting physician practices, and sustaining safety-net health care infrastructure.

Impact and Response

Most of OBBBA's changes have not taken effect yet and many of the law's provisions will not become effective until 2027 or later. However, the law's impacts on Medicaid are already being felt and states and other interested parties are responding:

- **State responses to financing constraints.** If states are unable to continue financing their Medicaid programs at pre-OBBBA levels due to the loss of revenue from provider taxes and new restrictions on state-directed payments, they will be forced to make difficult budgetary decisions. As provider taxes and state-directed payments are frequently used to finance enhanced reimbursement rates or expansions in services, it is probable that states will respond by cutting provider rates or rolling back services, in addition to other cuts to state spending on Medicaid. In some states, Medicaid funding cuts have already been announced for 2026.
- **Patient impacts.** Major changes to Medicaid eligibility (work requirements and more frequent eligibility checks for certain adult beneficiaries, narrowing eligibility for legally present non-citizens) will take effect in the coming months. These changes, which present an extreme challenge for states to implement in a short timeframe, will disqualify many patients and could result in many more eligible patients losing coverage due to difficulties in navigating new procedures.
- **Provider impacts.** If, as expected, states reduce spending on Medicaid reimbursement rates and services and patients lose coverage, providers will be affected. Negative impacts will be felt most acutely in rural areas and other underserved communities where patients disproportionately rely on Medicaid. Some physician practices have already reported closures or consolidations in response to OBBBA's cuts.

PUBLIC DENUNCIATION OF MEDICAID CUTS

Immediately following congressional action of Public Law 119-21, the AMA publicly denounced the legislation's Medicaid provisions through public statements and media engagements. On July 1, and July 3, 2025, the AMA issued national press statements following Senate and final congressional passage of the reconciliation bill, explicitly opposing the Medicaid and CHIP cuts and warning of coverage losses, cost shifting to states and providers, and harm to rural and underserved communities. AMA statements also underscored that reduced access to preventive and primary care would likely result in worsening health outcomes and higher long-term costs, as treatable conditions progress into more serious and costly illnesses. These statements were issued by AMA leadership and disseminated nationally through the AMA's press and media channels.

In addition, AMA published multiple AMA News Wire articles and policy analyses explaining the provisions of the law, outlining anticipated impacts on patients and physicians, and reinforcing the AMA's longstanding position that Medicaid is a critical source of coverage for low-income patients and an essential component of the nation's health care safety net.[1] Altogether, these actions constituted a clear, public denunciation of the Medicaid cuts enacted in OBBBA and communicated the AMA's opposition to policymakers, physicians, and the public.

In addition to press statements and media engagement, the AMA has developed and disseminated policy analyses, issue briefs, educational resources, and other advocacy materials regarding the Medicaid provisions of Public Law 119-21. As implementation proceeds, the AMA will continue to evaluate and deploy, as appropriate, the range of public-facing communications tools contemplated by Policy D-290.970, including formal position statements, opinion pieces, and other communications that elevate physician and patient concerns.

[1] AMA resources, press statements, and key advocacy activities are published on the AMA website, available at https://www.ama-assn.org/OB3 .

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ENGAGEMENT WITH STATE MEDICAL ASSOCIATIONS AND NATIONAL MEDICAL SPECIALTY SOCIETIES

Convening the Federation of Medicine

The AMA has served as a central convener for the Federation of Medicine to facilitate coordinated state responses to the Medicaid provisions of Public Law 119-21. Through regular national coordination calls, targeted small-group discussions, webinars, and active listservs, the AMA has connected state medical association and national medical specialty society government affairs leaders to share strategies, resources, and early insights into emerging implementation challenges. At the request of its Federation partners, the AMA created and maintains a centralized repository for advocacy materials, enabling medical association staff to exchange analyses, draft letters, and talking points and reduce the need for duplicative work. This convening role has strengthened cross-state collaboration and improved the ability of physician advocates across the country to anticipate and respond to policy developments affecting Medicaid financing and access to care.

The AMA also convened multiple national webinars and briefing calls for state medical associations and national medical specialty societies focused on the Medicaid provisions in OBBBA. These sessions provided timely analysis of statutory changes, implementation timelines, and state-level decision points. Specifically, in August, the AMA convened state and specialty medical association staff at the AMA State Advocacy Roundtable for a focused discussion on approaches to implementing the law's Medicaid provisions and identifying shared priorities across the Federation. During the fall, the AMA hosted two national calls for state medical associations and specialty societies on the Rural Health Transformation Program, with particular attention to its interaction with state scope of practice laws. The AMA also hosted a publicly available Advocacy Insights webinar in November, attended by nearly 800 participants, which examined the effects of the law on patients and physicians and identified key points of influence for the AMA and other medical organizations. In December, the AMA conducted a Federation-wide webinar on Medicaid provider taxes, examining the details of provider tax rollbacks and outlining state policy options to mitigate funding losses. Additional briefings and educational sessions were held for state medical association audiences, AMA Sections, and allied organizations. Medicaid policy and implementation challenges were also a central focus of strategy discussions at the 2026 AMA State Advocacy Summit, including engagement with Medicaid officials regarding state-level implementation considerations.

Development and Dissemination of Policy Tools and Resources

In parallel with its convening efforts, the AMA has developed and disseminated a suite of policy tools and expert resources to support state advocacy and implementation efforts. These include issue briefs, policy summaries, and analyses addressing Medicaid work requirements, changes to Medicaid financing, and modifications to eligibility and enrollment processes. The AMA also produced detailed analyses, data tables, and slide decks to inform Rural Health Transformation Program applications.

The AMA has also produced detailed toolkits for state and national medical specialty association staff with specific recommendations for engaging lawmakers and Medicaid officials on medical frailty exemptions and hardship exemptions. To ensure accuracy and credibility, the AMA has engaged former Medicaid officials, tax experts, current state policymakers, think tanks, and advocacy partners in the development of these materials and more. In addition to evolving our suite of materials for our Federation partners, the AMA is in the process of producing communication materials for physicians and patients to help explain upcoming Medicaid changes and coverage risks, supporting continuity of care and informed patient decision-making.

Individualized State-Level Technical Assistance

Beyond broad-based education and advocacy, the AMA has provided individualized, one-on-one consultation to state medical associations tailored to state-specific circumstances. This support has included reviewing legislation, assessing options to mitigate impact of provider tax rollbacks, advising on Medicaid work-requirement exemptions, and supporting engagement with state legislatures and Medicaid agencies. In addition, the AMA provided extensive individualized assistance, including state-specific funding estimations, to state medical associations as they collaborated with state officials on Rural Health Transformation Program applications, particularly as related to incentives in the program for state policymakers to expand scope of practice laws for non-physician providers. Importantly, these efforts were highly successful, with only one-fifth of states signaling intent to pursue scope of practice expansions in their program applications.

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The AMA Advocacy Resource Center has also launched a new State Advocacy Accelerator Grant Program to provide targeted, short-term funding to support high-priority state legislative or regulatory campaigns. Grants, typically ranging from $25,000 to $50,000, are intended to support discrete advocacy activities at critical moments, including contract lobbying, targeted communications, physician grassroots engagement, coalition development, and rapid-response research, and can be used to support Medicaid advocacy, as well as other issues.

COLLABORATION WITH STATE AND NATIONAL STAKEHOLDERS

The AMA has also actively engaged Medicaid officials, patient advocacy organizations, hospital groups, safety-net providers, and policy experts to exchange information and track the real-world impact of Medicaid cuts. Through webinars, coalition calls, and ongoing consultation, the AMA has facilitated cross-sector dialogue on implementation challenges, mitigation strategies, and opportunities for policy adjustments. This collaborative approach has supported more informed advocacy and helped ensure that physician and patient perspectives are incorporated into ongoing implementation discussions.

FEDERAL ADVOCACY AND REGULATORY ENGAGEMENT

In addition to the above, the AMA has engaged in robust advocacy efforts at the federal level. During congressional consideration of Public Law 119-21, the AMA strongly opposed the Medicaid cuts, among other policies, through vigorous lobbying, letters to the House and Senate, and in public statements.

With OBBBA now law, the AMA has redirected its efforts towards advocating to federal policymakers as they begin implementing OBBBA's Medicaid provisions. The AMA is particularly focused on the Centers for Medicare & Medicaid Services (CMS), the primary federal agency responsible for overseeing Medicaid. The AMA has made recommendations to CMS regarding the implementation of new restrictions on Medicaid provider taxes, the requirement that certain beneficiaries verify their Medicaid eligibility on a more frequent, biannual basis, and the requirement that states establish community engagement requirements (also known as "work requirements") for certain beneficiaries as a condition of Medicaid coverage. The AMA's recommendations to CMS include maximizing automatic, data-driven eligibility and renewal processes that do not burden patients or physicians with administrative tasks, providing flexibility and technical support to state Medicaid agencies, and communicating with states and interested parties about OBBBA implementation in a timely, transparent, and thorough fashion. Through all of these efforts, the AMA's central aim is to ensure that OBBBA's provisions are implemented in a manner that minimizes harms to patients and disruptions to care.

Although opportunities for federal legislative action to reverse or mitigate OBBBA's impacts are limited, the AMA is encouraging Congress to provide strong oversight of OBBBA's implementation to ensure patient access is not compromised, support state flexibility and requests for technical assistance, and monitor patient and provider impacts, especially in rural and safety net settings.

ONGOING EFFORTS

The AMA's work to reverse or mitigate Medicaid cuts is ongoing. The AMA continues to monitor and inform federal and state implementation of Public Law 119-21, as well as provide coordinated, operational support to state and specialty medical associations. This includes ongoing national and issue-specific calls, targeted strategy meetings, and in-person convenings to support information-sharing and coordinated advocacy on Medicaid eligibility and redeterminations, work requirements, provider taxes and other financing issues, and the Rural Health Transformation Program. These forums will continue to be used to identify emerging implementation issues, share legislative and regulatory approaches, and elevate physician concerns to state and federal policymakers to mitigate the harm of the enacted federal Medicaid cuts.

In addition, the AMA will continue delivering individualized technical assistance and advocacy resources to support state and specialty advocacy efforts. This includes one-on-one consultation with medical associations, review of state legislation, development and dissemination of advocacy toolkits, and timely briefings as federal guidance and state implementation evolve. As implementation proceeds, the AMA will continue to refine its resources and advocacy strategies in response to emerging challenges and state-specific developments.

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STRATEGIC PRIORITIES GOING FORWARD

As implementation of Public Law 119-21 proceeds, the AMA's Medicaid advocacy strategy will continue to operate on both federal and state tracks. Federal priorities include minimizing coverage loss and administrative churn, maximizing automatic and data-driven renewal processes, protecting patient access, preserving state flexibility, and ensuring strong federal oversight of implementation. State priorities include supporting medical associations and physician advocates on provider taxes and other financing issues, eligibility and redeterminations, work requirements, reimbursement and access concerns, and the Rural Health Transformation Program. The AMA will pursue these priorities through direct lobbying and regulatory engagement, public-facing communications, coordinated convenings, one-on-one technical assistance, and development of advocacy resources for state and specialty medical associations.

CONCLUSION

Through prompt public condemnation of Medicaid cuts, sustained collaboration with the Federation and other stakeholders, and targeted advocacy efforts, the AMA has acted consistently with the directives of Policy D-290.970. The Board of Trustees remains committed to opposing policies that undermine Medicaid and to working with partners at all levels to protect patients, physicians, and the health care safety net.

RECOMMENDATION

The Board of Trustees recommends that the following be adopted and the remainder of the report be filed.

1. That AMA Policy D-290.970, "Call for Action by the AMA to Reverse or Mitigate Medicaid Cuts," be amended to read as follows:
   1. Publicly denounce cuts to Medicaid in Public Law 119-21 (known as the "One Big Beautiful Bill Act of 2025");
   2. Through, but not limited to, press releases, position statements, op-eds in major outlets, press conferences and lobbying, work to reverse or mitigate Public Law 119-21 as it relates to Medicaid;
   3. Continue working with state medical societies, specialty societies, patient advocacy groups, hospital systems and safety net organizations to advocate for the reversal or mitigation of Medicaid-related cuts in Public Law 119-21~~;~~.
   4. Report back to the AMA's House of Delegates at A-26~~7~~.

2. That existing AMA policies "Preservation of Medicaid" (H-290.951), "Call for Action by the American Medical Association to Reverse or Mitigate Medicaid Cuts" (D-290.970), "Opposition to Medicaid Work Requirements" (H-290.961), and "Support for State Provider and Managed Care Organization Taxes to Sustain Federal Medicaid Matching Funding" (H-285.898) be reaffirmed.

Fiscal note: Less than $500.

25. FEDERAL LEGISLATION TO PROHIBIT THE CORPORATE PRACTICE OF MEDICINE

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: RECOMMENDATIONS ADOPTED
REMAINDER OF REPORT FILED
See Policies H-215.958 and H-215.981

At the 2025 Interim Meeting of the American Medical Association (AMA), Resolution 225, "Federal Legislation to Prohibit the Corporate Practice of Medicine," was introduced by the American Academy of Emergency Medicine and was referred. The Resolution as introduced, proffered new policy and sought to amend existing policy as follows:

> RESOLVED, That our American Medical Association advocate for federal legislation that prohibits lay corporations, including insurance companies, private equity firms, and other non-physician-owned entities, from owning or controlling medical practices and healthcare decision-making, and prohibits such entities from participation in federal healthcare payment programs, in order to protect physician autonomy and strengthen the physician-patient relationship (Directive to Take Action); and be it further

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RESOLVED, That our AMA amend Policy H-215.981 – Corporate Practice of Medicine under items #1 and #2 by addition and deletion as follows:

1. Our American Medical Association ~~vigorously opposes any effort to pass federal legislation or regulation preempting state laws~~ supports the passage of federal legislation prohibiting the corporate practice of medicine.
2. Our American Medical Association vigorously opposes any effort to pass state or federal legislation or regulation that removes or weakens existing state laws prohibiting the corporate practice of medicine.

Resolution 225-I-25 endorses a federal ban on the corporate practice of medicine (CPOM) with the caveat that such legislation must not weaken existing state laws. It also seeks to prohibit all non-physician-owned entities from participating in federal health care payment programs, which would include Medicare. Testimony on Resolution 225-I-25 overwhelmingly agreed that patient care is threatened where non-physicians may influence a physician's health care decision-making. The concerns prompting referral of Resolution 225-I-25 centered on two issues: (1) uncertainty around whether it is appropriate for the AMA to seek a CPOM ban at the federal level and (2) potential consequences of prohibiting non-physician-owned entities from participating in federal health care payment programs.[1] This report addresses these concerns and the questions underlying them.

BACKGROUND

This section offers background on the CPOM doctrine and its implementation, considers legal and practical implications of a federal CPOM ban, discusses the impact of provisions that would prohibit non-physician-owned entities from participating in federal payment programs, and shares how the AMA supports physicians in preventing corporate influence at the practice level.

Corporate Involvement in Physician Practices

Over the last two decades, corporations and private equity or hedge fund-backed entities have increasingly entered health care delivery. The consumerization of health care has fostered opportunities for corporations not traditionally involved in health care delivery to enter these spaces, purporting to offer greater convenience at a lower cost.[2] Occurring alongside this trend is the acquisition of independent physician practices by large corporations, hospitals, and payers. According to one estimate, corporate entities acquired over 30,000 physician practices between 2019 and 2021.[3]

Some see corporate entry into health care as positive, believing it will make health care more sustainable and grant physicians greater access to capital and the latest technology. In the optimal scenario, private sector investment in physician practices may be helpful in providing infrastructure. Owners of private practices increasingly seek to remain independent, and some have argued that corporate investment can provide them with the agency and revenue to do so.[4] However, accepting corporate investment does not necessarily mean that physicians must allow corporations to own or influence their operations or clinical autonomy—it can be a transactional financial arrangement.

Without guardrails, corporate investment may disrupt high-quality, coordinated care delivered by a physician-led team, and many believe it decreases access and competition.[5] Corporate investment in health care is also thought to

[1] *See* American Medical Association House of Delegates (I-25), Final Report of Reference Committee B at 69. Available at https://www.ama-assn.org/system/files/i25-refcomm-b-annotated.pdf.
[2] *See, e.g.*, CB Insights. The Big Tech In Healthcare Report: How Facebook, Apple, Microsoft, Google, & Amazon Are Battling For The $8.3T Market. Published November 30, 2021. https://www.cbinsights.com/research/report/famga-big-tech-healthcare/
[3] Japsen B. Amazon Could Fuel Doctor Buyouts In 2023 If One Medical Deal Goes Through. Forbes. Published December 20, 2022. https://www.forbes.com/sites/brucejapsen/2022/12/20/amazon-could-fuel-doctor-buyouts-in-2023-if-one-medical-deal-goes-through/
[4] Wolf D, Yoo J, Collins A. Selling to SMBs, a Founder's Playbook. Andreessen Horowitz. Published December 13, 2022. https://a16z.com/2022/12/13/selling-to-smbs-a-founders-playbook/
[5] Kane CK. Updated Data on Physician Practice Arrangements: For the First Time, Fewer Physicians Are Owners Than Employees. American Medical Association. Published 2019. https://www.ama-assn.org/system/files/2019-07/prp-fewer-owners-benchmark-survey-2018.pdf

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accelerate consolidation in medical specialties, which changes the practice landscape for physicians and can drive down physician wages while increasing health care costs for patients.[6]

In any case, when a corporate investor acquires a physician practice, the investor and the physicians often have divided loyalties: physicians tend to value providing the highest quality care and feel a deep sense of responsibility to their patients, while private equity firms and other corporate investors, who are primarily accountable to shareholders and not patients, are likely to pursue profit maximization. To this end, corporate investors may implement policies that prioritize dividends at the expense of physician and patient interests. Physicians working in corporate-owned practices note that corporate involvement can interfere with their ability to make decisions around governance, care delivery, or practice operations. When there is a conflict between providing appropriate care and the need for corporate investors for monetary return, not only can moral injury result, but there also a potential conflict of interest for physicians that is exacerbated if the corporation can terminate employment of the physician without cause. Accordingly, when a corporate entity invests in a physician practice, there is a need to ensure that corporate influence does not dictate decisions around care delivery and that physicians maintain not only clinical autonomy but operational authority of their practices. Laws banning CPOM provide one such tool.

The CPOM Doctrine

The CPOM doctrine refers to a long-standing legal precept intended to preserve the independent clinical judgment of physicians and safeguard patient care from undue corporate influence. At present, CPOM laws are enacted, implemented, and enforced by states. While specific provisions vary, CPOM laws generally limit the ability of lay (i.e., non-physician) corporations to intervene with the practice of medicine or own physician practices. Broadly, CPOM restrictions aim to (1) avoid the commercialization of medical practice that might result when corporations own practices or perform activities that constitute the practice of medicine; (2) address any lack of alignment between a corporation's obligation to its shareholders and a physician's obligation to their patients; and (3) ensure that a physician's exercise of independent medical judgment is not threatened because they are employed by a corporate entity.

Specific provisions in a CPOM law may include rules to protect a physician's independent exercise of clinical decision-making, practice ownership restrictions which may include requirements around how many shareholders or directors must be physicians, requirements around what entities may employ physicians, bans on fee-splitting arrangements, provisions around auditing and enforcement, and a range of exemptions. More recently, novel provisions have emerged in state legislatures that impose requirements on the structural relationship between a physician practice and a management services organization (MSO).[7]

Regulation of CPOM

States have long regulated the practice of medicine in light of local needs and in the context of state health care markets—in many states, CPOM laws date back centuries. The CPOM doctrine in each state has evolved over time, not only through legislation but also through judicial decisions, Attorney General opinions, and medical board policy. As a result, there is variation in how the doctrine has developed across the country. For example, while some states simply ban the unlicensed practice of medicine, others broadly prohibit all corporate entities from employing physicians, and still others have specific rules around what constitutes a permissible ownership structure for a medical practice.[8] Exceptions to CPOM bans also vary, with many states allowing hospitals, health maintenance organizations, or other entities to employ physicians.

[6] Fuse Brown, E et al., Private Equity Investment As A Divining Rod For Market Failure: Policy Responses To Harmful Physician Practice Acquisitions. Published 2021. Available at: https://www.brookings.edu/wp-content/uploads/2021/10/Private-Equity-Investment-As-A-Divining-Rod-For-Market-Failure-14.pdf
[7] *See, e.g.*, OR SB 951 (2025), amended by OR HB 3410 (2025). 83rd OREGON LEGISLATIVE ASSEMBLY--2025 Regular Session
[8] Dilani Logan and Katherine L. Gudiksen. The Source on Healthcare Price & Competition. The Corporate Practice of Medicine: Time for a Reevaluation? March 2025. Available at: https://sourceonhealthcare.org/wp-content/uploads/2025/03/The-Source-Corporate-Practice-of-Medicine-02.pdf

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Scholars have questioned the impact and effectiveness of the CPOM doctrine as it currently stands,[9] with two primary factors driving this skepticism. First, enforcement of CPOM bans is functionally dormant in many states. Second, CPOM laws often leave room for structural workarounds that enable corporations to influence the practice of medicine, most commonly through MSOs, often in combination with a "friendly physician" who may facilitate corporate influence over care delivery.[10]

A handful of states do have enforcement mechanisms for CPOM prohibitions in place. Still, there is room to modernize and strengthen state corporate practice restrictions, and recent growth in corporate investment in health care has spurred a renewed groundswell of interest in the potential of CPOM prohibitions, prompting state legislative action in this area. About a dozen bills implicating CPOM were introduced in state legislatures last year, with Oregon and California enacting particularly notable legislation.[11]. Notably, several bills have also been introduced for consideration during the 2026 legislative session.[12]

Frequently, these state bills aim to strengthen CPOM provisions by setting discrete parameters for what constitutes corporate interference with medical practice and clearly establishing oversight. Many would also implement provisions to address the MSO loophole, for example by requiring that physicians who contract with an MSO retain meaningful control over clinical decisions or prohibiting certain types of dual affiliation between the leadership of an MSO and a practice with which the MSO contracts. Indeed, both California and Oregon recently enacted legislation that limits MSOs from controlling physicians' clinical or operational decisions, and novel provisions in Oregon's bill impose requirements that erode "friendly physician" arrangements.[13] Related state legislation, including bills in Massachusetts and California,[14] among other states, would promote transparency around corporate involvement in health care by authorizing designated state agencies to review or approve health care transactions involving corporate entities—these bills bolster existing CPOM bans by shining light on transactions that may pose a threat to physician autonomy and providing a clear basis for the exercise of state enforcement authority.

The CPOM doctrine has not reached its full potential in the states, but state CPOM laws provide a long-standing legal framework to protect the practice of medicine from undue corporate influence in a manner that is responsive to the specific needs that arise in local health care markets. The AMA tracks state legislation that would restrict the corporate practice of medicine and provides support and resources to state medical associations aiming to limit corporate influence on the delivery of care.[15]

The Option for a Federal CPOM Ban

Those enthusiastic about a federal approach posit that a uniform set of federal CPOM requirements would bring clarity to the doctrine, provide an opportunity to create a strong baseline prohibition that would override weaker state laws (i.e., establish a "federal floor"), and reinvigorate enforcement of CPOM bans. However, questions surrounding the practical and legal considerations of a federal ban prompted the referral of Resolution 225-I-25 and required review.

A One-Size-Fits-All Standard

A federal CPOM ban would establish a single, easily understood law nationwide, which would consolidate the doctrine and reduce legal complexity. However, uniformity risks destabilizing health care markets. Because variations in state laws governing CPOM reflect the unique characteristics of local health care economies, a single federal CPOM standard is unlikely to address the specific needs of physicians in every state. Pursuit of a workable standard would

[9] Zhu, J M.D., M.P.P., M.S.H.P. https://orcid.org/0000-0002-4868-6078, Hayden Rooke-Ley, J.D., and Erin Fuse Brown, E J.D., M.P.H. A Doctrine in Name Only—Strengthening Prohibitions Against the Corporate Practice of Medicine. N Engl J Med 2023;389:965-968. Published September 9, 2023.
[10] Id.
[11] OR SB 951 (2025), amended by OR HB 3410 (2025); *See also* CA SB 351 (2025)
[12] Among the states where legislation related to CPOM has been introduced are Connecticut, Rhode Island, New Jersey, Maine, and New Mexico.
[13] *Supra* note 11.
[14] MA HB 5159 (2025) and CA SB 351 (2025)
[15] *See, e.g.* American Medical Association, Advocacy Resource Center. Legislative approaches to curb corporate influence in health care: State-level policy options to protect the integrity of medical practice amidst increased investment in health care by private equity firms and other corporate entities. https://www.ama-assn.org/system/files/state-leg-approaches-to-curb-corporate-influence-in-health-care.pdf

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require careful, nuanced distinctions between arrangements that support physician autonomy and those that factually undermine it, which may prove more aspirational than practical. A federal rule risks interference with existing state-tailored solutions, potentially harming physician autonomy, patient access to care, and the stability of health care markets that have evolved to meet local needs.

The risk of destabilizing health care practices and the markets in which they operate would be especially pronounced should federal law displace state laws that impose requirements around ownership structures for physician practices or around the relationship between physician practices and MSOs. Some states strictly limit practice ownership to physicians, while others allow more flexibility, such as majority physician shareholders or carefully regulated, but variable, MSO structures. These and their related exceptions reflect deeply rooted local practices and regulatory approaches. If a federal ban were to impose a one-size-fits-all standard, it could render existing practice arrangements unlawful, possibly undermining some practices and requiring a degree of unwinding.[16] Thus, should a federal standard be imposed, there may need to be a transition period to allow unentangling of practice agreements. Even still, the impact of federal CPOM policy, especially where it implicates practice structure, is likely to be felt unevenly across states, disrupting some markets more dramatically than others.

Federal Preemption

Underlying the policy proposed in Resolution 225-I-25 is an expectation that the desired federal CPOM ban will supplant state laws deemed weaker than the federal standard yet allow state laws that impose stricter requirements to remain in force. Principles of federal preemption inform the validity of this assumption. Rooted in the Supremacy Clause of the United States Constitution, the doctrine of federal preemption establishes that federal law prevails when compliance with both federal and state law is impossible, or when state law otherwise conflicts with federal objectives.[17] Because preemption is highly context specific, the doctrine determines whether and to what extent federal law displaces state law in a given regulatory scheme.

The federal CPOM ban envisioned here would operate as a form of floor preemption. Under this model, federal law establishes a minimum set of requirements within a particular regulatory domain, but permits states to enact and enforce laws that impose more stringent standards in that same area.[18] Floor preemption may be express, implied, or both: it is express when the federal statute includes explicit language related to preemption, and implied when there is no preemptive language but a court infers Congressional intent to preempt state law.[19] Express preemptive language is typically specific and crafted to apply uniquely to the subject matter being regulated.[20]
A CPOM law's preemptive effect would likely be determined via comparative assessment of the relative stringency of the respective state and federal provisions at issue, or a similar analysis. Courts must decide whether a state provision is genuinely stricter than the federal baseline or simply different in structure or scope. Ultimately it will need to be determined whether a specific state CPOM provision augments a federal floor or conflicts with it, but comparing multiple diverse frameworks to a single federal standard will require nuanced interpretive work. Given the wide variety in existing state CPOM laws, the preemptive effect of the federal standard may be evaluated in several different jurisdictions.

The preemption analysis is fact-specific and interpretively complex, making it difficult to predict.[21] Complicating this, once a bill is introduced in Congress, large scale amendments are often made, some of which fundamentally change the nature of the original text. The likelihood of state authority being preserved increases if the final federal statute includes an explicit clause permitting stricter state laws, but the actual preemptive effect will depend on judicial

[16] To indicate, state bills such as CA SB 351 (2025) prohibited certain agreements between MSOs and physician practices (PC) and implemented strong enforcement measures, prompting the restructuring of non-compliant arrangements. *See, e.g.,* Carsonie F, et al. Benesch. California Enacts SB 351: New Restrictions on Private Equity and Hedge Fund Involvement in Physician and Dental Practices. October 14, 2025. https://www.beneschlaw.com/insight/california-enacts-sb-351-new-restrictions-on-private-equity-and-hedge-fund-involvement-in-physician-and-dental-practices/
[17] *See* Adkins, Bryan L.; Pepper, Alexander H.; Sykes, Jay B. Federal Preemption: A Legal Primer. Congressional Research Service Report Number R45825. Updated May 18, 2023. Available at https://www.congress.gov/crs-product/R45825.
[18] *Geier v. Am. Honda Motor Co*., 529 U.S. 861, 120 S. Ct. 1913
[19] *Supra* note 17.
[20] *See, e.g.,* the preemptive language in the HIPAA regulations. 45 C.F.R. § 160.201 *et. seq.*
[21] *Supra* note 17.

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interpretation of specific statutory provisions and the extent to which Congress intended to occupy the field or restrict supplemental state regulations. The floor envisioned by Resolution 225-I-25 is certainly possible with careful drafting; however, it is also possible that a federal CPOM ban could result in state laws being preempted and replaced with a federal standard that may be less protective than existing requirements.

Federal Enforcement of a CPOM Ban

A federal CPOM prohibition would likely delegate enforcement power to a federal agency such as the Department of Justice (DOJ) or the Federal Trade Commission. Yet effective enforcement of CPOM violations requires a detailed understanding of state-level licensing, local market conditions, and complex corporate structural agreements. Unlike state regulators, who operate within these jurisdictions and have direct access to relevant records and personnel, federal authorities generally lack the local presence and specialized expertise needed to assess these arrangements. If oversight of CPOM violations is left strictly to the federal government, it could create enforcement gaps that only state regulators—who operate on the ground and understand local practices—can address. In that case, a federal CPOM ban would likely operate more as a deterrent than as a consistently enforced constraint.

There is little precedent for federal enforcement activity around intrastate, practice-level matters. Medical licensing violations, corporate structuring issues, and day-to-day operational practices are traditionally enforced by state regulators. Federal agencies typically focus enforcement efforts on matters with broad interstate impact, such as antitrust issues or major fraud. The DOJ's robust enforcement of The Physician Self-Referral Law (also known as The Stark Law) and the Anti-Kickback Statutes (AKS) do provide some exceptions. However, fraud is a top federal priority,[22] Medicare is of national interest, fraudulent transactions are detectable through analysis of Medicare claims data,[23] and even still, most violations are discovered through civilian-initiated *qui tam* actions rather than investigations initiated by the DOJ.[24] Further, these violations trigger False Claims Act liability and AKS includes criminal penalties, both of which strengthen enforcement leverage.

Federal enforcement of a CPOM ban may not be similarly robust. The federal government has failed to strongly enforce laws that impose a broad substantive mandate similar to the restriction of corporate control over clinical decision-making.[25] Regulators enforcing a CPOM ban must detect non-quantitative violations within complex contractual and financial arrangements—enforcement demands examination of management services agreements, equity structures, compensation models, and de facto control rights. Unlike fraud and abuse violations, CPOM violations are not connected to a federal payment program. Finally, enforcing CPOM bans is challenging because violations are difficult to detect. Data analytics will not expose CPOM violations, which are qualitative in nature, and most transactions that raise CPOM concerns (e.g., the acquisition of a medical practice by private equity) fall well below the threshold that triggers review under federal antitrust laws.[26]

All this notwithstanding, a whistleblower program has the potential to increase visibility and therefore enforcement of CPOM violations and create a threat of exposure that may provide meaningful incentive for compliance. For example, the DOJ implemented a whistleblower program for antitrust violations in 2024 that specifically targets health care enforcement.[27] It is modeled after a program implemented by the Securities Exchange Commission which has significantly increased enforcement of anti-retaliation laws.[28] A similar program may be feasible here.

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[22] *See, e.g.,* U.S. Department of Justice. National Health Care Fraud Takedown Results in 324 Defendants Charged in Connection with Over $14.6 Billion in Alleged Fraud. Published June 30, 2025.
[23] U.S. Department of Justice Criminal Division. Fraud Section: Year in Review 2025 at 25. Available at https://www.justice.gov/criminal/media/1425226/dl
[24] U.S. Department of Justice. Fraud Statistics – Overview. Available at: https://www.justice.gov/opa/media/1424121/dl
[25] For example, the Mental Health Parity and Addiction Equity Act. 29 U.S.C. § 1185a. *See also* K Pestaina. Kaiser Family Foundation. Mental Health Parity at a Crossroads. Published August 18, 2022. Available at: https://www.kff.org/mental-health/mental-health-parity-at-a-crossroads/
[26] As of February 2026, the valuation threshold for reportability under the Hart-Scott-Rodino Act is $133.9 million. U.S. Federal Trade Commission. New HSR thresholds and filing fees for 2026. Published January 20, 2026. Available at: https://www.ftc.gov/enforcement/competition-matters/2026/01/new-hsr-thresholds-filing-fees-2026
[27] U.S. Department of Justice. Corporate Whistleblower Awards Pilot Program. Revised May 12, 2025. Available at: https://www.justice.gov/criminal/media/1400041/dl?inline.
[28] U.S. Securities Exchange Commission. Office of the Whistleblower. Annual Report to Congress for Fiscal Year 2025. February 11, 2026. Available at: https://www.sec.gov/files/fy25-annual-whistleblower-report.pdf.

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Banning Non-Physician-Owned Entities from Participating in Federal Payment Programs

Resolution 225-I-25 seeks policy banning all non-physician entities—which may include hospitals and integrated health systems in addition to many private-equity backed groups and other corporate investors—from participating in federal health care payment programs like Medicare. The Board of Trustees (the Board) infers that the intent behind this proposal is to add leverage to enforcement of CPOM provisions, given precedent set by the Anti-Kickback Statutes, which grant the Office of the Inspector General (OIG) authority to bar individuals found guilty of violating the statute from participating in Medicare and state health care payment programs.[29]

In the context of CPOM, the Board notes that this policy would have significant and probably unintended consequences. Conditioning Medicare payment on CPOM compliance could suspend Medicare billing for an entire practice; however, depending on the practice agreement it is possible that it would to disproportionately punish physicians over corporate owners. Where physician payment arrangements are based on Relative Value Unit or salary/bonus models, physicians may be shielded and the corporate entity would be penalized. However, Medicare privileges generally sit with the individual physician, not the upstream practice owners, thus targeting financial penalties would be preferable to Medicare participation/privilege. Thus, this policy could disrupt physician income streams while penalizing clinicians who may not control or even have clear knowledge of their practice's specific ownership structure or the details of any agreements in place that may violate CPOM provisions.

Finally, lack of clarity around what constitutes "ownership" would need to be addressed as state laws vary widely—once this is done, the consequences described here may be disproportionately severe in some states. As previously debated in the HOD, the litmus test could be operational authority at the most basic level.

While in theory, conditioning Medicare participation on CPOM compliance would create leverage for enforcers, it also risks harm to physicians and patients, uneven enforcement, and destabilization of practice infrastructure. In addition, the Board is concerned that proposing a broad-stroke federal CPOM prohibition may have some risk of unintended consequences, especially of jeopardizing existing state regulations and laws that may be stricter than what can be realistically passed federally. Thus, any proposal would need to account for a phase-in period and the need for carefully calibrated policies that address the concern of preemption and appropriately targeted penalties.

AMA's Support of Private Practice Physicians

While legislation provides one avenue for protecting physicians from corporate influence in their practice, and AMA actively supports states seeking to enact strong CPOM laws, action can also be taken at the practice level, for example in careful contracting with any corporate partners. Because many corporate investments in independent practice have not been positive, the AMA has offered guidance to assist physicians with required due diligence in any contractual arrangement with private equity firms, venture capital, and hedge funds.

The High-Performing Private Practice Initiative (the Initiative) was launched in 2021 to enhance the AMA's efforts to address a concerning downward trend in physician practice ownership. The Initiative created essential resources to support private practice. Between 2021 and 2022, the Initiative developed the Private Practice Web Toolkit, the Simple Solutions educational series, the Thriving in Private Practice podcast, and the Private Practice Playbook v1.0. Further, the Navigating Practice program introduced medical students to independent practice as a viable career path. By 2023-2024, programming expanded with the STEPS Forward® Attending to Business podcast and an updated Private Practice Playbook v2.0. The June 2024 Business of Medicine Workshop represented a pivotal evolution from passive resources to active business education. Resources to support physician practices in matters related to CPOM include a series on venture capital and private equity investment, one component of which is a contracting toolkit for physicians entering arrangements with corporate investors.[30]

Notably, in the fall of 2026, the AMA will launch the Independent Practice Accelerator—a two-day intensive workshop distilling essential competencies through expert sessions, case studies, and peer networking. This accessible format will provide physicians exploring or beginning independent practice with foundational knowledge in strategic

[29] 42 U.S.C. 1320a-7(b)(7)
[30] *See, e.g.* American Medical Association. Venture Capital and private equity investment – Snapshot. Available at: https://www.ama-assn.org/system/files/2019-07/investment-snapshot.pdf. *See also* American Medical Association. Venture capital and private equity investment: How to evaluate contractual agreements. Available at: https://www.ama-assn.org/system/files/2019-07/evaluate-contractual-arrangements.pdf.

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planning, obtaining capital, business fundamentals, revenue cycle management, operations, leadership, and marketing. By preserving physician choice and practice model diversity, the program advances the AMA's core mission of removing obstacles to patient care and ensuring high-quality care delivery.

DISCUSSION

Well-founded concerns about erosion of clinical autonomy underscore the desire for a federal CPOM prohibition that creates a uniform federal standard upon which state law may build. However, a categorical ban on CPOM is unlikely to achieve the intended effect without careful calibration, because uniform structural requirements around physician ownership could require the unwinding of existing physician practice arrangements that may be working. However, if it is working, it is possible that an arrangement would still work under an appropriately tailored CPOM law that would be beneficial to both parties. Further, broad substantive requirements are difficult for federal agencies to enforce, and a federal prohibition raises preemption concerns. In addition, conditioning participation in federal health care payment programs on CPOM compliance would have consequences that disproportionately impact physicians and patients rather than corporate owners. Existing AMA policy opposes the corporate practice of medicine and tends to support AMA engagement on this issue.

AMA POLICY

Current AMA policy opposes the corporate practice of medicine as well as efforts to weaken or remove existing laws or regulations prohibiting CPOM, acknowledging that the corporate practice of medicine can erode the patient-physician relationship. It offers guidance to physicians seeking relationships with corporate entities, including examples of activities that constitute clinical decisions that must remain under the control of the physician.

AMA Policy H-215.981, "Corporate Practice of Medicine" states that:

1. Our AMA vigorously opposes any effort to pass federal legislation or regulation preempting state laws prohibiting the corporate practice of medicine.
2. Our AMA vigorously opposes any effort to pass legislation or regulation that removes or weakens state laws prohibiting the corporate practice of medicine.
3. Our AMA opposes the corporate practice of medicine and supports the restriction of ownership and operational authority of physician medical practices to physicians or physician-owned groups.
4. Our AMA, at the request of state medical associations, will provide guidance, consultation, and model legislation regarding the corporate practice of medicine, to ensure the autonomy of hospital medical staffs, employed physicians in non-hospital settings, and physicians contracting with corporately owned management service organizations.
5. Our AMA will continue to monitor the evolving corporate practice of medicine with respect to its effect on the patient-physician relationship, financial conflicts of interest, patient centered care and other relevant issues.
6. Our AMA will work with interested state medical associations, the federal government, and other interested parties to develop and advocate for regulations and appropriate legislation pertaining to corporate control of practices in the healthcare sector such that physician clinical autonomy and operational authority are preserved and protected.
7. Our AMA will create a state corporate practice of medicine template to assist state medical associations and national medical specialty societies as they navigate the intricacies of corporate investment in physician practices and health care generally at the state level and develop the most effective means of prohibiting the corporate practice of medicine in ways that are not detrimental to the sustainability of physician practices.
8. Our AMA supports enforcement of existing regulations and legislation pertaining to corporate control of practices in the health care sector to ensure that physician clinical autonomy and operational authority is preserved and protected.
9. Our AMA supports capital reserve requirements and leverage standards that preserve access to care for patients and fulfillment of contractual obligations to physicians and trainees by providing stable financing for hospitals, clinics, and other health care facilities.

Policy H-160.887, "Corporate Practice of Medicine," acknowledges that the corporate practice of medicine has the potential to erode the patient-physician relationship and may create a conflict of interest between profit and best practices in residency and fellowship training.

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Policy H-160.891, "Corporate Investors and Other Corporate Entities," offers the following guidelines for physicians contemplating corporate entity relationships:

1. Our AMA encourages physicians who are contemplating corporate investor partnerships or corporate entity relationships, including those under "friendly" physician professional corporation (PC) arrangements with Management Service Organizations (MSOs), to consider the following guidelines:
    a. Physicians should consider how the practice's current mission, vision, and long-term goals align with those of the corporate investor/entity.
    b. Due diligence should be conducted that includes, at minimum, review of the corporate investor/entity's business model, strategic plan, leadership and governance, and culture.
    c. External legal, accounting and/or business counsels should be obtained to advise during the exploration and negotiation of corporate investor/entity transactions.
    d. Retaining negotiators to advocate for best interests of the practice and its employees should be considered.
    e. Physicians should consider whether and how corporate relationships may require physicians to cede varying degrees of control over practice decision-making and day-to-day management.
    f. Physicians should consider the potential impact of corporate relationships on physician and practice employee satisfaction and future physician recruitment.
    g. Physicians should have a clear understanding of compensation agreements, mechanisms for conflict resolution, processes for exiting corporate relationships, and application of restrictive covenants, including any changes in the scope or implementation of any current or proposed restrictive covenants based on the corporate relationship.
    h. Physicians should consider corporate procedures for medical staff representation on the board of directors and medical staff leadership selection as well as processes for resolution of conflict between medical staff leadership and the corporate entity.
    i. Physicians should retain responsibility for clinical governance, patient welfare and outcomes, physician clinical autonomy, and physician due process under corporate relationships.
    j. Prior to entering into a relationship with a corporate entity, physicians and the corporate entity should explicitly identify the types of clinical and business decisions that should remain in the ultimate control of the physician, including but not limited to:
        i. Determining which diagnostic tests are appropriate;
        ii. Determining the need for referrals to, or consultation with another physician or licensed health professional;
        iii. Being responsible for the ultimate overall care of the patient, including treatment options available to the patient;
        iv. Determining how many patients a physician shall see in a given period of time or how many hours a physician should work;
        v. Determining the content of patient medical records;
        vi. Selecting, hiring, or firing physicians, other licensed health care professionals, and/or other medical staff based on clinical competency or proficiency;
        vii. Setting the parameters under which a physician or physician practice shall enter into contractual relationships with third-party entities;
        viii. Making decisions regarding coding and billing procedures for patient care services; and
        ix. Approving the selection of medical equipment and medical supplies.
    k. Each individual physician should have the ultimate decision for medical judgment in patient care and medical care processes, including supervision of non- physician practitioners.
    l. Clear protection and dispute resolution processes for physicians advocating on patient care and quality issues should be incorporated into an agreement between physicians and corporate entities.
    m. Physicians should retain primary and final responsibility for structured medical education inclusive of undergraduate medical education including the structure of the program, program curriculum, selection of faculty and trainees, as well as education and disciplinary issues related to these programs.
2. Our AMA supports improved transparency regarding corporate investments in and/or relationships to physician practices, subsidiaries and/or related organizations that interact with the physician group and/or patients of the physicians, and subsequent changes in health care prices, quality, access, utilization, and physician payment.
3. Our AMA encourages national medical specialty societies to research and develop tools and resources on the impact of corporate investor relationships on patients and the physicians in practicing in that specialty.
4. Our AMA supports consideration of options for gathering information on the impact of private equity and corporate investors/entities on the practice of medicine.

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5. Our AMA supports meaningful physician representation in any corporate governance structure (e.g., seats on the board of directors, and/or other relevant leadership bodies) of any entity with which a physician practice, hospital, or other health care organization establishes a corporate relationship.

CONCLUSION

The Board understands the urgency with which corporate intrusion on the practice of medicine needs to be addressed, and appreciates that at present, state enforcement of CPOM bans is largely lacking. At the same time, we acknowledge certain risks and limitations associated with a federal approach. However, given the importance of this issue, we support the notion that the AMA should take an active stance against corporate intrusion on the delivery of care at both the state and federal level. A more stable path for federal engagement on CPOM might pursue a narrowly tailored federal law to protect core elements of clinical independence, and craft it carefully to include language reflecting an intent to preserve state authority to enact and enforce related and more stringent laws. Especially if associated with a whistleblower program to add leverage to federal enforcement activity, this model would protect physician autonomy without risking destabilization of state health care markets, while leaving room for states to implement and enforce related provisions.

RECOMMENDATIONS

The Board recommends that the following be adopted in lieu of Resolution 225-I-25 and that the remainder of this report be filed:

1. That the American Medical Association, in order to protect physician autonomy and strengthen the physician-patient relationship, support federal legislation prohibiting lay entities, including but not limited to insurance companies, private equity firms, non-physician individual licensed health care professionals and other non-physician-owned entities or individuals, from interfering with, controlling, or otherwise directing 1) the independent professional judgment or clinical decisions of a physician, or 2) the operational authority of physicians within their practices, provided that any such legislation include a specific saving clause clarifying an intent to preserve the right of states to enact and enforce more stringent state laws.
2. That the AMA support whistleblower programs that allow individuals to report knowledge of violations of a law prohibiting lay entities from interfering with, controlling, or otherwise directing the professional judgment, clinical decisions, or operational authority of a physician to the appropriate enforcement agency.
3. That the AMA support the implementation and enforcement of strong state laws or regulations that prohibit the corporate practice of medicine
4. That Policy H-215.981, "Corporate Practice of Medicine," be amended by addition and deletion as follows:

   ~~1. Our American Medical Association vigorously opposes any effort to pass federal legislation or regulation preempting state laws prohibiting the corporate practice of medicine.~~

   1.~~2~~. Our AMA vigorously opposes any effort to pass legislation or regulation that removes or weakens state or federal laws prohibiting the corporate practice of medicine.

   2.~~3~~. Our AMA opposes the corporate practice of medicine and supports the restriction of ownership and operational authority of physician medical practices to physicians or physician-owned groups.

   3. Our AMA, at the request of state medical associations, will provide guidance, consultation, and model legislation regarding the corporate practice of medicine, to ensure the autonomy of hospital medical staffs, employed physicians in non-hospital settings, and physicians contracting with corporately owned management service organizations.

   4.~~5~~. Our AMA will continue to monitor the evolving corporate practice of medicine with respect to its effect on the patient-physician relationship, financial conflicts of interest, patient centered care and other relevant issues.

   5.~~6~~. Our AMA will work with interested state medical associations, the federal government, and other interested parties to develop and advocate for regulations and appropriate legislation pertaining to corporate control of practices in the health care sector such that physician clinical autonomy and operational authority are preserved and protected.

   6.~~7~~. Our AMA will create a state corporate practice of medicine template to assist state medical associations and national medical specialty societies as they navigate the intricacies of corporate investment in physician practices and health care generally at the state level and develop the most effective means of prohibiting the corporate practice of medicine in ways that are not detrimental to the sustainability of physician practices.

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7.~~8~~. Our AMA supports enforcement of existing regulations and legislation pertaining to corporate control of practices in the health care sector to ensure that physician clinical autonomy and operational authority is preserved and protected.
8.~~9~~. Our AMA supports capital reserve requirements and leverage standards that preserve access to care for patients and fulfillment of contractual obligations to physicians and trainees by providing stable financing for hospitals, clinics, and other health care facilities.

Fiscal Note: Less than $500.

26. AMA ETHICS FELLOWSHIPS

Informational report; no reference committee hearing.

HOD ACTION: FILED

At the 2025 Interim Meeting, the American Medical Association (AMA) House of Delegates (HOD) adopted Policy D-300.971, "Upholding Professional Integrity and Ethical Leadership," which states the following:

1. Our American Medical Association is committed to sustaining accessible, physician-led education and discourse on the ethical challenges in medicine.

2. Our AMA will develop and publicize opportunities for medical ethics engagement and learning across the association.

3. Our AMA will continue to advance and fund opportunities for editorial fellowships in ethics for trainees and early-career physicians commensurate to the AMA Journal of Ethics Editorial Fellowship.

4. Our AMA will report back on its progress and advancement for medical ethics engagement and editorial fellowships for trainees and early-career physicians at Annual 2026.

This report is submitted as information to the House of Delegates about a new ethics opportunity at the AMA.

NEW ETHICS FELLOWSHIP

Building on the *AMA Journal of Ethics*' record of engagement with the next generation of physicians, a new ethics fellowship, crafted to retain key elements that were valued by past journal editorial fellows, was recently launched. Key aspects of the new fellowship program are as follows:

- Every April, a "Call for Ethics Fellows," seeking applications from medical students, resident physicians, and fellows in U.S.-based accredited MD or DO programs, will be posted and promoted though AMA membership and communication channels.
- Fellowship applications will propose a timely and important medical ethics topic and how it can be explored through a multimedia approach such as video or podcast.
- Fellows will also secure a faculty mentor who will work along with AMA Ethics staff to help them conceptualize the topic, refine questions to be addressed, and identify experts to be featured. It is worth noting that this opportunity to collaborate with subject matter experts in their home institution (and the AMA) was routinely highlighted in Dean's letters of previous journal editorial fellows and became an insightful point of conversation during medical students' residency interviews.
- Up to six Fellows will be selected in response to the annual Call with each Fellow receiving a $2,500 honorarium. The number of Fellows per year may increase over time to meet growing interest and available resources.
- All selected Fellows will meet in Chicago for a working conference with reasonable travel expenses covered by the AMA. Led and facilitated by AMA staff this Chicago meeting will provide a valuable opportunity for

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the Fellows to learn from and work with their peers to further refine and develop their multimedia content outline.

Multimedia production will be handled within the AMA. The finalized multimedia content with CME credit will be published on the AMA EdHub platform.

27. UPDATE THE STATUS OF VIRTUAL CREDIT CARD POLICY, EFT FEES, AND LACK OF ENFORCEMENT OF ADMINISTRATIVE SIMPLIFICATION REQUIREMENTS BY CMS

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: RECOMMENDATIONS ADOPTED
REMAINDER OF REPORT FILED
See Policies D-190.965, D-190.968, D-190.970 and H-190.955

At the 2025 Interim Meeting of the American Medical Association (AMA) House of Delegates (HOD), Resolution 819, "Update the Status of Virtual Credit Card Policy, Electronic Funds Transfer (EFT) Fees, and Lack of Enforcement of Administrative Simplification Requirements by the Centers for Medicare & Medicaid Services (CMS)," was adopted as amended and became Policy D-190.965. It asked the following:

> Our American Medical Association report at the Annual 2026 Meeting on the progress of, and action items for implementation of AMA Policies D-190.970, H-190.955, and D-190.968. (Directive to Take Action)

Testimony before the Reference Committee was limited but uniformly supportive. Delegates expressed continued concern that, despite sustained AMA advocacy, the financial burden associated with virtual credit card (VCC) payments and EFT processing fees persists and, in some cases, has intensified. Testimony highlighted the cumulative impact of these fees on physician practices, particularly small and rural practices operating on narrow margins. An amendment was offered to require that the progress report be delivered one year earlier than originally proposed and to specify that the report include concrete "action items" outlining the AMA's regulatory and legislative strategy. Delegates emphasized the urgency of the issue and the need for visible enforcement of existing Administrative Simplification requirements by CMS. The Reference Committee recommended adoption of the resolution as amended, and the House concurred.

BACKGROUND

To reduce paperwork and streamline business processes across the health care system, the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and subsequent policies adopted certain national standard transactions for the electronic exchange of health care data. These transactions included EFT payments and electronic remittance advice. Beginning in the early 2000s, health plans began transitioning from issuing paper checks to using electronic payment methods for physicians.

This shift was significantly accelerated by the Patient Protection and Affordable Care Act (ACA) of 2010, which included provisions aimed at increasing administrative efficiency, notably the establishment of a standard for EFT. Under this requirement, health plans had to offer physician practices the option to receive payments via the Automated Clearing House (ACH) Network. Health plans may use clearinghouses and other vendors to meet their obligation to offer standard electronic transactions. Health plans and their vendors have sought alternatives to the ACH EFT standard since its adoption, which compete with and deter adoption of electronic transactions as envisioned by the ACA. Health plans or their vendors have leveraged flexibility in the EFT final rule, which permits nonstandard electronic payments using VCCs. VCCs are often promoted as the easiest and quickest form of payment, despite significant processing fees. Alternatively, plans or their vendors force physicians to accept additional "value-added services" and associated percentage-based fees with EFT payments. The fees that health plans and their vendors charge practices for simply receiving electronic payments create significant administrative burdens and divert funds that could otherwise support patient care.

Challenges around electronic transactions from health plans and clearinghouses were further exacerbated by the Change Healthcare cyberattack in February 2024 and the subsequent service outage. The Board of Trustees is well

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aware of the financial and administrative burdens that this unprecedented cyber event placed on physician practices and patients nationwide. The AMA was actively engaged with Optum and Change Healthcare to address ongoing issues related to the disruption and requested increased flexibility in the recoupment of payments on loans to practices, as well as in meeting timely claim-filing deadlines for the period when Change Healthcare's systems were non-functional, and practices were unable to file claims.

Unfortunately, the cyberattack and outage also compromised existing electronic transaction enrollments with vendors and clearinghouses, requiring re-enrollment to protect patient and physician data. Issues with the timing, costs, and other obstacles facing practices in re-enrolling to receive electronic transactions, such as EFT, hampered the recovery from the cyberattack. When EFT enrollments expired, many health plans and their vendors did not contact physician practices in advance to facilitate swift re-enrollment; instead, they automatically defaulted to VCC or fee-based EFT payments. Overall, the cyberattack and its aftermath only compounded the challenges and burdens that physician practices have long faced with electronic transaction fees.

AMA POLICY

The AMA has longstanding policy on VCCs and EFT electronic processing fees. First, the Board of Trustees notes three policies that are particularly relevant to the discussion that focus on increasing education around the use of VCCs in physician practices, as well as advocacy that promotes advance disclosure by payers of transaction fees and physician access to no-fee EFT options as an alternative to VCCs:

Policy H-190.955, "Virtual Credit Card Payments"

1. Our American Medical Association will educate its members about the use of virtual credit cards by third party payers, including the costs of accepting virtual credit card payments from third party payers, the beneficiaries of the administrative fees paid by the physician practice inherent in accepting such payments and the lower cost alternative of electronic funds transfer via the Automated Clearing House.
2. Our AMA will advocate for advance disclosure by third-party payers of transaction fees associated with virtual credit cards and any rebates or other incentives awarded to payers for utilizing virtual credit cards.
3. Our AMA supports transparency, fairness, and provider choice in payers' use of virtual credit card payments, including: advanced physician consent to acceptance of this form of payment; disclosure of transaction fees; clear information about how the provider can opt out of this payment method at any time; and prohibition of payer contracts requiring acceptance of virtual credit card payments for network inclusion.

Policy D-190.970, "CMS Administrative Requirements"

1. Our American Medical Association will forcefully advocate that the Centers for Medicare and Medicaid Services (CMS) investigate all valid allegations of HIPAA Administrative simplification requirements thoroughly and offers transparency in its processes and decisions as required by the Administrative Procedure Act (APA).
2. Our AMA will forcefully advocate that the CMS resolve all complaints related to the non-compliant payment methods including opt-out virtual credit cards, charging processing fees for electronic claims and other illegal electronic funds transfer (EFT) fees.
3. Our AMA will communicate its strong disapproval of the failure by the CMS Office of Burden Reduction to effectively enforce the HIPAA administrative simplification requirements as required by the law and its failure to impose financial penalties for non-compliance by health plans.
4. Our AMA will through legislation, regulation or other appropriate means, advocate for the prohibition of health insurers charging physicians and other providers to process claims and make payment.

Policy D-190.968, "Amend Virtual Credit Card and Electronic Funds Transfer Fee"

1. Our American Medical Association will advocate for legislation or regulation that would prohibit the use of virtual credit cards (VCCs) for electronic health care payments.
2. Our AMA will advocate on behalf of physicians and plainly state that it is not advisable or beneficial for medical practices to get paid by VCCs.
3. Our AMA will engage in legislative and regulatory advocacy efforts to address the growing and excessive electronic funds transfer (EFT) add-on service fees charged by payers when paying physicians, including advocacy efforts directed at:

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a. The issuance of Centers for Medicare & Medicaid Services (CMS) regulatory guidance affirming physicians' right to choose and receive timely basic EFT payments without paying for additional services.
b. CMS enforcement activities related to this issue.
c. Physician access to a timely no fee EFT option as an alternative to VCCs.

AMA policy provides a clear and longstanding framework for addressing virtual VCC payments EFT fees, and enforcement of Administrative Simplification requirements. In 2015, the House of Delegates adopted Policy H-190.955, which commits the AMA to educating physicians about the costs and mechanics of VCC payments, promoting advance disclosure of transaction fees and payer incentives, and protecting physician choice through an initial opt-in model, meaningful opt-out rights and opposition to contractual provisions that require acceptance of VCCs as a condition of network participation.

In 2022, the AMA adopted Policy D-190.970, directing the AMA to advocate that CMS investigate and resolve violations of HIPAA Administrative Simplification requirements, ensure transparency in enforcement processes, and oppose improper payment practices, including illegal EFT fees and failure to provide compliant payment options.

In 2023, the AMA adopted Policy D-190.968, which strengthens this framework by promoting physician access to a timely, no-fee EFT option, opposing excessive EFT add-on service fees, urging CMS to clarify physicians' right to receive basic EFT payments without additional charges, and supporting robust enforcement of existing regulatory standards.

Together, these policies, adopted in 2015, 2022, and 2023, establish a comprehensive advocacy foundation centered on transparency, physician autonomy, regulatory enforcement, and protection against improper transaction fees. They provide the basis for the AMA's ongoing regulatory and legislative efforts to ensure physicians can receive timely electronic payments without coercive practices or unnecessary financial loss.

DISCUSSION

The Board of Trustees understands the concerns that prompted Resolution 819 and recognizes the challenges that VCCs and electronic processing fees pose for physician practices. AMA advocacy is squarely focused on addressing these issues from both the regulatory and legislative perspectives.

For example, in June 2025 and July 2025 letters to Department of Health and Human Services (HHS) and CMS, the AMA emphasized how VCCs and fee-based EFT payments continue to pose significant problems for physicians, as these payment methods impose fees (up to five percent of the claim amount) that can add up to substantial financial losses to practices that are already struggling. Physician practices that lose up to five percent of claims payments due to EFT fees are less able to invest in the additional staff, medical equipment, data analytics, and information technology that could improve care access and quality. This is an especially salient issue for rural physician practices operating on thin margins, which are already struggling to provide timely care without having to factor in the greater administrative burdens and fees that come with receiving electronic payments. The AMA has continued to raise these concerns in subsequent federal discussions and stakeholder engagement.

In addition, these fees represent a reduction in the negotiated rate the health plan has agreed to pay the physician for a rendered service. Moreover, VCC and EFT fee programs are often opaque, with many physicians unaware of the associated financial losses until months after being unwittingly charged these fees. To compound these issues, the process of reversing and reissuing payments via a preferred method is often so tedious and time-consuming that physicians simply cannot afford to spend the time to request corrections. The lack of transparency, in part, results from coercive business practices, with most plans and vendors defaulting to fee-based transactions and forcing physician practices to "opt out" of VCCs or fee-based EFT. We have heard from many practices that this "opt out" process can be extremely time-consuming and administratively burdensome. Taken together, these negative factors have led to suboptimal EFT utilization: the most recently available data from the 2024 CAQH Index shows EFT adoption at only 77 percent, compared with 98 percent for electronic claims.

To address these concerns with HHS and CMS and ensure that EFT standard transactions reap their intended benefits, the AMA has recommended that the agencies vigorously enforce existing guidance regarding health plans' use of VCC or EFT fee-based programs.

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The AMA has also urged the agencies to issue additional guidance that will protect physicians from unfair business practices by:

- Clarifying that health plans and their contracted vendors cannot require a physician to agree to additional services and/or fees as a condition of receiving payments using the EFT standard;
- Requiring health plans and their vendors to prominently offer an ACH EFT option with no associated fees;
- Requiring health plans and their vendors to offer VCC or fee-based EFT strictly using an opt-in model, under which physicians receive clear and full information about the additional costs involved and proactively agree to using this method before any payments are issued; and
- Requiring all health plans and their vendors to contact physicians in advance of any expiration of EFT enrollment and facilitate swift reenrollment vs. automatically defaulting to VCC or fee-based EFT payments.

Ultimately, AMA wants the agencies to support the EFT regulation's underlying goals and create the much-needed transparency that physicians and other providers need to make informed, independent choices about the appropriate payment method for their practices.

Legislative Action

In addition, the AMA is proceeding with advocacy before Congress to act on behalf of physicians. The AMA helped introduce the "No Fees for EFTs Act" (H.R. 6487) introduced by Representative Greg Murphy, MD (R-NC) in November 2023 and companion legislation in the Senate (S. 3805), led by Senators Bill Cassidy, MD (R-LA) and Maria Cantwell (D-WA). These bills, which received bipartisan support, would prohibit health plans from "imposing fees on providers for EFTs and health care payment and remittance advice transactions." During that Congress, AMA staff worked with Congressional champions to address proposed legislative language changes and to preserve provisions aligned with AMA policy objectives. Although negotiations ultimately stalled and the legislation was not advanced before the close of the 118th Congress, the issue remains a priority. The AMA continues to work with Congressional champions to reintroduce the "No Fees for EFTs Act" this Congress. Progress was slowed by staff transitions within key Congressional offices; however, AMA staff have met with the bill sponsors and their teams and understand that the legislation remains a priority. The AMA anticipates continued engagement aimed at securing reintroduction in the near term.

State legislatures are also increasingly examining the use of VCCs by health plans and their contracted vendors. The AMA has supported state-level efforts consistent with existing AMA policy and has worked with state medical societies and coalition partners to advance legislation that promotes transparency, voluntary physician choice, and access to no-fee EFT options. Several states, including Alabama, Arizona, Georgia, and New York, have enacted legislation designed to increase transparency in electronic payment practices, clarify physician choice, and limit the imposition of excessive transaction fees. These laws generally require clearer disclosure of payment methods and associated fees, prohibit default enrollment into VCC programs without affirmative consent, and, in some cases, restrict the ability of plans or vendors to condition participation on acceptance of fee-based payment mechanisms. Going forward, the AMA will continue to collaborate with interested state medical associations, monitor emerging legislative proposals, and support state initiatives that address coercive payment practices, enhance disclosure requirements, and reinforce physicians' right to timely, no-fee electronic payment options.

State efforts reflect growing recognition that VCC practices can erode negotiated payment rates and impose avoidable administrative burden on physician practices. While statutory approaches vary by state, the common themes include strengthening opt-in protections, enhancing transparency around fees and incentives, and reinforcing the availability of lower-cost ACH EFT options. The AMA continues to monitor these developments and support state medical associations as they pursue reforms consistent with AMA policy.

ACTION ITEMS

The Board of Trustees recommends that, consistent with Resolution 819 and existing AMA policy, the AMA pursue the following implementation priorities over the coming year:

1. The AMA will engagement with HHS and CMS to press for stronger enforcement of existing HIPAA Administrative Simplification requirements related to electronic payment standards.

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2. The AMA will request that CMS issue clarifying guidance affirming physicians' right to receive timely ACH EFT payments without being required to purchase additional services or incur add-on processing fees and reinforcing that nonstandard payment options must not undermine the intent of the EFT standard.
3. The AMA will work with congressional champions to reintroduce and advance the "No Fees for EFTs Act" in the 119th Congress
4. The AMA will support state medical societies in state legislative and regulatory efforts that increase transparency around VCC use, limit coercive opt-out structures, or restrict excessive electronic payment fees, consistent with existing AMA policy.
5. The AMA will communicate with physicians regarding the financial implications of VCC and fee-based EFT programs and reinforce available information about compliant ACH EFT options and physician rights under existing standards.

CONCLUSION

The financial and administrative burdens associated with VCC payments and fee-based EFT programs remain significant and persistent. Despite longstanding statutory standards under HIPAA Administrative Simplification and the Affordable Care Act's EFT requirements, many health plans and their vendors continue to default physicians into payment methods that impose avoidable fees, reduce negotiated reimbursement, and create unnecessary administrative burden. The Change Healthcare cyberattack further exposed vulnerabilities in electronic payment systems and highlighted the consequences of inadequate enforcement and oversight.

Through regulatory advocacy, legislative engagement, and state-level collaboration, the AMA has continued to advance policies designed to protect physician autonomy, support transparency, and secure access to timely, no-fee electronic payments. However, relief will require stronger enforcement by CMS, clear regulatory guidance, and Congressional action to eliminate improper transaction fees. The Board of Trustees will continue to pursue a coordinated legislative and regulatory strategy consistent with Policies H-190.955, D-190.968, and D-190.970. The recommendations below also include rescission of Policy D-190.965, as its reporting directive has been fulfilled through submission of this report.

RECOMMENDATIONS

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

1. That Policy D-190.965 be amended to read as follows:
   Our American Medical Association report at the Annual 2026~~7~~ Meeting on the progress of, and action items for implementation of AMA Policies D-190.970, H-190.955, and D-190.968.
2. That our AMA reaffirm Policies H-190.955, "Virtual Credit Card Payments;" D-190.968, "Amend Virtual Credit Card and Electronic Funds Transfer Fee;" and D-190.970, "CMS Administrative Requirements."

Fiscal Note: Less than $500.

28. ACCOUNTABILITY IN THE USE OF AUGMENTED INTELLIGENCE FOR PRIOR AUTHORIZATION

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: RECOMMENDATION ADOPTED AS FOLLOWS
REMAINDER OF REPORT FILED
See Policies D-480.948 and D-480.956

At the 2025 Interim Meeting, the House of Delegates (HOD) adopted Resolution 823, "Accountability in the Use of Augmented Intelligence for Prior Authorization," which modified existing AMA Policy D-480.956, "Use of Augmented Intelligence for Prior Authorization" to read as follows:

1. Our American Medical Association will work with stakeholders to advocate for legislative and/or regulatory action for greater regulatory oversight related to the use of augmented intelligence for review of patient

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claims and prior authorization requests, including whether insurers and/or contracted third parties are using a thorough and fair process that:

a. is based on accurate and up-to-date clinical criteria derived from national medical specialty societies' evidence-based guidelines and peer-reviewed clinical literature.
b. includes reviews by physicians and other health care professionals who are not incentivized to deny care and with expertise for the service under review.
c. provides for transparency and accountability over the use of augmented intelligence for all medical service denials, to include a direct review of patient records by a qualified clinician.
d. requires direct review of the patient record by a qualified clinician of all medications flagged for denial by augmented intelligence platforms that were previously approved by payers.
e. provides robust appeals processes and guardrails to prevent algorithmic discrimination and ensure equitable access to care.

2. Our AMA will report on actions taken by the 2026 Annual Meeting of the AMA House of Delegates.

Resolution 823 amended Policy D-480.956 to more clearly articulate that insurer use of augmented intelligence in claims review and PA must be subject to meaningful regulatory oversight and grounded in a thorough and fair process. As amended, the policy specifies that such processes must be based on accurate and up-to-date clinical criteria derived from national medical specialty societies' evidence-based guidelines and peer-reviewed literature; include review by physicians and other health care professionals who are not incentivized to deny care and who have expertise in the service under review; provide transparency and accountability for all medical service denials; require direct review of patient records by a qualified clinician, including for medications previously approved by payers; and include robust appeals processes and guardrails to prevent algorithmic discrimination and ensure equitable access to care.

The AMA is actively pursuing legislative and regulatory strategies to advance these guardrails at both the federal and state levels. This report outlines the actions taken before and after adoption of Resolution 823-I-25 to implement the amended policy and fulfill the reporting requirement.

AMA POLICY

Policy D-480.956, "Use of Augmented Intelligence for Prior Authorization" (See above)

Policy H-480.931, "Assessing the Intersection Between AI and Health Care"

(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

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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.

DISCUSSION

The AMA's strategy to address the growing use of AI by payers in claims review and PA includes strong advocacy efforts to pursue legislative and regulatory solutions that ensure meaningful oversight of these tools and the processes surrounding them. Specifically, we support standards requiring that AI-informed determinations be grounded in current, evidence-based clinical guidelines; incorporate independent review by qualified clinicians with relevant expertise; and provide clear transparency, accountability, and robust appeals protections. Together, these reforms are intended to safeguard patient access to medically necessary care and prevent inappropriate, biased, or financially driven denials. The following section includes the steps taken between now and the previous meeting directed at this issue:

Insurer use of AI should be based on accurate and up-to-date clinical criteria derived from national medical specialty societies' evidence-based guidelines and peer-reviewed clinical literature.

The AMA is establishing and advancing a clear set of federal guardrails for insurer use of AI in coverage decisions. AI-driven automation is increasingly being used to accelerate denials and coverage limitations, with significant downstream burdens for physicians and clinically harmful delays for patients. AMA policy and congressional facing advocacy emphasize that, absent stronger guardrails, AI-enabled processes can undermine individualized patient assessment and contribute to inappropriate denials that patients and physicians struggle to understand and overturn. Consistent with the resolution's core requirement, AMA policy states that insurer AI used to determine coverage limits, make claim determinations, or engage in benefit design must be based on easily accessible, evidence-based clinical guidelines (not proprietary payer criteria) and disclosed to patients and physicians in an understandable way. The AMA is reinforcing this position in congressional advocacy, urging policymakers to require public reporting and disclosure of AI use and to ensure that the basis for coverage decisions is transparent and clinically grounded rather than opaque or proprietary. In addition, the AMA supports state-based advocacy efforts to advance these guardrails and collaborates with state medical associations and patient advocacy organizations to promote transparency, clinician oversight, and equitable access to care. The AMA has engaged with national organizations, including the National Association of Insurance Commissioners (NAIC), on broader PA and UM reforms that intersect with oversight of automated decision-making tools.

The AMA is advocating that insurer AI coverage criteria must be accountable to the medical evidence base, requiring payers to identify and cite peer-reviewed studies evaluating system accuracy and the validity of predictions, and to provide affected patients and physicians access to the relevant coverage criteria, results, and clinical guidelines used in the determination. Despite these established guardrails and repeated engagement with policymakers, including communication to the Senate Committee on Health, Education, Labor and Pensions and the Office of Science and Technology Policy, AMA's advocacy underscores that insurer noncompliance and continued opaque AI-driven denials necessitate stronger oversight expectations to ensure AI is used only in ways that reduce administrative burden without restricting medically necessary care.

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Insurer AI use must include reviews by physicians and other health care professionals who are not incentivized to deny care and with expertise for the service under review.

The AMA advocates that insurer use of AI in coverage determinations must not substitute for independent clinical judgment, particularly given the real-world pattern of AI enabled automation being used to accelerate denials and compound administrative burden and delays in care. The AMA has therefore advanced guardrails that center on two complementary requirements: (1) case level clinician review that is clinically meaningful and specialty appropriate before an adverse determination is finalized; and (2) structural protections to reduce conflicts of interest and ensure decisions reflect independent medical judgment rather than denial-driven incentives.

At the case level, AMA policy states that when AI is used for payer coverage limits, claim determinations, or benefit design, payers should be required to ensure that decisions are reviewed by physicians and other health care professionals who are not incentivized to deny care and who have expertise for the service under review, a standard that directly aligns with this resolution's requirement for specialty appropriate clinician oversight. With the AMA's support, California enacted Senate Bill 1120 (2024 Cal. Stat. ch. 879 (S.B. 1120)) in 2024 which mandates that AI tools used for utilization review or UM decisions comply with a variety of requirements, including that the tool: does not supplant individualized health care provider decision-making; does not directly or indirectly discriminate; be fairly and equitably applied; and be open to audit for compliance. California's new law also specifies that an AI tool cannot deny, delay, or modify health care services based on medical necessity and that such decisions shall only be made by a physician or health care professional competent to evaluate the specific clinical issues involved. At the federal level, Centers for Medicare and Medicaid Services (CMS) is testing technology-enabled review processes through the Wasteful and Inappropriate Service Reduction (WISeR) model, developed by the Center for Medicare & Medicaid Innovation. The model incorporates the use of advanced analytics, including AI-supported tools, to assist in reviewing certain services within Medicare fee-for-service. CMS has indicated that the model will include safeguards such as clinician review of determinations and documentation regarding the role of AI tools in coverage decisions. The AMA is closely monitoring implementation of the model and engaging CMS to promote transparency, accountability, meaningful physician oversight, robust guardrails, streamlined administrative processes, patient access to timely care, and greater use of evidence-based clinical guidelines consistent with AMA policy governing the use of AI in coverage determinations.

The AMA is reinforcing the need for meaningful clinician review in congressional advocacy by pressing for requirements that adverse AI recommendations be subject to physician review before finalization and that coverage decisions be grounded in independent clinical judgment rather than opaque automated workflows. To facilitate and track human review of payer AI use, the AMA was successful in modifying national AI technical standards that indicate whether a human was involved in the coverage decisions and an optional code to allow for sending the reviewer's specialty information.

At the structural level, the AMA is emphasizing that insurer review processes and UM governance must be designed to prevent conflicts of interest from shaping clinical outcomes. In its 2026 Medicare Advantage comment letter, the AMA urged strengthening UM committee composition and independence, recommending that these committees include practicing physicians, and that independent physician participation be increased to a majority to ensure that coverage criteria and adverse determinations are informed by practicing clinician expertise and insulated from incentives that could compromise independent clinical judgment.

Despite these established guardrails, AMA's ongoing advocacy reflects that insurer AI use continues to undermine independent clinical review in practice, reinforcing the need for stronger oversight expectations to ensure that AI-supported coverage decisions remain accountable to qualified, specialty-appropriate clinicians and do not become a vehicle for inappropriate denials and avoidable care delays.

Insurers provide transparency and accountability over the use of AI for all medical service denials, to include a direct review of patient records by a qualified clinician.

The AMA advocates that insurer use of AI-driven automated decision-making in coverage determinations must be subject to clear transparency and real accountability. Opaque AI-enabled denials can scale quickly, exacerbate PA burdens, and create avoidable delays in medically necessary care. AMA's policy and congressional-facing advocacy underscore that patients and physicians must be informed and empowered to question AI-supported coverage decisions, and that stronger oversight expectations are warranted when insurers use these systems for coverage, claims determinations, and benefit design.

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At the point of denial, the AMA is advancing clear transparency expectations. AMA policy calls for insurer use of automated decision-making systems to be publicly reported and disclosed to patients and physicians in an easy-to-understand manner, including clear communication that AI was used when it was part of the denial decision-making. The AMA further specifies that individuals impacted by an insurer's automated decision-making system, including patients and their physicians, must have access to all relevant information underpinning the coverage determination, including the coverage criteria, the results that led to the determination, and the clinical guidelines used. In parallel, the AMA warns that a core failure mode of insurer automation is the absence of individualized review, where denials are made without patient specific assessment and, in some cases, without opening or reviewing the patient's medical record, underscoring why transparency must be paired with meaningful clinical accountability whenever AI is used to recommend or trigger a denial.

On accountability, the AMA is urging routine auditing and public reporting to detect and correct harmful patterns. AMA policy calls for insurers using automated decision-making systems to conduct regular system audits to ensure AI use is not increasing overall or disparate denials/coverage limits or otherwise reducing access to care, and to make approval, denial, and appeal rate statistics publicly available in a readily accessible format with patient population demographics to contextualize equity implications. Notably, the AMA has vigorously advocated for passage of H.R. 3514/S. 1816, the "Improving Seniors' Timely Access to Care Act of 2025," which would make important reforms in Medicare Advantage PA programs. The bill would require Medicare Advantage plans to publicly disclose the percentage and number of PA requests that were denied in the previous plan year "through the utilization of decision support technology, artificial intelligence technology, machine-learning technology, clinical decision-making technology, or any other technology specified by the Secretary," as well as disclose and describe the technology utilized in evaluating PA requests. In December 2025, the AMA led over 120 physician organizations in a sign-on letter to congressional leadership expressing long-standing support for this bill and the improved transparency it would bring to Medicare Advantage PA programs, including this critical public reporting of plans' use of AI in coverage determinations.

AMA efforts have supported several states that have now enacted laws that establish guardrails that directly constrain insurer use of AI and automated tools in UM and adverse determinations. In Maryland (H.B. 820), plans must report quarterly to the Insurance Commissioner whether an "artificial intelligence, algorithm, or other software tool" was used in an adverse decision, and they must ensure that any such tool is applied to the patient's individual medical history and clinical circumstances, does not replace provider judgment, avoids discrimination, is regularly evaluated for accuracy and reliability, and does not use patient data beyond its stated purpose. In Arizona (H.B. 2175), a claim denial based on medical necessity requires individual review by the plan's medical director, exercising independent medical judgment and not relying solely on recommendations from other sources. Nebraska (LB 77) bars an AI algorithm from being the sole basis for denying, delaying, or modifying services based on medical necessity, and requires disclosure when AI is used in UM. Texas (S.B. 815) prohibits the use of automated decision systems to make adverse determinations, while allowing such tools for administrative support or fraud detection, and clarifies the Insurance Commissioner's authority to audit and inspect these tools.

The NAIC Big Data and Artificial Intelligence Working Group has made insurer use of AI a sustained regulatory priority and is encouraging state insurance regulators to apply consistent governance expectations. In December 2023, NAIC issued a model bulletin for states to adopt, reminding insurers that AI-enabled decisions affecting consumers remain subject to existing state laws (including unfair trade practice and other consumer protection requirements), and outlining baseline governance expectations and the types of information regulators may request during examinations or investigations. To date, 25 states have adopted the bulletin. NAIC has also released data describing how health plans report using AI across functions such as contracting, fraud detection, pricing, plan design, risk adjustment, risk management, marketing, data processing, and claims determinations—information that can inform ongoing evaluation of state proposals addressing payer use of clinical algorithms and AI in medical necessity decision-making. AMA contributed suggestions for the NAIC survey of health insurers inquiring how they are using AI, including in PA and other UM. AMA provided significant input on the recently released NAIC PA white paper. AMA shared perspectives on and has been monitoring implementation of the NAIC model AI bulletin that covers all insurance.

At its 2025 Summer Meeting, the National Council of Insurance Legislators (NCOIL) Financial Services & Multi-Lines Issues Committee considered draft legislation on insurers' use of AI and specifically in the claims process. The Committee heard from stakeholders including the AMA, who supported guardrails around health plans' use of AI in the claims determination process, while representatives from the insurance industry discouraged the committee from

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developing any model, calling it premature. It seems likely that the committee will continue to discuss potential model legislation at upcoming meetings.

The AMA's broader advocacy also emphasizes that current protections remain insufficient and that AI-driven denials continue to occur without adequate visibility and individualized review, reinforcing the need for stronger oversight expectations to ensure AI improves administrative efficiency without becoming a mechanism for inappropriate denials and delayed care.

Insurers require direct review of the patient record by a qualified clinician of all medications flagged for denial by AI platforms that were previously approved by payers.

The AMA is advancing clear guardrails across its policy and federal advocacy to ensure that insurer use of AI does not create new pathways to interrupt medically necessary medications that have already been approved and initiated. In the AMA's view, AI may be used to flag cases for review, but it must never be used to automatically deny, terminate, or disrupt a previously approved medication, particularly in continuation or renewal scenarios where patients are clinically stable and interruptions can cause harm and compound administrative burden. The AMA has consistently emphasized that PA related disruptions already undermine continuity of care, and that deploying AI in these workflows without strong safeguards risks scaling inappropriate denials and worsening care delays.

AMA policy requires that any automated recommendation indicating a denial or limitation of care be automatically referred for physician review prior to any final determination, with the reviewer possessing appropriate licensure and specialty alignment, and with a meaningful opportunity for clinical discussion before an adverse decision is issued. This "AI flags, clinicians decide" construct is the factual backbone for requiring direct review of the patient record by a qualified clinician before any AI-triggered medication denial is finalized. The AMA is advancing the same principle in congressional-facing advocacy, warning that automated decision-making must not replace individualized assessment of patient specific needs, must allow flexibility to override automated outputs, and must not be based on generalized "similar patient" logic.

The AMA is taking these guardrails directly to federal policymakers. In engagement with Congress, the AMA is urging stronger transparency and oversight when payers use automated decision-making for coverage and benefit determinations, emphasizing that patients and physicians must be empowered to question automated decisions and that these systems must not override clinical judgment. In related congressional advocacy, the AMA is highlighting patterns showing inadequate individualized review and is calling for guardrails that include physician oversight for adverse AI-driven determinations and a pathway to ensure the treating physician can meaningfully engage before a denial is finalized.

In parallel, the AMA is pressing CMS to ensure coverage criteria and medical necessity determinations, particularly for prescription drugs, are grounded in sound clinical validity and transparency, noting the importance of protections for beneficiaries who rely on medications to maintain health and wellbeing. The AMA is supporting prohibitions on reopening favorable medical necessity decisions absent good cause, reinforcing the core reliance interest that patients and physicians should be able to depend on prior approvals without fear of subsequent reversal, an essential principle when AI is introduced into renewal/continuation workflows.

Insurers must provide robust appeals processes and guardrails to prevent algorithmic discrimination and ensure equitable access to care.

The AMA has consistently advocated that insurer use of AI in UM must be paired with practical, patient-centered safeguards. When automated systems accelerate denials or restrict coverage without meaningful checks, patients experience harmful delays and physicians face escalating administrative burden. The AMA is emphasizing that robust, workable appeals processes are not optional; they are a necessary backstop to ensure that inappropriate or erroneous AI-influenced denials can be promptly corrected and that patients are not deprived of medically necessary care.

Consistent with this resolution, AMA policy calls for insurer automated decision-making that recommends a denial or limitation to be referred for physician review before a final determination, and for that same clinician-centered safeguard to apply across the review continuum, including at the appeals level. The AMA's advocacy highlights that appeals processes frequently function poorly in practice, even when denials are inappropriate: available evidence shows that only a small fraction of Medicare Advantage PA denials are appealed (11.5 percent in 2024), yet a substantial share of appealed denials are overturned (80.7 percent in 2024), underscoring that many patients may forgo

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medically necessary care because the appeals pathway is too burdensome, too slow, or too opaque to navigate. This pattern reinforces why appeals must be designed to work in real world clinical settings: timely, accessible, and capable of meaningful review by qualified clinicians.

In addition, the AMA is urging that safeguards against algorithmic discrimination be built into insurer AI use so that automated decision-making does not systematically disadvantage certain patients or reduce equitable access to care. AMA policy calls for payers to demonstrate that automated systems do not discriminate and to implement protections to mitigate bias that could affect coverage determinations.

CONCLUSION

The AMA has taken substantial and coordinated action across federal and state advocacy channels to advance oversight, transparency, and accountability in the use of AI in PA and coverage determinations. Through comment letters, congressional engagement, technical standards development, support of federal legislation, and state-level policy advancement, the AMA has reinforced the core guardrails articulated in policy D-480.956 and H-480.931.

Specifically, the AMA has advanced requirements that insurer AI use be grounded in evidence-based clinical guidelines; that adverse determinations informed by AI be subject to review by qualified, specialty-appropriate clinicians who are not incentivized to deny care; that patients and physicians receive clear disclosure when AI is used and have access to the criteria and data underlying determinations; that previously approved medications not be disrupted without individualized clinician review; and that appeals processes and anti-discrimination safeguards function effectively in practice.

Despite these efforts, insurer use of AI in UM continues to expand in ways that risk accelerating inappropriate denials, increasing administrative burden, and delaying medically necessary care. The AMA's advocacy therefore remains ongoing and focused on strengthening enforceable guardrails, improving transparency, and ensuring that AI enhances administrative efficiency without supplanting individualized clinical judgment or compromising patient access.

The Board of Trustees will continue to monitor legislative, regulatory, and market developments related to payer use of AI and will report back to the House of Delegates as appropriate.

RECOMMENDATIONS

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

1. Our American Medical Association (AMA) will:
    1) Advance federal advocacy to ensure that insurer use of AI in prior authorization and claims review is grounded in accurate, up-to-date, evidence-based clinical guidelines derived from national medical specialty societies and peer-reviewed literature.
    2) Engage Congress, CMS, and other federal policymakers to strengthen requirements that AI-informed adverse determinations be subject to appeal and to review by 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,
    (b) of the same specialty as the physician who manages the medical condition or disease, or provides the health care service involved in the, and
    (c) who are not incentivized to deny coverage for care to ensure that automated systems do not supplant individualized clinical judgment.
    3) Support and seek advancement of federal legislation to promote transparency in all prior authorization programs, including public reporting of AI and automated decision-making use.
    4) Advocate for enhanced transparency and accountability in insurer use of AI, including clear disclosure when AI is used in coverage determinations and meaningful access for patients and physicians to the criteria, clinical guidelines, and data underlying those determinations.
    5) Press for safeguards protecting continuity of care, including requirements that previously approved medications not be denied or disrupted based solely on AI generated recommendations without direct review of the patient record by 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 and

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(b) of the same specialty as the physician who manages the medical condition or disease, or provides the health care service involved in the request.

6) Support development and adoption of state-level guardrails that limit reliance on automated systems as the sole basis for medical necessity denials and promote clinician oversight, audit authority, and protections against algorithmic discrimination.
7) Engage in national AI technical standards discussions to strengthen transparency regarding whether human review occurred in coverage determinations and to facilitate identification of reviewer specialty.

2. That item two of Policy D-480.956, "Use of Augmented Intelligence for Prior Authorization," be rescinded as having been accomplished by this report.

Fiscal Note: Less than $500.

29. EDUCATIONAL MATERIALS REGARDING ULTRA-PROCESSED FOODS

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: RECOMMENDATION ADOPTED
REMAINDER OF REPORT FILED
See Policy H-150.914

At the 2025 Annual Meeting of the American Medical Association (AMA) House of the Delegates (HOD), the first Resolve of 601-A-25 was adopted while the second was referred, which asked that:

> Our AMA work with select organizations in the HOD to develop patient educational materials in English and Spanish with regards to the health impact of ultra processed foods as well as pathways for personal dietary options as alternatives to ultra processed foods; and, that such developed materials will be provided by the AMA to members who request them for distribution to their patients.

BACKGROUND

An overwhelming majority of food in our modern society has been 'processed' to some degree (e.g., through fermentation, pasteurization, milling, or refining) but ultra-processed foods (UPFs) represent a category of food that are produced almost entirely from industrially processed ingredients. UPF are generally considered foods that are made with "formulations of ingredients, mostly of exclusive industrial use, that result from a series of industrial processes."[1] While there is not a single standard definition of "ultra-processed," the NOVA classification system, a system created by Brazilian nutrition researchers in 2009 that defines foods as ultra-processed based on the level of industrial processing the foods are subjected to, is among one of the most influential (see Appendix to view the different categories of processed food under the NOVA classification system).[2]

UPFs do not represent a 'new' dietary product, but in fact have been a growing component of the food system since World War II. During the war, there were important advances made in food technology and packaging, which accelerated the distribution of processed food which helped prevent starvation for many at the time.[3] Following the war, UPFs were introduced and heavily advertised to the American public.[3] Almost immediately following the introduction of UPFs, there were concerns raised among some physicians about the nutritional quality of these foods and how they could impact health.[3] These concerns have grown over the last thirty years.[3] For example, the number of research papers mentioning UPFs published between 2021 to 2023 increased by over 300 percent compared to the period between 2017 and 2020.[3]

Public health concerns over UPFs are driven by the fact that they are made with little to no whole food ingredients and are produced through numerous industrial processes that can reduce the nutritional value of the product or introduce harmful elements.[4] UPFs also frequently contain large amounts of sodium, sugars, and saturated fats, which have negative health impacts in their own right, as well as artificial colors and other additives to make them more palatable and increase their shelf life.[5] Examples of UPFs include packaged snacks, mass-produced baked goods, breakfast 'cereals,' hot dogs, sausages, pre-prepared pasta and pizza dishes. The following discussion summarizes the evidence on health risks associated with UPF consumption, as well as challenges for research in this area, followed by an overview of available educational resources on UPFs for both patients and physicians.

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DISCUSSION

Health Impacts of UPF Consumption

Currently, UPFs make up a substantial share of the American diet, and their consumption has grown over time. UPFs have gained prominence in the modern diet due to their affordability, extended shelf life, and convenience.[6] The consumption of ultra-processed foods has grown from 53.5 percent of calories since 2001-2002 to 57 percent in 2017-2018, while the consumption of whole foods has decreased by a similar percentage over the same period.[7] A study looking at data from August 2021–August 2023 found that 55 percent all calories consumed by Americans age one year and older are from UPFs (as defined under the NOVA system).[8] Among youth ages 1–18, the share of calories consumed from UPFs is even higher (61.9 percent).[8] Research has also shown that child-oriented marketing strategies, such as compelling graphic elements (i.e., bright colors); promotional, licensed, or cartoon characters; celebrity endorsers; sportspersons; graphic references to fun and play; and premium collectible offers with toys and child-friendly lettering, are commonly used on labels of UPFs, making them more desirable for young children.[9]

That UPFs constitute such a high proportion of the American diet is a serious concern given the growing evidence showing an association between UPFs and poor health. UPFs, as defined under the NOVA system, are associated with a wide range of health conditions.[10] A 2025 review of the available evidence on UPFs noted plausible mechanisms for adverse health impacts include "nutrient imbalances, overeating, reduced consumption of health-protective phytochemicals, toxic contaminants from processing or packaging, harmful additives and mixtures of additives, and subsequent inflammation, dysglycemia, dyslipidemia, microbiome dysbiosis, and renal or liver dysfunction."[4] Two recent systematic reviews have reported that consumption of UPFs across children and adults is associated with poor health outcomes, such as obesity, cardiovascular disease, and other diet-related diseases, as well as discrepancies across demographic groups that put certain Americans at an elevated risk of high intake and therefore chronic disease.[11,12] Additionally, several epidemiological studies have suggested that increased UPF intake increases the risk of developing chronic kidney disease and accelerates the disease progression.[5] A population based cohort study also found higher consumption of UPFs was associated with an increased risk of all-cause mortality, with greater consumption of certain food groups, such as processed meats and sugar sweetened beverages, demonstrating the strongest associations.[10,13]

Additionally, research has demonstrated an increased risk of certain cancers with increased UPF consumption. A meta-analysis and systematic review found that high UPF consumption, when compared to low UPF consumption, was associated with a significantly increased risk of certain site-specific cancers, particularly of the digestive tract and some hormone-related cancers, but there were differences in risks between genders.[14] More research is needed to better understand the potential causal pathways. Lastly, there is emerging research connecting greater UPF consumption to risks of cognitive decline and impairment as well as stroke.[15–17]

Research on UPFs has seen increased consistency in terms of defining UPFs since the introduction of the NOVA classification system in 2009, but challenges remain. Researchers have noted challenges with the NOVA classification system, including ambiguity, inconsistency in application, and the assignment of foods with nutritional value to the "ultra-processed" category.[18] For example, a 2024 study found that higher intake of *certain* UPFs were consistently associated with higher all-cause mortality, particularly the UPF subgroups of meat/poultry/seafood based ready-to-eat products, sugar sweetened and artificially sweetened beverages, dairy based desserts, and ultra-processed breakfast foods.[13] However, there are foods, such as some yogurts made with fruit or
granola, some milk alternatives, packaged whole grain bread, that are categorized as UPFs but still offer nutritional value.[19] This highlights that there may be important heterogeneity within different subgroups of foods categorized as UPFs in terms of their impact on health and some UPFs can s. Additionally, a recent review article noted the strength and credibility of evidence for many of UPF studies was either low and suggestive/weak.[10]

UPFs and the U.S. Dietary Guidelines

The 2025 Dietary Guidelines Advisory Committee's first print of their scientific report on the American Dietary Guidelines was the first time UPFs were included as a review topic and they stated there was limited evidence on the health impacts of UPFs to make definitive recommendations on its intake.[20] Instead, they recommended more research to inform future iterations of the guidelines. The new U.S. Dietary Guidelines for Americans, released in January 2026, makes a more definitive recommendation against eating highly processed foods, but avoids the term UPF. "Avoid highly processed packaged, prepared, ready-to-eat, or other foods that are salty or sweet, such as chips, cookies, and candy that have added sugars and sodium (salt)…Limit foods and beverages that include artificial flavors,

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petroleum-based dyes, artificial preservatives, and low-calorie non-nutritive sweeteners."[21] The U.S. Food and Drug Administration (FDA) and U.S. Department of Agriculture (USDA) released a Request for Information in the summer of 2025 to help develop a more unified and consistent definition of UPFs.[22]

Nutritional Literacy and Public Awareness of UPF Risks

In general, the U.S. population has low nutrition literacy, which is defined as "the degree to which individuals have the capacity to obtain, process, and understand nutrition information and skills needed in order to make appropriate nutrition decisions," with one estimate noting that just over one-third of adults have adequate nutrition literacy.[23,24] The Health Belief model suggests that the more people know about the risks of certain foods influences their eating behavior.[25] Having greater nutrition literacy has been correlated with better understanding of nutritional labels and healthier food decisions and thus improving nutritional literary in the general population has the potential to improve dietary choices and overall health.[24,26]

A literature search on U.S. public perceptions and knowledge on UPFs produced limited results. Outside of the U.S., studies on this issue have been largely limited to South American countries and more recently the United Kingdom (U.K.) and other countries in Europe. A study from the U.K. found that while most participants were aware of the term UPF, most could not accurately categorize whether foods were UPFs or not. There were important differences between participants with higher incomes and higher levels of education who were more likely to report both being aware of and avoid consuming UPFs.[27] A study on consumer perceptions and intake of UPFs found participants exposed to information on the negative health impacts of UPF reported increased concerns about consuming UPFs (relative to the control) but there was limited evidence that the acceptability of consuming UPFs was reduced.[26] In essence, while education on UPF increased concerns about UPFs, it didn't necessarily result in behavioral change in terms of UPF consumption. While public education on UPFs will likely affect consumer perceptions of UPFs, it may not impact immediate food intake.[26]

Additionally, physicians have historically lacked sufficient nutritional education or training to be able to provide high-quality, effective nutrition counseling despite recognition within the medical community about the importance of dietary behaviors for health.[28] However, awareness of the potential health risks associated with UPFs has grown and there has been increased attention from medical and public health organizations.[29,30] Additionally, the Make America Healthy Again 2025 report identifies poor diet and the growth of UPFs in the American diet as major concerns for childhood chronic disease.[31] The accompanying strategy document calls for the acceleration of federal efforts to address UPFs.[32] However, public awareness and understanding of UPFs may be exacerbated by the lack of clear labeling, regulatory standards, or educational resources to inform consumer choices with respect to UPFs.

Patient Information on UPFs

A scan of federal agency and health care organization websites as well as a search on PubMed for examples of educational materials on UPFs produced few results. While the USDA and the Department of Health and Human Services (HHS) both have repositories of nutrition-related printable materials and handouts, neither have resources specific to UPFs.[33] Most of these materials and handouts appear to only be available in English. While not specific to UPFs, the FDA has a social media toolkit for their Nutrition Facts Label Campaign, which is intended to help consumers make better informed decisions regarding food choices.[34] The FDA is also proposing to require a front-of-package nutrition label on most packaged foods to provide accessible, at-a-glance information on added sodium, sugar, and saturated fats to help consumers quickly and easily identify which foods are part of a healthy diet.[35] As UPFs generally contain a high amount of these three ingredients, this type of front-of-package label could be very helpful for consumers in identifying unhealthy UPFs.

One article addressed the development of UPF infographics for patients with chronic kidney disease, as UPFs can worsen blood pressure and glycemic control, and lead to constipation, hyperkalemia and hyperphosphatemia.[5] It is unknown whether the education materials referenced in this study have been widely distributed within or outside of this specific patient population. An example of one of the infographics from this paper is provided in Figure 1.

More commonly, health care systems and medical organizations have created dedicated webpages on UPFs. For example, the AMA, as part of their What Doctors Wish Patients Knew™ series, has published an informational page on UPFs.[36] Similarly, the American Heart Association has on their website, "Top Things to Know: Ultraprocessed Foods and Their Association with Cardiometabolic Health."[37] Health care organizations, like the Mayo Clinic and

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Massachusetts General Hospital (just to name a few), have also created webpages to improve patient education (See Figures 2 and 3).[38,39]

Physician Education and Resources on UPFs

Similar to patient resources, there are limited educational resources on UPFs for physicians. One of the leading organizations for physician education on nutrition is the Gaples Institute, an educational nonprofit dedicated to advancing the role of nutrition and lifestyle in medicine through education and advocacy.[40] While educational content from the Gaples Institute is featured and available on AMA's Ed Hub, they do not have educational content specifically on UPFs, even if some of their existing modules address them. As the Gaples Institute is a well-known provider of physician nutrition education, they could be an important organization to partner with on future clinician educational resources.

Although not specific to UPFs, available nutrition education on AMA's Ed Hub includes:

- Nutrition and Health – CME Course
- 2025 Update — Nutrition Science for Health and Longevity: What Every Physician Needs to Know from the Gaples Institute Nutrition and Lifestyle Education
- Heritage Diets: Adapting Nutrition Recommendations Across Cultures
- Talking to Patients About Using the Nutrition Facts Label to Make Healthy Food Choices (developed in collaboration with the FDA) – CME module

A scan of available nutrition education for physicians produced limited resources on UPFs but also included examples of 'Food is Medicine' courses or nutrition science courses. A few examples of nutritional education from other medical institutions and organizations are provided below:

- The Exam Room™ Podcast on processed foods featuring Dr. Neal Barnard, President of Physicians Committee for Responsible Medicine[41]
- The American Academy of Family Physicians has a publication entitled: Nutrition Myths and Healthy Dietary Advice in Clinical Practice[42]
- The American College of Lifestyle Medicine has multiple 'Food as Medicine' educational courses[43]
- The Stanford Center for Health Education has a Nutrition Science Online Short Course[44]

STATE AND FEDERAL LEGISLATION

Several states have adopted or are considering legislation that bans or prohibits UPFs, with California being the first to pass a law limiting UPFs from schools in October 2025.[45,46] As part of these efforts, the challenge of defining UPFs has been evident, and different states have taken different approaches to define unhealthy UPFs.[47] California's law is the first to create a statutory definition of UPFs, which is defined as:

An ultra-processed food contains one or more of the following:

- Surface-active agents
- Stabilizers and thickeners
- Propellents, aerating agents and gases
- Colors and coloring adjuncts
- Emulsifiers and emulsifier salts
- Flavoring agents and adjuvants
- Non-nutritive sweeteners [D-sorbitol, erythritol, hydrogenated starch hydrolysates, sucralose, isomal, lactitol, luo han fruit concentrate, maltitol, steviol glycosides, thaumatin, xylitol)

AND contains one or more of:

- Saturated fat at 10% or more of calories
- A ratio of mg sodium to calories of more than 1:1
- Sugars at 10% or more of calories[48]

There have also been a few pieces of legislation proposed at the federal level in 2025 and 2026. First introduced in December 2025 and reintroduced in January 2026, the Childhood Diabetes Reduction Act (H.R. 6294/S. 4195) is a bipartisan bill that would require the FDA to implement clear, front-of-package warning labels on foods high in sugar, salt, and saturated fat, or that are classified as a UPF.[49] The proposed bill also aims to restrict marketing of these

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products to children and directs the NIH to expand research on the harmful additives within them.[50] In the context of this bill, UPFs are defined as, "a food, including a beverage, containing one or more industrial ingredients, including surface-active agents, stabilizers and thickeners, propellants, aerating agents and gases, color and coloring adjuncts, emulsifiers and emulsifier salts, flavoring agents and adjuvants, flavor enhancers, surface-finishing, non-sugar sweeteners, and other ingredients, as the Secretary [of HHS] determines appropriate."[50] Additionally, in April 2025, the Healthy Lunch for Healthy Kids Act (H.R. 2530) was introduced which aims to amend the National School Lunch Act to prohibit the serving of specific ultra-processed foods, including those containing artificial dyes, titanium dioxide, and other additives in school cafeterias.[51]

CURRENT AMA POLICY AND ACTIVITIES

In the past several years, the AMA has been actively engaged on the issue of UPFs. AMA Policy H-150.914, "Addressing the Health Impacts of Ultraprocessed Foods", directs the AMA to support and promote public health awareness and education about the differences between healthful and unhealthful UPFs, alluding to the existing tensions on defining UPF and whether all UPFs should be considered unhealthy and discouraged. In addition, AMA Policy G-630.140, "Lodging, Meeting Venues, and Social Functions," directed AMA to offer food options of minimally processed fiber-rich foods at AMA-sponsored receptions or meals.[52]

In a February 2025 letter commenting on the Scientific Report of the 2025 Dietary Guidelines Advisory Committee, the AMA urged the Agencies to include more concrete recommendations regarding UPFs.[53] In September 2025, the AMA sent a letter in response to an FDA Request for Information to help develop a uniform definition of UPFs for human food products in the U.S. food supply. In the letter, it was recommended that the definition of UPFs be developed with the primary goal of improving public health and reducing chronic disease.[54] Lastly, the AMA is in the process of organizing a four-part webinar series for 2026 that will engage physicians, residents and medical students in evidence-based education, aligned with HOD policy, on what constitutes a healthy diet, how different dietary patterns impact overall health and how to talk with patients about their dietary choices. As part of this series, at least one of the webinars will cover processed foods.

CONCLUSION

There is a dearth of available educational resources and materials on UPFs, for both patients and physicians. In some respects, this can be attributed to ongoing inconsistencies of how to define UPFs but there is growing evidence that increased UPF consumption has negative health outcomes. As there are current federal efforts underway to develop a more unified and consistent definition of UPFs, it may be prudent for the AMA to focus on lower cost educational options until there is more clarity on the UPF definition. However, as an organization, AMA should continue to support the development of patient materials that help them make healthier dietary choices and improve their health.

RECOMMENDATIONS

The Board of Trustees recommends:

(1) That the second resolve of Resolution 601-A-25 not be adopted; and
(2) That Policy H-150.914, "Addressing the Health Impacts of Ultraprocessed Foods" be amended by addition and deletion to read as follows:

1. Our AMA supports and promotes ~~public~~ awareness and education, among both the public and clinicians, about the differences between healthy~~ful~~ and unhealthy~~ful~~ ultraprocessed foods (UPF) and the benefits of minimally processed and unprocessed foods.

2. Our AMA supports the development of multi-lingual patient educational materials with regard to the health impact of UPFs and will help disseminate available materials through relevant AMA platforms.

~~2.~~ 3. Our AMA supports federal, state, and local policies that promote and incentivize the production and distribution of healthier, affordable, minimally-processed and unprocessed foods.

~~3.~~ 4. Our AMA encourages the integration of nutrition education into all levels of medical education to empower clinicians to best counsel patients efficiently and effectively on reducing unhealthful UPF consumption.

~~4.~~ 5. Our AMA supports increased funding ~~to the FDA~~ for research into the health impacts of ultraprocessed foods and strategies to mitigate their risks.

Fiscal Note: Between $1,000 - $5,000

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APPENDIX

Table 1: NOVA Classification of Foods[1]

Category and Name	Definition
Group 1 – Unprocessed or minimally processed foods	Unprocessed foods or minimally processed foods that are altered by processes such as removal of inedible or unwanted parts, drying, crushing, grinding, fractioning, roasting, boiling, pasteurization, refrigeration, freezing, placing in containers, vacuum packaging or non-alcoholic fermentation. None of these processes add salt, sugar, oils or fats, or other food substances to the original food.
Group 2 – Processed culinary ingredients	These are ingredients obtained directly from group 1 foods or from nature, like oils and fats, sugar and salt. They are created by industrial processes such as pressing, centrifuging, refining, extracting or mining, and their use is in the preparation, seasoning and cooking of group 1 foods.
Group 3 – Processed foods	This category represents food products made by adding salt, sugar or other substance found in group 2 to group 1 foods, using preservation methods such as canning and bottling, and, in the case of breads and cheeses, using non-alcoholic fermentation. Food processing here aims to increase the durability of group 1 foods and make them more enjoyable by modifying or enhancing their sensory qualities.
Group 4 – Ultra-processed food and drink products	Food made from industrial formulations, typically with five or more and usually many ingredients. Such ingredients often include those also used in processed foods, such as sugar, oils, fats, salt, anti-oxidants, stabilizers, and preservatives. Ingredients only found in UPF products include substances not commonly used in culinary preparations, and additives whose purpose is to imitate sensory qualities of group 1 foods or of culinary preparations of these foods, or to disguise undesirable sensory qualities of the final product.

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Figure 1 – Educational Materials Developed for Patients with Chronic Kidney Disease[5]

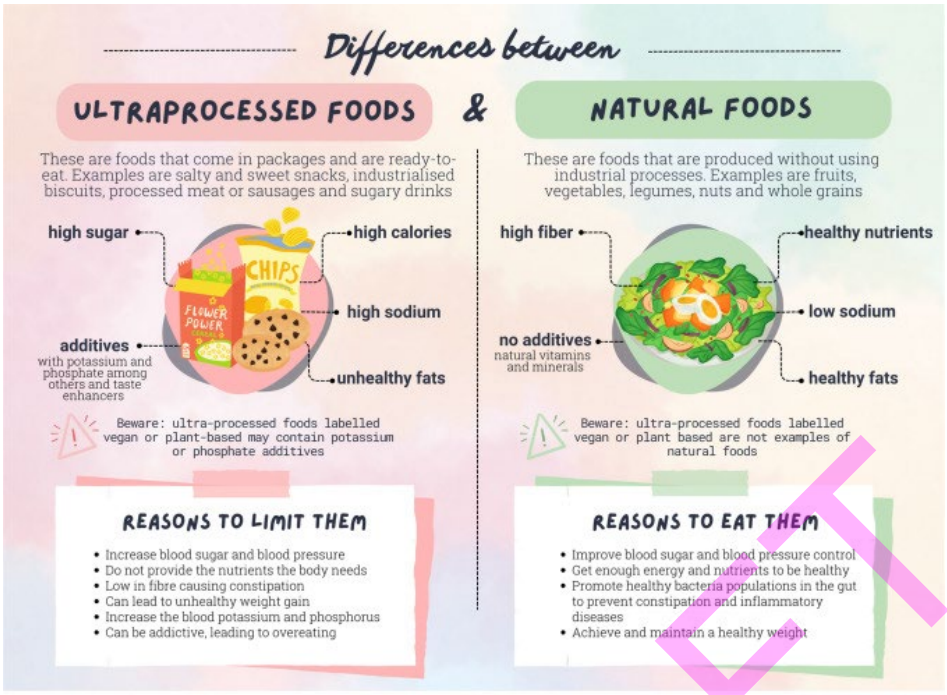
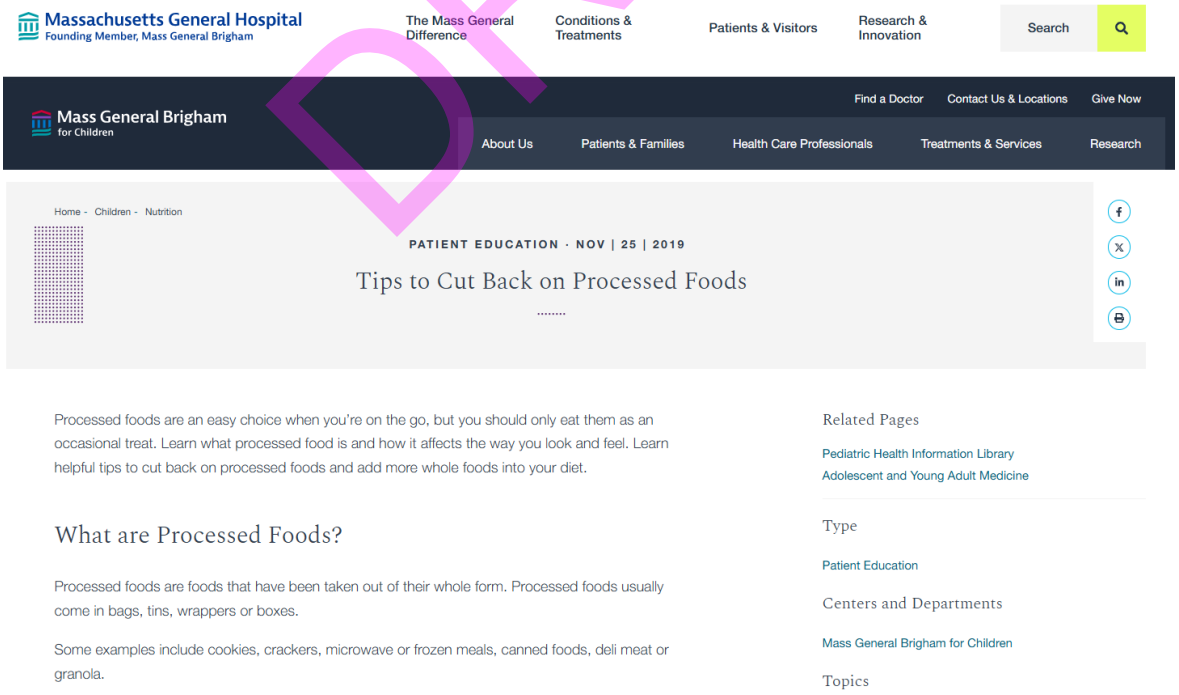


Figure 2 – Patient Education Webpage from Massachusetts General Hospital[39]



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Figure 3 - Patient Education Webpage from the Mayo Clinic[38]

SPEAKING OF HEALTH | THURSDAY, JULY 25, 2024

What you should know about processed, ultra-processed foods

TOPICS IN THIS POST

Nutrition | Get Healthy Recipes And Tips



Processed, and especially ultra-processed, foods have been blamed for the national rise in obesity, high blood pressure and diabetes. But what exactly are these foods, and are they really all that bad for you?

Defining processed foods

According to the Department of Agriculture, processed foods are any raw agricultural commodities altered from their original state. This includes washing, cleaning, milling, cutting, chopping, heating, pasteurizing, blanching, cooking, canning, freezing, drying, dehydrating, mixing or packaging.

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30. AMA REIMBURSEMENT OF NECESSARY HOD BUSINESS MEETING EXPENSES FOR DELEGATES AND ALTERNATES

Informational report; no reference committee hearing.

HOD ACTION: FILED

At the 2024 Interim Meeting, the House of Delegates adopted Policy D-600.951, Reimbursement of Necessary Business Meeting Expenses for Delegates and Alternates. This informational report responds to the first directive of the policy:

1. Our American Medical Association will issue a report at the 2025 Annual Meeting, and each meeting thereafter, identifying the number of delegates and alternate delegates supported by the grants and the total amount provided under our AMA House of Delegates Emergency Assistance Program (HOD EAP).

In 2025, AMA received requests from 21 societies to participate in the HOD EAP program. Three societies did not meet the criteria outlined in the policy adopted by the House. The EAP awarded grants to the remaining 18 federation societies.

Each qualifying society was required to submit a grant funding request form for each of the 2025 Annual and Interim Meetings indicating the number of delegates and alternates, regional medical student delegates and sectional resident

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and fellow delegates to be funded for each organization. Fifty percent of the requested amount was paid prior to the meeting with the remainder paid out based on verified actual attendance following the meeting.

For example, if a qualifying association had requested grant funding for four delegates and four alternates, two regional medical student delegates and one sectional resident delegate, that society would be eligible for grant money for 11 attendees or $16,500. The initial payment would have been calculated and paid at 50 percent of the requested amount or $8,250. Assuming only nine of those included in the initial request attended the meeting, the total grant would be recalculated at $1,500 times nine attendees or $13,500 and the final payment would be the difference between the recalculated grant amount and the first installment payment or $5,250. This was to ensure that grant funding is used solely for actual delegates and alternate delegates attending the meeting.

Based on grant funding requests, a total of $420,000 was made available for the 2025 Annual Meeting and 50 percent or $210,000 was paid to societies in advance of the meeting. After verification of actual attendance, a total number of delegates and alternate delegates attending the meeting from the 18 approved societies was 246, including 14 sectional residents and 16 regional students and the grant amounts paid for the Annual Meeting totaled $368,400.

For the November 2025 Interim Meeting, a total of $331,200 was made available and 50 percent or $165,600 was paid to societies in advance of the Interim Meeting. After the verification of actual attendance, the total number of delegates and alternate delegates attending the meeting was 243, including 13 sectional resident/fellows and 18 regional students and the total grant amounts paid for the Interim Meeting was $285,100. It should be noted that total funding for an organization was capped at $100,000 for the year and final payments were adjusted so that no society exceeded this cap.

In 2026, AMA received 24 requests to participate in the EAP program. Three organizations did not meet the criteria for the program. The EAP program will award grants to the remaining 21 federation societies which may potentially fund up to $872,200 for 315 delegates and alternates, 22 regional medical students and 15 sectional resident and fellow delegates and alternates for both the Annual and Interim Meetings. Funding requests are currently in process for the 2026 Annual Meeting.

31. ESTABLISHING AN ADVISORY COMMITTEE ON AI/AN AFFAIRS

Informational report; no reference committee hearing.

HOD ACTION: FILED

At the 2025 AMA Annual Meeting, the House of Delegates (HOD) adopted Policy D-615.976, "Advisory Committee on Tribal Affairs," which directs the AMA to:

> Our AMA will establish and report back at the 2025 Interim Meeting on the formation of a Task Force on Tribal Affairs composed of AMA members who themselves identify as American Indian and Alaska Native (AI/AN), close professional relationships with AI/AN communities (e.g., members of Association of Native American Medical Students and Association of American Indian Physicians), or have direct experience working with AI/AN communities at Indian Health Service federal direct-care, Tribally-operated and/or Urban Indian Health Programs (I/T/U) to advise the Board of Trustees on how to implement policy specific to AI/AN communities and that the Task Force report back at the 2026 Annual Meeting with recommendations for the establishment of an Advisory Committee to ensure sustained attention to tribal health equity and Indigenous physician representation.
>
> Our AMA will promote and foster educational opportunities for AMA members and the medical community to better understand the contributions of AI/AN communities to medicine and public health, including cultivating a rich understanding and appreciation of AI/AN perspectives on health and wellness."

At the 2025 AMA Interim Meeting, the Board of Trustees presented an informational report, BOT Report 17, indicating that that Board was taking the necessary steps to form an Advisory Committee on American Indian and Alaska Native (AI/AN) Affairs and would report back at the 2026 Annual Meeting. This follow-up report is informational.

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At its November 2025 meeting, the Board approved a charter for a new Advisory Committee on AI/AN Affairs. Under this charter, the Advisory Committee will advise the Board and AMA management on policy and advocacy matters pertaining to AI/AN medical students, physicians, and patients, and otherwise contribute to AMA initiatives related to this population.

The charter creates a seven-member Advisory Committee composed of:

- One medical student member,
- One resident or fellow member,
- One young physician member,
- Three physician members at-large (non-medical student/resident/fellow), and
- One physician representative of the Association of American Indian Physicians (non-medical student/resident/fellow).

Advisory Committee members are appointed by the Board, prioritizing candidates who:

- Have close professional relationships with AI/AN communities; and/or
- Have direct experience working with AI/AN communities through Indian Health Service programs, tribally operated programs, Urban Indian Health Programs, or other programs serving AI/AN communities.

The Board appointed the following members to the inaugural Advisory Committee, which will convene for the first time in conjunction with the 2026 AMA Annual Meeting:

- Medical student member: Mateo Perez
- Resident/fellow member: William Swain, MD
- Young physician member: Hannah Catherine Wenger, MD
- Member at-large: Janice Heaton-Sheufelt, MD (Vice Chair)
- Member at-large: Donald Warne, MD
- Member at-large: Siobhan Wescott, MD (Chair)
- AAIP Representative: Thomas “Blair” Matheson, MD

32. DISABILITY ADVISORY GROUP

Informational report; no reference committee hearing.

HOD ACTION: FILED

At the 2021 Interim Meeting of the American Medical Association (AMA) House of Delegates (HOD) BOT Report 19-I-21, “Advocacy for Physicians and Medical Students with Disabilities,” was adopted.

The policy states: Our AMA will: (1) establish an advisory group composed of AMA members who themselves have a disability to ensure additional opportunities for including physicians and medical students with disabilities in all AMA activities; (2) promote and foster educational and training opportunities for AMA members and the medical community at large to better understand the role disabilities can play in the healthcare work environment, including cultivating a rich understanding of so-called invisible disabilities for which accommodations may not be immediately apparent; (3) develop and promote tools for physicians with disabilities to advocate for themselves in their own workplaces, including a deeper understanding of the legal options available to physicians and medical students to manage their own disability-related needs in the workplace; and (4) communicate to employers and medical staff leaders the importance of including within personnel policies and medical staff bylaws protections and reasonable accommodations for physicians and medical students with visible and invisible disabilities.

This informational report provides the progress of the advisory group.

The Disability Advisory Group (DAG) has provided strategic guidance, subject matter expertise, and community outreach to ensure AMA policies and initiatives meaningfully address the needs of physicians, trainees, and patients with disabilities. The group currently includes 12 members with diverse representations, including disability type, career stage, and other identity factors—and incorporates input from external subject matter experts. The DAG has two active workgroups, one focused on education related to disability in medicine, and a second focused on strengthening accommodations in workplaces, educational institutions, and AMA meetings for physicians, trainees,

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and students with disabilities. With regular meetings and communication to the BOT through the two Board liaisons and other mechanisms, the DAG operates collaboratively to inform AMA efforts, always aligned with the organization's broader mission of supporting physicians and students, and optimizing health outcomes for all patients.

Current estimates suggest people with disabilities (PWD) are underrepresented in the physician workforce, with only 4.6 percent of medical students[1] and 3.1 percent of physicians[2] reporting a disability, compared to an estimated 26.7 percent of the adult U.S. population in 2022.[3] Federal law (the Americans with Disabilities Act[4]) requires public entities and employers to provide equal access and accommodations for PWD, ensuring non-discrimination and accessibility in services, programs, facilities, and employment opportunities. Data is not yet available regarding the prevalence of disability among AMA members; however, members of the DAG identified challenges to fully participating in AMA meetings due to unmet accessibility needs.

In addition to accessibility challenges, knowledge gaps regarding disability are shaped by the way disability is taught in medical education. Because training often emphasizes the medical model (framing disability primarily as a health problem to be solved),[5] health care professionals' attitudes and practices may overlook other important factors. The biopsychosocial model of disability considers not only medical aspects, but also personal, social, environmental, and cultural contexts, offering a more complete understanding of disability.[6] This more expansive approach to disability is also supported by the World Health Organization.[7] Given this, the DAG identified the need to create additional educational resources for medical students and physicians to address ableism in medical training and improve quality of care for PWD.

DISCUSSION

2024-2025 ACCOMPLISHMENTS

In its first 18 months, the DAG collaborated with AMA staff, Board members, and aligned organizations (e.g., the Association of American Medical Colleges (AAMC) and the Docs With Disabilities Initiative (DWDI) to create educational content as well as operational and policy recommendations to improve disability inclusion in medicine and optimize health outcomes for people with disabilities (PWD).

Workplace Inclusion Workgroup

The Workplace Inclusion Workgroup reflected on gaps in accommodations for PWD experienced at past HOD meetings, and suggested changes to improve access for physicians and staff with diverse needs. Members of the working group collaborated closely with the staff to enact some of these changes in 2025.

Numerous strategies to improve access for physicians and others with disabilities were undertaken. For example, power strips were made accessible through the end of HOD meetings to ensure PWD can charge communication and mobility equipment as needed. The physical layouts of meeting venues were reviewed and adjusted to better accommodate wheelchairs; at the 2025 Annual and Interim meetings, for example, ramps were added to ensure access to all podiums. Specific areas for wheelchair users were also marked in reference committee meetings to ensure access, and microphone placements were reviewed and adjusted to allow wheelchair users and others with limited mobility to access them. Pressure sensors were added in front of microphones to communicate when someone approaches; this ensures Speakers are aware of all individuals waiting to speak, including PWD who may not be as easily seen as non-disabled physicians (e.g., when using a wheelchair). In addition to improving physical access at meetings, virtual spaces and digital content were reviewed and adjusted. For example, the font size and text color in presentations were

[1] Meeks LM, Case B, Herzer K, Plegue M, Swenor BK. Change in Prevalence of Disabilities and Accommodation Practices Among US Medical Schools, 2016 vs 2019. *JAMA*. 2019;322(20):2022-2024. doi:10.1001/jama.2019.15372
[2] Nouri Z, Dill MJ, Conrad SS, Moreland CJ, Meeks LM. Estimated Prevalence of US Physicians With Disabilities. *JAMA Netw Open*. 2021;4(3):e211254. doi:10.1001/jamanetworkopen.2021.1254
[3] Centers for Disease Control and Prevention, National Center on Birth Defects and Developmental Disabilities, Division of Human Development and Disability. Disability and Health Data System (DHDS) Data [online]. Centers for Disease Control and Prevention. January 14, 2025. Accessed January 14, 2025. https://www.cdc.gov/index.htm
[4] *Americans With Disabilities Act*. 1990. Accessed February 2, 2026. https://www.ada.gov/pubs/adastatute08.htm
[5] Hogan AJ. Social and medical models of disability and mental health: evolution and renewal. *CMAJ Can Med Assoc J*. 2019;191(1):E16-E18. doi:10.1503/cmaj.181008
[6] *Id.*
[7] World Health Organization. Disability. 2026. https://www.who.int/healthtopics/disability#tab=tab_1

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updated to meet current web content accessibility guidelines, improving access for people with visual disabilities. Based on input from the DAG, the Meeting Services team supported the addition of live captioning and American Sign Language interpreters for 2025 meetings. There has been improvement in data collection and feedback regarding experiences of PWD as HOD attendees; however, this is currently collected in an ad hoc manner. Feedback mechanisms could be formalized for future meetings.

Education Workgroup

A dedicated education workgroup has advanced several initiatives to improve disability inclusion in medicine, both for physicians with disabilities and in providing better care for patients with disabilities. Informed by input from members of the DAG, expert interviews, and collaboration with key external organizations, staff is developing and platforming foundational educational modules to address gaps in physician education around ableism in health care. These resources aim to help learners identify ableism, understand its impact, and foster more equitable health outcomes for PWD.

The DAG members contributed to designing multiple live educational events, including at the HOD Annual meeting in 2024 (recording platformed as enduring educational content here) and a panel discussion on disability inclusion in medical education at the 2025 Interim HOD meeting, both of which offer free CME. An interactive foundational module, "Disability Inclusion: Addressing Ableism in Medical Education and Health Care" was built in close collaboration with the DAG and published on EdHub in late 2025.[8]

2026 PRIORITIES

In 2026 and beyond, staff will continue the work initiated by the DAG. The DAG has identified opportunities to collaborate with other organizations (e.g., AAMC) to address challenges, e.g., the revision of technical standards that may inadvertently exclude students with disabilities from participating in medical education and training. Opportunities remain to review and suggest improvements to AMA policy and procedures as the Board considers how to address ableism in organizational policies and practices.

Workplace Inclusion Workgroup

While much has been accomplished with input from the DAG, work remains to ensure that AMA meeting spaces are inclusive of PWD. In 2026, the DAG Workplace Inclusion Workgroup will continue to collaborate with staff to improve accessibility and inclusion at AMA meetings, particularly the Annual meetings in Chicago. Key areas of exploration and focus will include: increasing time between sessions for PWD to move between rooms; creating a mechanism to signal that someone needs more time to reach a microphone before giving testimony; and involving DAG members or other PWD in 1) pre-meeting planning, 2) on-site accessibility assessments in hotels, and 3) venue selection for future sites. The workgroup will also continue to work to suggest feasible support for accommodating service animals and personal care assistants and propose funding mechanisms to support PWD attendees. They will continue to work with the Council on Long Range Planning and Development (CLRPD) to identify strategies through which the AMA can better understand the prevalence of disability and accommodation needs among HOD attendees and AMA members more broadly. Lastly, the workgroup aims to develop and share a model accessibility guide, with suggested operational improvements for varied workplace and educational settings.

Education Workgroup

Additional educational projects underway for 2026 publication include content to increase disability inclusion and improve care for PWD. Interactive modules to ensure a more inclusive environment for students and physicians with disabilities are being created in collaboration with the DWDI, focusing on addressing ableism in medical school admissions and residency selection. Furthermore, a video-based educational series is in development in collaboration with the University of Colorado's Anschutz School of Medicine. This series will equip clinicians with strategies to improve care for PWD and overcome common barriers in clinical settings.

[8] AMA Center for Optimal Health Outcomes. An Introduction to Ableism in Medical Education and Health Care. October 7, 2025. Accessed February 2, 2026. https://edhub.ama-assn.org/ama-center-optimal-health-outcomes/module/2840024

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CONCLUSION

The AMA Board of Trustees has determined that the DAG will continue for an additional two years and will continue the meeting cadence set forth in the original DAG Charter. The AMA Board of Trustees thanks the current DAG Members for all their work since the DAG was made effective on August 15, 2024. The AMA Board of Trustees will call for nominations for a new group of AMA members, whose AMA membership is active and in good standing, to serve on the DAG for the next two years (2026-2028). Current DAG members may reapply to serve during the 2026-2028 term. AMA staff will work with the new DAG membership to continue to improve the experience and inclusion of PWD by continuing to create educational and training content, developing policy recommendations, establishing inclusion practices in AMA-led spaces, and working in consultation with other aligned national organizations such as the AAMC, the Accreditation Council for Graduate Medical Education, DWDI and other relevant organizations to improve accommodations for, and inclusion of, PWD, in organized medicine.

Fiscal Note: To be determined

33. TASK FORCE TO PRESERVE THE PATIENT-PHYSICIAN RELATIONSHIP WHEN EVIDENCE-BASED, APPROPRIATE CARE IS BANNED OR RESTRICTED

Informational report; no reference committee hearing.

HOD ACTION: FILED

This report provides an update on the activities of the American Medical Association (AMA) Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care is Banned or Restricted (the Task Force) in accordance with Policies G-605.009, D-5.998, and D-605.982. (Note: Because of approval deadlines, this report was prepared in February and may not include more recent developments.)

BACKGROUND

Policy G-605.009, "Establishing A Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care is Banned or Restricted," was adopted at the 2022 Annual Meeting of the AMA House of Delegates (HOD). Policy G-605.009 instructs that:

1. Our AMA will convene a task force of appropriate AMA councils and interested state and medical specialty societies, in conjunction with the AMA Center for Health Equity, and in consultation with relevant organizations, practices, government bodies, and impacted communities for the purpose of preserving the patient-physician relationship.
2. This task force, which will serve at the direction of our AMA Board of Trustees, will inform the Board to help guide organized medicine's response to bans and restrictions on abortion, prepare for widespread criminalization of other evidence-based care, implement relevant AMA policies, and identify and create implementation-focused practice and advocacy resources on issues including but not limited to:
    a. Health equity impact, including monitoring and evaluating the consequences of abortion bans and restrictions for public health and the physician workforce and including making actionable recommendations to mitigate harm, with a focus on the disproportionate impact on under-resourced, marginalized, and minoritized communities;
    b. Practice management, including developing recommendations and educational materials for addressing reimbursement, uncompensated care, interstate licensure, and provision of care, including telehealth and care provided across state lines;
    c. Training, including collaborating with interested medical schools, residency and fellowship programs, academic centers, and clinicians to mitigate radically diminished training opportunities;
    d. Privacy protections, including best practice support for maintaining medical records privacy and confidentiality, including under HIPAA, for strengthening physician, patient, and clinic security measures, and countering law enforcement reporting requirements;
    e. Patient triage and care coordination, including identifying and publicizing resources for physicians and patients to connect with referrals, practical support, and legal assistance;

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f. Coordinating implementation of pertinent AMA policies, including any actions to protect against civil, criminal, and professional liability and retaliation, including criminalizing and penalizing physicians for referring patients to the care they need; and
g. Anticipation and preparation, including assessing information and resource gaps and creating a blueprint for preventing or mitigating bans on other appropriate health care, such as gender affirming care, contraceptive care, sterilization, infertility care, and management of ectopic pregnancy and spontaneous pregnancy loss and pregnancy complications.

Adopted during the AMA 2022 Interim Meeting, Policy D-5.998, "Support for Physicians Practicing Evidence-Based Medicine in a Post Dobbs Era," added a requirement for an annual report of the Task Force. Policy D-5.998(1) instructs that:

1. Our AMA Task Force developed under HOD Policy G-605.009, "Establishing A Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care is Banned or Restricted," will publish a report with annual updates with recommendations including policies, strategies, and resources for physicians who are required by medical judgment and ethical standards of care to act against state and federal laws.

At the AMA 2023 Interim Meeting, the HOD amended Policy G-605.009, adding the creation of an ad hoc committee on payment and reimbursement issues in gender affirming care to the Task Force's directives. Specifically, the amendment instructs that:

1. Our American Medical Association will appoint an ad hoc committee or task force, composed of physicians from specialties who routinely provide gender-affirming care, payers, community advocates, and state Medicaid directors and/or insurance commissioners, to identify issues with physician payment and reimbursement for gender-affirming care and recommend solutions to address these barriers to care.

At the AMA 2024 Interim Meeting, the HOD amended Policy G-605.009, adding that the Task Force:

h. Work with interested parties to encourage the development of institution-level guidance and protection for physicians practicing in states with restrictions potentially interfering with the patient-physician relationship.

Also at the AMA 2024 Interim Meeting, the HOD adopted Policy D-605.982, "Accountability for G-605.009: Requesting A Task Force to Preserve the Patient-Physician Relationship Task Force Update and Guidance," which states:

1. Our American Medical Association's Task Force, to Preserve the Patient-Physician Relationship, will present annual updates on their findings at AMA Annual Meetings until the objectives have been completed.

Then at the AMA 2025 Annual Meeting, the HOD adopted Policy D-5.995, "Protecting Access to Emergency Abortion Care Under EMTALA," which states:

2. Our AMA task force established under AMA Policy G-605.009, "Establishing A Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care Is Banned or Restricted," will provide ongoing recommendations and updates on navigating conflicting state and federal regulations on emergency pregnancy care.

DISCUSSION

Task Force Formation

As directed by the HOD and in response to the 2022 U.S. Supreme Court's landmark decision in *Dobbs v. Jackson Women's Health Organization*, which held that the U.S. Constitution does not confer a constitutional right to abortion and returned the authority to regulate abortion to the states and the subsequent enactment of abortion bans in half the states, the AMA Board of Trustees' (the Board) formed the Task Force in June of 2023. With the formation of the Task Force and consistent with AMA Policies G-605.009 and D-5.998, as noted above, the Board instructed that the Task Force would advise the Board of new and emerging threats to the provision of evidence-based medical care and

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appropriate and innovative responses to protect access to care and to preserve the role of the patient-physician relationship as a central element in medical decision-making.

In accordance with the specific language of AMA Policies G-605.009 and D-5.998, in September 2023, the Chairs of the AMA Councils on Legislation, Medical Service, Medical Education, Science and Public Health, and Ethics and Judicial Affairs each appointed two Council members to serve on the Task Force. As a result, 10 Council representatives serve on the Task Force. At that time, the Chair of the Board, Willie Underwood III, MD, MSc, MPH, appointed Madelyn E. Butler, MD, AMA Trustee, and Maryanne C. Bombaugh, MD, MBA, MSc, member of the Executive Committee for the AMA Council on Legislation, to serve as Co-Chairs of the Task Force.

In addition, and in accordance with the underlying policy, in the spring of 2024, AMA invited 10 state medical associations and 13 national medical specialty societies to appoint a physician representative to serve on the Task Force. The organizations were selected based on their expertise, experience, and response to an AMA survey fielded in November 2022 (which was described in detail in the 2023 report of the Task Force) that asked about priorities and capacity to engage on the issues identified in Policy G-605.009.

Seven state medical associations and 11 national medical specialty societies nominated a physician representative to serve on the Task Force. The participating national medical specialty societies include:

- American Academy of Child and Adolescent Psychiatry
- American Academy of Dermatology
- American Academy of Family Physicians
- American Academy of Pediatrics
- American College of Emergency Physicians
- American College of Obstetricians & Gynecologists
- American College of Physicians
- American Psychiatric Association
- American Society for Reproductive Medicine
- American Society of Clinical Oncology
- The Endocrine Society

The participating state medical associations include:

- California Medical Association
- Idaho Medical Association
- The Maryland State Medical Society (MedChi)
- Massachusetts Medical Society
- Pennsylvania Medical Society
- Texas Medical Association
- Medical Society of Virginia

In total, there are 29 physician members on the Task Force.

Overview of Task Force Meetings

As the Task Force formed, staff across the AMA conducted environmental scans and gaps analyses of the issues identified in Policy G-605.009. These landscape analyses identified implementation-focused practice and advocacy resources on issues including health equity, practice management, medical education, privacy, and legal issues and identified potential resource gaps. The landscape analyses were presented to Council representatives monthly, beginning in January of 2024 and concluding in May of 2024. The landscape analyses were used (and will continue to be used) to identify key topics of discussion for meetings of the Task Force and were distributed to all Task Force members prior to the first in-person meeting of the Task Force.

Since its inception in spring of 2024, the Task Force has held six virtual meetings, four in-person meetings, and three informational sessions. The virtual meetings were held in May 2024, December 2024, January 2025, May 2025, October 2025, and December 2025. This total does not include additional virtual meetings conducted with Task Force subcommittees or project teams. In-person meetings were held in July 2024, February 2025, July 2025, and February

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2026. The informational sessions were held at the AMA 2024 Interim Meeting in November 2024, the AMA 2025 Annual Meeting in June 2025, and the AMA 2025 Interim Meeting in November 2025.

Virtual Task Force Meetings

In 2024, the Task Force held two virtual meetings for all members of the Task Force. The Task Force held a virtual kick-off meeting in May 2024, in which the Task Force Co-Chairs laid out the Task Force's scope, deliverables, and calendar for upcoming meetings. In December 2024, the Task Force held a meeting to discuss the remarks given at the informational session at the 2024 Interim Meeting of the HOD and discuss ongoing Task Force projects.

In 2025, the Task Force held virtual meetings on a quarterly basis. First, in January 2025, the Task Force met to review research conducted into strategy and messaging. (Note: Additional details about the research discussed in the January meeting are provided later in this report.) Then, in May of 2025, the Task Force met to discuss emerging research into the impact of abortion bans and restrictions on the workforce. Then, at the Task Force's fifth virtual meeting in October of 2025, the Task Force met to review and provide feedback on the resource hub the Task Force developed. (Note: Additional details about the resource hub created by the Task Force are provided later in this report.) Finally, at the Task Force's sixth virtual meeting in December 2025, the Task Force met to discuss American College of Obstetricians & Gynecologists (ACOG)'s project to develop and implement state-specific guidance and protocols at institutions in states banning or restricting abortion. (Note: Additional details about the project discussed in the December meeting are provided later in this report.)

In addition to the six virtual meetings with all members of the Task Force, numerous virtual meetings for various Task Force subcommittees and project teams were also held to coordinate ongoing projects, prepare for upcoming meetings with external stakeholders, and ensure that project milestones were met.

In-Person Task Force Meetings

Over the course of two years, the Task Force held four all-day, in-person meetings at the AMA Headquarters in Chicago. These meetings were structured to focus the Task Force's attention on the specific aspects of abortion care impact by *Dobbs* and gender-affirming care, as laid out in AMA Policy G-605.009. Nationally recognized experts in legal issues, payment and reimbursement for gender-affirming care in adult patients, medical education and training, and public health and health outcomes equipped Task Force members with the latest information, research, data, and resources. These presentations and discussions supplemented Task Force members clinical expertise, supporting discussions to identify relevant resource gaps and opportunities to fill them.

The Task Force held its first in-person meeting in July 2024 in Chicago. The in-person meeting focused on legal issues in abortion care and featured a range of speakers and presenters on topics all relating to legal issues in abortion care including, abortion-related litigation activity across the country, legal resources for physicians, the Emergency Medical Treatment and Active Labor Act (EMTALA), and shield law protections for abortion care providers. Following each presentation, Task Force members asked questions and discussed issues and concerns. During a working lunch, Task Force members were asked to strategize and identify resource gaps and potential deliverables for the Task Force regarding advocacy, health equity, medical education and workforce, legal issues, practice issues, and public health. The exercise generated numerous ideas for action. At the conclusion of the day, as directed by the Board and in accordance with Policies G-605.009 and
D-5.998, which instructed the Task Force to identify and create implementation-focused practice and advocacy resources, the Task Force discussed existing resources and limitations of those resources, and identified gaps where resources need to be developed.

In accordance with the amendment to Policy G-605.009 adopted at the AMA 2023 Interim Meeting, in summer of 2024 the Task Force formed a subcommittee to focus on payment and reimbursement issues in gender-affirming care for adults. Members of the subcommittee represent the following nine organizations:

- AMA Board of Trustees
- AMA Council on Legislation
- AMA Council on Ethical and Judicial Affairs
- American Academy of Child and Adolescent Psychiatry
- American Academy of Dermatology
- American Psychiatric Association

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- American Society for Reproductive Medicine
- The Endocrine Society
- Idaho Medical Association

AMA staff conducted a landscape analysis on payment and reimbursement issues that hinder access to gender-affirming care in adults, which, like the landscape analyses on abortion, identified existing resources and gaps in those resources and helped inform discussion during in-person meetings. The subcommittee met in August 2024 to identify issues in payment and reimbursement for gender-affirming care in adults and plan the topics, structure, and agenda for the Task Force's meeting in February 2025 dedicated to these issues.

One of the issues identified by the subcommittee was challenges arising from CPT® coding for gender-affirming care in adults. As such, the subcommittee collaborated with the LGBTQ+ Section to field a survey to better understand these coding challenges. The input from this survey aided the Task Force's discussion of coding issues during its February 2025 meeting.

As directed by AMA Policy, the Task Force met in February of 2025 in Chicago to "identify issues with physician payment and reimbursement for gender-affirming care and recommend solutions to address these barriers to care." The meeting featured a range of speakers on topics all involving payment and reimbursement limitations and administrative challenges that impede access to gender-affirming care for adults, including challenges stemming from limited or non-specific billing codes, inadequate provider networks, low reimbursement rates, discriminatory laws and policies, and state and federal efforts to restrict or criminalize access to gender-affirming care. Speakers included physicians who provide gender-affirming care to adult patients, attorneys, coding experts, a state insurance regulator, and a Medicaid expert. The meeting was structured to allow ample time after each presentation for Task Force members to ask questions of the presenters and discuss barriers to care with one another. These discussions focused on the current landscape and highlighted potential pain points for physicians and patients. Much of the discussion also centered around recent federal executive orders to prohibit federal funding of services for minors and the impact those policies could have on care for other populations. In the last session of the meeting, as directed by the Board and consistent with Policy G-605.009, which instructs the Task Force to recommend solutions to these barriers to care, the Task Force members discussed opportunities and strategies for improving access to care and alleviating administrative burden, including working towards creating more specific CPT codes, where appropriate, continuing to advocate against criminalization, and supporting physicians who care for transgender and gender diverse patients. This discussion was informed by Task Force members' perspectives as clinicians, the speaker presentations, and discussions throughout the meeting.

In July 2025, the Task Force held its third in-person meeting. Featuring nine speakers across four sessions, the meeting's agenda focused on the impact of medical care restrictions on medical education, training, and the physician workforce. In the first session of the morning, speakers from the Accreditation Council on Graduate Medical Education (ACGME) examined program requirements, challenges facing training programs, and the impact of abortion restrictions on clinical training. The meeting's second session explored opportunities to expand clinical training options for trainees, including how programs are adapting to the post-*Roe* environment and how the legislative landscape is impacting clinical training in gender-affirming care. During the meeting's third session, Task Force members heard from a resident and two medical students about the challenges they are facing, how abortion care restrictions are impacting residents and medical students' educational opportunities, and how the current legislative landscape is affecting LGBTQ+ residents and medical students' medical education. In the meeting's last session, speakers from the American Association of Medical Colleges (AAMC) discussed the impact of abortion restrictions on medical schools and the physician workforce pipeline, highlighting research into changes in residency applications in states with abortion restrictions. During the final session of the meeting, as directed by the Board and in accordance with Policies G-605.009 and D-5.998, which instruct the Task Force to identify and create implementation-focused practice and advocacy resources, the Task Force discussed existing resources and limitations of those resources, and identified gaps where resources need to be developed.

The Task Force held its fourth and final all-day, in-person meeting in February of 2026. The goal of the Task Force's fourth meeting was to examine the intersection of abortion and public health and identify and evaluate available resources to help physicians and medical students navigate those issues. Invited speakers across four discussions and presentations focused the conversation on various facets of public health or health care delivery and the challenges faced by physicians, medical students, and patients in that space. The meeting's agenda included a discussion on the current political and legal landscape, a presentation on *Dobbs'* impact on health care delivery and health outcomes, a presentation on issues and disparities in medication abortion access, and a presentation on the impact of *Dobbs* on

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medical liability and population health. Following each presentation, the Task Force asked questions of the presenter, discussed the issues raised, and discussed resources available or needed to support physicians and medical students.

Informational Sessions

In accordance with AMA policy, which directs the Task Force to present updates of its findings including policies, strategies, and resources, the Task Force hosted a series of informational sessions at Annual and Interim meetings of the HOD. These informational sessions served to facilitate engagement with AMA Delegates, Alternate Delegates, and representatives from the AMA Sections and to elevate important voices that are not members of the Task Force.

The Task Force hosted its first informational session at the AMA's 2024 Interim Meeting. At the session, the Task Force co-chairs presented on the Task Force's directives, scope, and activities in 2024. Following the presentation, selected representatives from the AMA's Sections were invited to provide remarks about their experience with laws restricting or banning reproductive health care. The representatives' remarks focused on state laws' impacts on patient care, career and family decisions, educational opportunities, fears for patient outcomes, and, overall, increased physician stress and anxiety. The selected speakers from the AMA Sections represented:

- Women Physicians Section
- Medical Student Section
- Resident and Fellow Section
- Young Physicians Section
- Minority Affairs Section
- LGBTQ+ Section
- Private Practice Physician Section
- Organized Medicine Staff Section
- Academic Physicians Section
- International Medical Graduates Section
- Senior Physician Section

After the representatives from AMA's Sections spoke, AMA Delegates, Alternate Delegates, and other interested parties were invited to ask questions or provide remarks on issues being considered by the Task Force that had not been addressed by previous speakers. These speakers focused their remarks on requests for more communication about the Task Force's work and opportunities for future engagement with the Task Force.

Then at the Annual Meeting of the HOD in June of 2025, the Task Force hosted its second informational session. The purpose of the informational session was to continue engagement with the AMA Delegates, Alternate Delegates, Council members, representatives from AMA Sections and other interested parties. During the informational session, the Task Force showcased some of the research and resources it has developed to support physicians navigating the post-*Roe* legal landscape. The highlighted resources included a presentation on messaging strategy and a presentation on the legal assistance available from the Abortion Defense Network. (Note: Additional details about the messaging strategy and the legal assistance resources are provided later in this report.) In addition, the informational session included a question-and-answer portion to provide an opportunity to ask questions of the Task Force and an opportunity to share perspectives on its work. The perspectives shared by Delegates, Alternate Delegates, representatives from AMA Sections and other interested parties at the informational session were informative, shaping how the Task Force approached its ongoing work.

Once again at the Interim meeting of the HOD in November of 2025, the Task Force hosted a third informational session to facilitate resource-sharing and engagement with AMA Delegates, AMA Alternate Delegates, Council members, representatives from AMA Sections, and other interested parties. At this informational session, the Task Force launched its website: the Reproductive Health Resource Navigator, which is a resource hub for physicians navigating abortion bans and restrictions. (Note: The Reproductive Health Resource Navigator is available at https://www.rhrnavigator.org/. Additional details about the Reproductive Health Resource Navigator are provided later in this report.) Following a demonstration and overview of the website, invited speakers gave presentations on resources their organizations offer to physicians, residents, and medical students. Repeatedly in conversations with AMA Sections and other interested parties, the Task Force has heard about the need for legal assistance for physicians navigating the post-*Roe* legal landscape. In response, at the informational session the Task Force hosted the Abortion Defense Network to present on the legal assistance, representation, and legal defense funding that they provide to physicians navigating the post-*Roe* legal landscape. Then during their presentation, the Ryan Residency Training

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Program examined the current clinical training landscape and discussed their efforts to provide out-of-state clinical training opportunities to residents in states with abortion bans and restrictions.

In the last portion of the informational session, attendees were invited to ask questions of the presenters and share their perspectives on the work of the Task Force. This engagement from attendees was extremely important to the Task Force and ensured that the perspectives and experiences from members of the HOD and AMA Sections are considered in the work of the Task Force. These remarks highlighted important requests and concerns for the Task Force to address in its work. As it contemplates its work in 2026, the Task Force reaffirms its commitment to ensuring underrepresented voices continue to be uplifted through its work.

Task Force Outreach

In addition to the informational sessions, the Task Force conducted outreach with any interested AMA Sections, AMA Councils, and specialty groups in the lead up to the past three HOD meetings and met with the groups at their request. As part of this outreach, the Task Force met with AMA's Council on Legislation, Council on Medical Service, and ACOG's delegation to the HOD. In addition, these meetings facilitated open communication and provided a forum for valuable dialogue with AMA Sections, including the AMA Women Physicians Section, AMA LGBTQ+ Section, AMA Academic Physicians, and AMA Medical Students Section. The perspectives shared during these meetings were critical in shaping the Task Force's work and ensuring that pressing needs, requests, and concerns are addressed. For example, as part of this engagement and to address concerns raised during these discussions, the Task Force partnered on a survey with the LGBTQ+ Section that focused on physician well-being and informed the development of well-being resources.

Ongoing Projects of the Task Force

As a result of reproductive care resource gaps identified by the Task Force, and at the direction of the Board, AMA staff has undertaken a series of projects and initiated partnerships and collaborations to fill those gaps.

Reproductive Health Resource Navigator

In accordance with the directive to identify and create implementation-focused practice and advocacy resources, the Task Force recommended that AMA develop a website, the Reproductive Health Resource Navigator, to serve as a resource hub for physicians navigating abortion bans and restrictions. The AMA agreed that this was a priority and supported the funding of its development. The website is publicly available at https://www.rhrnavigator.org/. The Reproductive Health Resource Navigator houses more than 300 resources developed by the Task Force, AMA, state medical associations and national medical specialty societies, and external organizations. The resources address legal considerations, clinical care, practice management, medical education, and patient resources and are organized in by topic in a searchable format. In accordance with the directive in Policy D-5.995 to provide resources to assist physicians navigating conflicting state and federal regulations on emergency pregnancy care, the site also includes guidance on complying with EMTALA obligations. Additionally, legal representation resources and physician well-being resources are highlighted for site visitors.

Public Opinion Research and Messaging

To support coordinated advocacy, effective engagement, and in accordance with the directive to guide organized Medicine's response to abortion restrictions, the Task Force recommended AMA commission qualitative public opinion research using surveys, in-depth interviews, and focus groups. The research helped explain how different messages, language, and tone resonate across key constituent audiences and build a more compelling narrative for reproductive health advocacy grounded in a strategic messaging foundation. The research provided insight for Task Force members and their organizations on physicians' and the public's perception of the current reproductive health care landscape and will inform strategy for the Task Force going forward. The Task Force met in January 2025 to review the research findings. Findings were also shared with Task Force member organizations and other Federation of Medicine partners.

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Research on the Workforce Impact

To better understand how abortion bans and restrictions impact the physician workforce and to carry out the directive that the Task Force monitor workforce impacts, the Task Force recommended AMA conduct research on the impact of abortion bans and restrictions on the physician workforce and again, the AMA agreed to fund this research. Accordingly, AMA staff initiated a research project examining the impact of abortion restrictions on the physician workforce and where physicians choose to practice. The research and mapping project was completed in spring 2025 and the findings were presented to Task Force members during its virtual meeting in May of 2025.

Legal Assistance and Resources for Physicians

In accordance with the directive to publicize resources for physicians to connect with legal assistance and to protect physicians against civil or criminal prosecution, the Task Force worked with the AMA to support the Abortion Defense Network (ADN) and their network of attorneys and law firms that provide legal advice and representation to physicians navigating the post-*Roe* legal landscape. ADN's resources are available to physicians and other health care providers at www.abortiondefensenetwork.org. Their resources include 26 in-depth "Know Your State's Abortion Laws" guides for medical professionals, which aim to provide clarification on what conduct is permitted and what the law requires in states with abortion restrictions. The partnership between the Task Force and ADN resulted in 10 additional state law guides (Alabama, Arizona, Mississippi, Montana, Nevada, New Hampshire, North Dakota, South Dakota, Virgina, and West Virgina). The guides cover state laws and professional guidelines on numerous facets of reproductive health care, including medication abortion, contraception, and obligations under EMTALA. The state law guides are available on the ADN's website at https://abortiondefensenetwork.org/resources/providers/.

In addition to their written legal resources, ADN connects physicians and others involved in providing abortion care with personalized legal advice and financial assistance. The Task Force urged AMA to support greater physician access to legal assistance, representation, and legal defense funding to physicians navigating the post-*Roe* legal landscape. AMA agreed and provided financial assistance to ADN. Physicians and medical professionals seeking personalized legal assistance can contact ADN using their online form at https://abortiondefensenetwork.org/get-in-touch/. After submitting the form, physicians and medical professionals can expect a response from an attorney within 24 hours. ADN's legal assistance is typically provided *pro bono*. In instances where additional legal funding assistance for a civil or administrative action is needed, physicians and medical professionals may be able to access legal defense funds through ADN.

Through 2025 and 2026, AMA staff has continued regular meetings with ADN to discuss opportunities to collaborate, publicize, and promote ADN's legal services and resources. In addition, these meetings have covered the development of additional ADN resources, including "Know Your Rights" one-pagers and resources related to EMTALA.

Institution-level Guidance

In accordance with a directive adopted at the 2024 Interim Meeting instructing the Task Force to work with interested parties to encourage the development of institution-level guidance, the Task Force is collaborating with ACOG to promote adoption of state-specific, institution-level guidance for managing pregnancy-related medical emergencies in states with abortion restrictions. Using sample protocols drafted by ACOG with support from Lawyers for Good Government, this initiative clarifies institutional policies on abortion to ensure pregnant patients receive appropriate medical care in compliance with state law.

The institutional guidance project is a joint initiative of ACOG and Lawyers for Good Government, with support from the Society for Maternal-Fetal Medicine and the AMA. At ACOG's request, the AMA added a statement of support to ACOG's protocol materials. ACOG also requested the AMA help make connections with individuals and organizations who could help support adoption of the protocol. To further the initiative, the AMA's role has been to support the targeted and intentional promotion of the project, identify champions to advance the protocols at their own institutions, and connect ACOG to relevant state-level contacts. To accomplish this, the AMA facilitated convenings and information sharing with relevant state medical associations, the AMA's Organized Medical Section, and the AMA's Integrated Physician Practice Section. AMA is eager to continue supporting ACOG in the implementation of this project and looks forward to the continued collaboration.

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Collaboration with Elected Prosecutors and District Attorneys

To gain clarity on how abortion bans may be enforced against physicians, and in accordance with AMA policy to protect against civil, criminal, and professional liability and retaliation, the Task Force identified an opportunity to engage with an organization representing elected prosecutors and district attorneys nationwide. The AMA agreed that this would be a productive use of time and resources and, as a result, in March of 2025, seven Task Force members participated in a full day convening with elected prosecutors from around the country. The convening helped professionals on each side understand the others' perspectives, processes, and challenges, and brainstorm strategies to mitigate risk of prosecution for physicians providing abortion care under exceptions in state law. Following the March meeting, a local convening modeled after the national meeting was held. This meeting convened local prosecutors, state legislators, and local physician leaders.

Continuing the collaboration, a new group of seven Task Force members attended a second convening with the national prosecutors' group in December of 2025. As a result of this meeting, the Task Force and participating prosecutors are planning two upcoming webinars to educate both prosecutors and physicians. Specifically, one webinar will educate physicians about the criminal prosecution process and relevant legal standards; the other webinar will educate prosecutors about pregnancy complications and the incompatibility between abortion laws and clinical practice. This work is on-going. (Note: This report was prepared in February and may not include more recent developments.) The AMA is continuing to collaborate with prosecutor groups to educate the prosecution field and establish collaborative relationships to help inform prosecutorial actions.

Support for Residents and Medical Students

As a result of the Task Force's discussions on challenges and barriers facing medical students and residents, and in accordance with AMA policy to mitigate radically diminished training opportunities, AMA staff initiated several projects and collaborations to support residents and medical students navigating bans and restrictions on abortion. The Task Force recommended that the AMA provide financial assistance to facilitate out-of-state training opportunities. The AMA agreed and helped fund the UCSF Ryan Residency Training Program in order to provide financial assistance to enable residents in ban states to travel to out-of-state institutions for abortion training, support for institutions who receive out-of-state residents, and build capacity within the Ryan Residency Training Program to further support institutional partnerships to ensure availability of abortion training.

All OB-GYN residency programs are required by ACGME to provide training in abortion care. In states where abortion is banned or severely restricted, residency programs cannot fulfill this requirement without sending residents to external sites. Many institutions, particularly in the South and Midwest, report that they lack resources or face legal or policy barriers to funding residents' travel, leaving residents personally responsible for those costs. The AMA's financial assistance for resident travel costs help to fill that gap, ensuring that residents are able to accept temporary placement and gain competency in managing abortion, miscarriage, and pregnancy complications.

A critical barrier to maintaining out-of-state training partnerships is the strain placed on the clinical sites that host visiting residents. These receiving institutions must absorb significant administrative, supervisory, and logistical burdens, from processing temporary licenses, malpractice coverage, and onboarding requirements to adjusting clinic schedules and supervision ratios to accommodate additional trainees. Many are safety-net or academic centers already operating at capacity. The Ryan Program will provide direct financial and technical support to these host institutions, helping offset the costs of integrating visiting residents while preserving high-quality training for all learners. By supporting receiving institutions, the contribution will help ensure these cross-state partnerships remain sustainable for receiving institutions.

While short-term funding for resident placements is urgently needed, the Ryan Program's broader infrastructure helps make those rotations possible. The Ryan Program serves as the central convener and technical resource for residency programs navigating legal, logistical, and educational complexities in the post-*Dobbs* environment. The AMA's funding helped enable the program to expand and formalize these efforts by developing standardized affiliation agreements, refining compliance and risk-management tools, facilitating communication between sending and receiving sites, and building the capacity of faculty and program administrators to manage these cross-state collaborations effectively. This investment ensures that the national system for arranging out-of-state training is scalable and sustainable for the future.

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Lastly, in response to the Task Force's discussions on moral distress, trainee mental health, and the need to support medical student well-being, the AMA published two issue briefs on moral distress in medical students, available resources, and AMA policies to support medical student well-being. These issue briefs are available at https://www.ama-assn.org/system/files/Issue-brief-moral-distress.pdf and https://www.ama-assn.org/system/files/issue-brief-med-student-resources.pdf.

The Task Force continues to consider additional deliverables to support physicians navigating state laws restricting or banning abortion.

CONCLUSION

The Board, through the Task Force, will continue to implement Policies G-605.009 and D-5.998, monitor and prepare for new and emerging threats to the provision of evidenced-based medical care, and work to protect access to care and preserve the role of the patient-physician relationship as a central element in medical decision-making.

34. DISCONTINUATION OF AMA CITATION FOR DISTINGUISHED SERVICE

Reference committee hearing: see report of Reference Committee F.

HOD ACTION: RECOMMENDATION ADOPTED
REMAINDER OF REPORT FILED

The Awards and Nominations Committee of the American Medical Association (AMA) Board of Trustees administers all AMA Awards. In 2025, the Board voted to discontinue the Citation for Distinguished Service, one of only two awards referenced in the Bylaws.

The Citation for Distinguished Service was created in 1948, with the first citation awarded in 1952. The Citation was intended to recognize individuals who were not part of the medical profession but who have "by their cooperation and aid in the advancement of medical science, medical education or medical care contributed to the achievement of the ideals of American medicine." The last AMA Citation for Distinguished Service was awarded in 2009 with no subsequent nominations. Due to the lack of interest, on recommendation of the Awards and Nominations Committee, the Board voted to discontinue the Citation. However, as the Award is referenced in the AMA Bylaws, a bylaw amendment is needed. The Board also wants to apprise the House of its decision and rationale for discontinuing it.

RECOMMENDATION

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

That the AMA Bylaws be amended to eliminate reference to the Citation for Distinguished Service.

Fiscal Note: Less than $500

35. SPECIALTY SOCIETY REPRESENTATION IN THE HOUSE OF DELEGATES - FIVE-YEAR REVIEW

Reference committee hearing: see report of Reference Committee on Ethics and Bylaws.

HOD ACTION: RECOMMENDATION ADOPTED
REMAINDER OF REPORT FILED
See Policy D-600.984

The Board of Trustees (BOT) has completed its review of the specialty organizations seated in the House of Delegates (HOD) required to submit information and materials for the 2026 American Medical Association (AMA) Annual Meeting in compliance with the five-year review process established by the House of Delegates in Policy G-600.020, "Summary of Guidelines for Admission to the House of Delegates for Specialty Societies," and AMA Bylaw 8.5, "Periodic Review Process."

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Organizations are required to demonstrate continuing compliance with the guidelines established for representation in the HOD. Compliance with the five responsibilities of professional interest medical associations and national medical specialty organizations is also required as set out in AMA Bylaw 8.2, "Responsibilities of National Medical Specialty Societies and Professional Interest Medical Associations."

The following organizations were reviewed for the 2026 Annual Meeting:

American Academy of Child and Adolescent Psychiatry
American Association of Clinical Endocrinology
American Association of Physicians of Indian Origin
American College of Medical Genetics and Genomics
American College of Radiation Oncology
American Institute of Ultrasound in Medicine
American Orthopaedic Foot and Ankle Society
American Society for Clinical Pathology
American Society of Anesthesiologists
American Society of Cataract and Refractive Surgery
American Society of Colon and Rectal Surgeons
American Society of Dermatopathology
American Society of Neuroradiology
Obesity Medicine Association
Post-Acute and Long-Term Care Medical Association
Renal Physicians Association
Society of Critical Care Medicine
Society of Interventional Radiology

The American Vein and Lymphatic Society and The Triological Society were also reviewed at this time because they failed to meet the requirements in June 2025 and were granted a one-year grace period.
Each organization was required to submit materials demonstrating compliance with the guidelines and requirements along with appropriate membership information. A summary of each group's membership data is attached to this report (Exhibit A). A summary of the guidelines for specialty society representation in the AMA HOD (Exhibit B), the five responsibilities of national medical specialty organizations and professional medical interest associations represented in the HOD (Exhibit C), and the AMA Bylaws pertaining to the five-year review process (Exhibit D) are also attached.

The materials submitted indicate that: American Academy of Child and Adolescent Psychiatry, American Association of Clinical Endocrinology, American College of Medical Genetics and Genomics, American College of Radiation Oncology, American Institute of Ultrasound in Medicine, American Orthopaedic Foot and Ankle Society, American Society for Clinical Pathology, American Society of Anesthesiologists, American Society of Colon and Rectal Surgeons, American Society of Dermatopathology, American Society of Neuroradiology, Obesity Medicine Association, Post-Acute and Long-Term Care Medical Association, Renal Physicians Association, Society of Critical Care Medicine, and Society of Interventional Radiology meet all guidelines and are in compliance with the five-year review requirements of specialty organizations represented in the HOD.

The materials submitted also indicate that The Triological Society met all guidelines and are in compliance with the five-year review requirements of specialty organizations represented in the HOD.

The materials submitted also indicate that the American Association of Physicians of Indian Origin, American Society of Cataract and Refractive Surgery, and American Vein and Lymphatic Society did not meet all guidelines and are not in compliance with the five-year review requirements of specialty organizations represented in the AMA HOD.

RECOMMENDATIONS

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

1. The American Academy of Child and Adolescent Psychiatry, American Association of Clinical Endocrinology, American College of Medical Genetics and Genomics, American College of Radiation Oncology, American Institute of Ultrasound in Medicine, American Orthopaedic Foot and Ankle Society,

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American Society for Clinical Pathology, American Society of Anesthesiologists, American Society of Colon and Rectal Surgeons, American Society of Dermatopathology, American Society of Neuroradiology, Obesity Medicine Association, Post-Acute and Long-Term Care Medical Association, Renal Physicians Association, Society of Critical Care Medicine, and Society of Interventional Radiology retain representation in the American Medical Association House of Delegates.

2. Having failed to meet the requirements for continued representation in the AMA House of Delegates as set forth in the AMA Bylaw B-8.5, the American Association of Physicians of Indian Origin and American Society of Cataract and Refractive Surgery be placed on probation and be given one year to work with AMA membership staff to increase their AMA membership.
3. Having failed to meet the requirements for continued representation in the AMA House of Delegates as set forth in the AMA Bylaw B-8.5 at the end of the one-year grace period, the American Vein and Lymphatic Society lose representation in the AMA HOD but retain it for the AMA Specialty and Service Society (SSS) and may apply for reinstatement in the HOD, through the SSS, when they believe they can comply with all of the current guidelines for representation in the HOD, in accordance with AMA Bylaw B-8.5.3.2.2.

Fiscal Note: Less than $500

36. UPDATE ON THE REPORT OF THE TRHT TASK FORCE TO THE AMA BOARD OF TRUSTEES

Reference committee hearing: see report of Reference Committee on Ethics and Bylaws.

HOD ACTION: RECOMMENDATIONS ADOPTED
REMAINDER OF REPORT FILED
See Policy D-600.949

At the June 2021 Special Meeting of the American Medical Association (AMA) House of Delegates (HOD), AMA took a critical step toward addressing historical and contemporary injustices in medicine by adopting, as amended, the Council on Medical Education Report 5 (CME 5) entitled, "Promising Practices Among Pathway Programs to Increase Diversity in Medicine". This report recognized longstanding systemic barriers that have marginalized certain populations in medicine and called for the establishment of a task force to guide the AMA's transformation toward restorative justice. The directive emphasized a commitment to truth, reconciliation, and healing in both medicine and medical education.

In response, the AMA Truth, Reconciliation, Healing and Transformation (TRHT) task force was formed and convened quarterly between 2023-2024. The task force conducted historical research, collected contemporary narratives, and developed a final consensus report with actionable recommendations.

In 2025, the AMA Board of Trustees received the final TRHT task force's report, which documented historical findings related to the AMA's role in creating and perpetuating concepts, structures, and systems that marginalized or directly harmed multiple groups of medical aspirants, trainees, and physicians, as well as contributed to inequitable health outcomes. The report also outlined a series of recommendations aimed at addressing both historical and ongoing harms and strengthening equitable systems of care.

The Board agreed to engage in thoughtful and deliberate review of the report's recommendations, including:

- a legal and regulatory assessment to determine how the AMA can best advance the recommendations consistent with our mission, governance structure, and organizational capacity;
- a review in alignment with our AMA's Constitution and Bylaws and internal financial operating procedures; and
- structured Board discussions to determine the best path forward for public management and future action.

While the legal and regulatory review has been completed, the financial review and structured dialogue are ongoing. The Board remains committed to ensuring that implementation efforts are thoughtful, compliant with applicable legal frameworks, financially responsible, and aligned with the AMA's long-term strategic priorities.

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DISCUSSION

Strengthening Strategic Partnerships and Collaborative Policy Development

The AMA continues to engage with the Strategic Opportunities Workgroup, an internal initiative that aligns closely with TRHT recommendations related to trust-building, partnership, and shared policy development.

The workgroup convenes national physician organizations, including the National Medical Association (NMA), National Hispanic Medical Association, National Council of Asian Pacific Islander Physicians, Association of American Indian Physicians (AAIP), and GLMA: Health Professionals Advancing LGBTQ+ Equality. These organizations represent physicians and communities that have historically experienced exclusion or harm within the health care system.

Through this workgroup, the AMA facilitates structured dialogue to identify and advance policy opportunities, elevate community-informed solutions, support coordinated national strategies, and inform AMA policy priorities. While the workgroup predates the TRHT task force report, its continued evolution reflects a deliberate shift toward sustained engagement and co-development of policy. In support of this work, each participating organization received $40,000 in grant funding during the current 2026 cycle to strengthen infrastructure, support mission-aligned programming, and enhance membership development. This investment recognizes the critical role these organizations play in advancing physician leadership and addressing emerging health system challenges.

The AMA expanded its broader partnership strategy in 2026 to further advance reconciliation, rebuild trust and support organizations representing historically marginalized communities. This includes engagement across key convenings such as the NMA Annual Convention and National Colloquium on African American Health, the Congressional Black Caucus Foundation Annual Legislative Conference, the Asian Pacific American Institute for Congressional Studies Awards Gala, the National Hispanic Health Foundation Health Professional Student Scholarship Gala, the Bernard Lown Social Responsibility Conference and Awards Dinner, and the Anarcha, Lucy, Betsey Conference. These engagements are supplemented by sponsorships and collaborations with organizations such as the Association of Black Cardiologists, Minority Health Institute, and the American Society of Medical Association Counsel.

The AMA has also expanded partnerships tied to the Release the Pressure (RTP) campaign, including collaboration with the American Heart Association, health systems, and community-based organizations to address hypertension disparities through culturally responsive outreach and community engagement. The RTP public materials, initially focused on African American women, has expanded to include Latina women, South Asian women, American Indian and Alaska Native (AI/AN) women, and White women in rural communities. Further partnerships with organizations such as the National Health Council, National Rural Health Association, National Medical Fellowships and the National Hispanic Health Foundation extend the AMA's reach across policy, workforce development and community-based initiatives.

The AMA has also strengthened partnerships focused on educational and workforce development efforts. This includes hosting Internal Medicine Residents from the University of California, Los Angeles in the Washington, DC office for a second consecutive year to provide direct exposure to federal equity advocacy. Additionally, the AMA has expanded its partnership with the Morehouse School of Medicine Satcher Health Leadership Institute by doubling participation in the Medical Justice in Advocacy Fellowship (MJAF) from 10 to 20 fellows for the 2026–2027 cycle and collaborating on the development of a Health Policy, Advocacy, and Justice Lectureship at Morehouse School of Medicine. There are 33 MJAF alumni, and the AMA's Center for Optimal Health Outcomes is working to develop more consistent engagement.

Complementing these efforts, the AMA remains engaged with West Side United, where ongoing work includes the development of a Social Return on Investment (SROI) analysis of its Anchor Mission Partnership. Preliminary findings demonstrate a 4.4x to 8.6x return on investment across community-focused initiatives, including support for local businesses and strengthened clinical-community linkages. AMA is also partnering with Live Healthy Chicago (LHC), a citywide civic initiative to reduce heart attack and stroke risk via improving blood pressure control. It is an innovative outcomes-based prevention financing model building clinical workflow transformation by integrating the AMA MAPTM framework for hypertension control into primary care, deploying mobile community care teams and launching a public health awareness campaign. LHC targets 27 South and West Side Chicago neighborhoods—nearly 740,000 residents—where cardiovascular risk is nearly double the citywide rate and mortality from heart attacks and strokes is disproportionately high. Another organization AMA is working with is the Atlanta Hypertension Initiative

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(AHI), which brings together public health, health care, community and faith-based organizations, government, academia and professional associations to address longstanding inequities in hypertension control across metro Atlanta. Grounded in truth and accountability for disparate outcomes, AHI focuses on repair and healing through community partnership, clinical quality improvement, and shared capacity-building. Over the next five years, the initiative aims to improve blood pressure control for more than 500,000 adults by contributing to transformative reductions in preventable heart attacks, strokes, and cardiovascular disease.

These engagements further reinforce the value of collaborative, community-informed investment strategies. Collectively, these efforts reflect a coordinated and intentional approach to strengthening partnerships, investing in trusted organizations, and ensuring that policy development and implementation are informed by those most directly impacted by inequities in care delivery.

Advancing Policy Supporting Indigenous Health and Sovereignty

In parallel with partnership-building efforts, the AMA has advanced internal policy initiatives that align with TRHT recommendations focused on structural change and support for historically excluded communities.

At the 2025 AMA Annual Meeting, the House of Delegates adopted Resolution 303-A-25: Support for the Establishment of Indigenous-Led Medical Schools in the United States, which supports the establishment of Indigenous-led medical schools in the United States. This policy emphasizes governance structures grounded in tribal sovereignty, cultural integrity, accountability to Indigenous Nations, inclusion of Indigenous leadership, and alignment with community-defined priorities.

Additionally, the House of Delegates adopted Resolution 604-A-25: Advisory Committee on Tribal Affairs, which directs the AMA to establish a Task Force on Tribal Affairs composed of individuals with lived experience, professional engagement, or direct service within American Indian and Alaska Native (AI/AN) communities. This task force is charged with advising the Board of Trustees on implementation of policies impacting AI/AN communities and developing recommendations for the creation of a permanent Advisory Committee on Tribal Affairs. To date, seven members have been appointed by the Board to serve on the Advisory Committee, and a charter has been drafted. Terms will begin immediately and will end upon the conclusion of the Annual Meeting in the appropriate year for the term length.

This work also includes efforts to promote educational opportunities that enhance understanding of AI/AN contributions to medicine and public health. In support of these efforts, the AMA has collaborated with the AAIP to identify individuals with the expertise and experience necessary to inform this work.

In preparation for the 2026 Annual Meeting, the Council on Medical Education has submitted the following two reports for consideration:

- CME Report 3: Support for the Establishment of Indigenous-Led Medical Schools in the United States
- CME Report 4: Reflecting the Values and Priorities of Tribal Communities in Indigenous-Led Medical Schools in the United States

Together, these actions represent meaningful steps toward strengthening Indigenous representation, advancing culturally grounded approaches to medical education, and ensuring sustained attention to tribal health equity.

Strengthening Maternal Health Systems and Workforce Through Advocacy

Consistent with TRHT recommendations related to maternal health equity, the AMA has advanced its policy and advocacy efforts to strengthen access to care, workforce capacity and care delivery systems.

The AMA has engaged in federal policymaking through input on the Center for Medicare & Medicaid Services Innovation Center's Transforming Maternal Health Model and has submitted recommendations to Congress aimed at strengthening and retaining the maternal health workforce, particularly in rural and underserved areas. The AMA has also supported legislation such as the Rural Obstetrics Readiness Act to expand emergency obstetric training in facilities without dedicated obstetric units.

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In addition, the AMA has advanced policies supporting telehealth and remote patient monitoring, including support for the Connected MOM Act, to improve access to maternal health services in shortage areas. Ongoing work related to AMA's Current Procedural Technology (CPT®) coding reforms, including the proposed unbundling of global maternity care CPT codes, may further support flexible, team-based models of care. The AMA has also supported initiatives to expand maternal health workforce pathways, including rural residency training programs and efforts such as the Teaching Health Center Graduate Medical Education Program and the National Health Service Corps' Maternity Care Target Area initiative. These efforts aim to strengthen care delivery in communities disproportionately impacted by maternal health inequities.

CONCLUSION

The AMA will continue to further its ongoing work aligned with TRHT recommendations through strengthened partnerships, focused policy development, and strategic investments. At the same time, as the AMA looks ahead to future implementation, sustained commitment, dedicated resources and coordinated action across the organization which will be essential to building on this foundation. Continued focus on partnership, accountability and measurable impact will be critical to advancing reconciliation and strengthening equitable systems of care. The AMA remains committed to this work and to advancing policies and practices that improve health outcomes for all communities.

RECOMMENDATION

That our American Medical Association establish a multi-session educational series for the House of Delegates, commencing at I-26, focused on the work of the Truth, Reconciliation, Healing, and Transformation (TRHT) Task Force, including:

1. Opportunities for members to directly engage in programming regarding the Task Force's process, historical findings, framework, and lessons learned;
2. Sessions organized around major areas of historical examination undertaken by the Task Force; and
3. An open forum as part of this educational series to provide members an opportunity to participate in dialogue regarding truth, reconciliation, healing, and transformation, strengthen organizational capacity, and identify opportunities to advance TRHT principles to the extent allowed by fiduciary, legal, and financial review.

37. AMA POLICIES ON GENDER AFFIRMING CARE

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: FILED

This report is submitted as information to the House of Delegates as a summary of the policies that form the foundation of our American Medical Association's (AMA) position on gender affirming care and to address concerns related to our failure to accurately and completely communicate those policies. Specifically, the report addresses the medical necessity of such care, the role of shared decision-making, and considerations related to gender-affirming surgery.

BACKGROUND

The policies outlined in this report establish the basis of the AMA's position on gender-affirming care. Taken together, they inform an approach to medical and surgical interventions, including in minors, that supports evidence-based treatment.

Intending to align with these policies, the AMA Board of Trustees approved the following statement:

> "We support evidence-based treatment for medical care, including gender affirming care. Currently, the evidence for surgical intervention in minors is insufficient for us to make a definitive statement. In the absence of clear evidence, surgical interventions in minors should be generally deferred to adulthood.
>
> Treatment decisions should be made between the physician and the patient (and family) based on the best medical evidence and clinical judgment."

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This statement was not intended to change existing or establish new AMA policy. Nothing in this statement was intended to alter the AMA's support for access to medically-necessary gender affirming care, our reliance on evidence-based guidance from relevant specialty societies, our support of shared decision making between patients, families and the health care team, or our opposition to government or third-party interference in the patient-physician relationship.

We recognize, however, that this statement failed to accurately and completely reflect the breadth of AMA policy on gender affirming care, and that the way it was communicated to the media compounded that failure. We further recognize that some characterizations of our statement created confusion about AMA policy and caused concerns and harm among members and stakeholders. After much discussion, we have taken steps to ensure the future comments undergo more thorough review, are vetted by the appropriate experts, and are communicated with greater clarity, precision, and transparency. We remain committed to the health and well-being of transgender and gender diverse people.

AMA POLICY

AMA Policy H-185.927, "Clarification of Evidence-Based Gender-Affirming Care," states that:

> "Our American Medical Association recognizes that medical and surgical treatments for gender dysphoria and gender incongruence, as determined by shared decision making between the patient and physician, are medically necessary as outlined by generally accepted standards of medical and surgical practice. Our AMA will work with state and specialty societies and other interested stakeholders to: advocate for federal, state, and local laws and policies to protect access to evidence-based care for gender dysphoria and gender incongruence; oppose laws and policies that criminalize, prohibit or otherwise impede the provision of evidence-based, gender-affirming care, including laws and policies that penalize parents and guardians who support minors seeking and/or receiving gender-affirming care; support protections against violence and criminal, civil, and professional liability for physicians and institutions that provide evidence-based, gender-affirming care and patients who seek and/or receive such care, as well as their parents and guardians; and communicate with stakeholders and regulatory bodies about the importance of gender-affirming care for patients with gender dysphoria and gender incongruence. Our AMA will advocate for equitable, evidence-based coverage of gender-affirming care by health insurance providers, including public and private insurers."

AMA Policy H-185.905, "Advocating for the Informed Consent for Access to Transgender Health," states that:

> "Our American Medical Association unambiguously supports access to and insurance coverage of medically necessary gender-affirming care but does not identify a preferred model of care for determining medical necessity. The AMA vigorously advocates for equitable payment policies, relying on the evidence-based professional guidelines and recommendations set by professional medical associations, as well as individual physician clinical judgment, on questions of appropriate clinical criteria."

AMA Policy H-460.893, "Patient-Reported Outcomes in Gender Confirmation Surgery," states that:

> "Our AMA supports: (1) initiatives and research developed by specialty societies and other relevant stakeholders to establish standardized protocols for patient selection, surgical management, and preoperative and postoperative care for transgender patients undergoing gender confirmation surgeries; and (2) implementation of standardized tools, such as questionnaires, developed by specialty societies and other relevant stakeholders to evaluate outcomes of gender confirmation surgeries."

AMA Policy H-140.824, "Healthcare Equity Through Informed Consent and a Collaborative Healthcare Model for the Gender Diverse Population," states that:

> "Our American Medical Association supports shared decision making between gender diverse individuals, their health care team, and, where applicable, their families and caregivers. Our AMA supports treatment models for gender diverse people that promotes informed consent, personal autonomy, increased access for gender affirming treatments and eliminates unnecessary third-party involvement outside of the physician-patient relationship in the decision-making process."

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DISCUSSION

AMA policy affirms that gender-affirming care is medically necessary, as articulated in AMA Policy H-185.927. Adopted by the House of Delegates in 2016 and amended and reaffirmed on several occasions since, this policy states that our AMA "recognizes that medical and surgical treatments for gender dysphoria and gender incongruence, as determined by shared decision-making between the patient and physician, are medically necessary as outlined by the generally accepted standards of medical and surgical practice." AMA Policy H-185.905, adopted in 2024, reiterates our position and states that the AMA "unambiguously supports access to and insurance coverage of medically necessary gender-affirming care."

Furthermore, while these policies do not explicitly address application to minors, language regarding civil and criminal legal protections, including "parents and guardians," imply that support for the medical necessity of gender-affirming care extends to all patients. Accordingly, the reference to "generally accepted standards of medical and surgical practice" in AMA Policy
H-185.927 applies to all patient populations, including minors.

As a general principle, the AMA does not typically endorse guidelines or establish standards of care, including any specific treatments for gender dysphoria or gender incongruence. Instead, the AMA defers to national medical specialty societies on these matters.

Specifically, regarding gender-affirming surgery, AMA Policy H-460.893 expressly supports specialty societies' development of "standardized protocols for patient selection, surgical management, and preoperative and postoperative care." Further, AMA Policy H-185.905 relies on "evidence-based professional guidelines and recommendations set by professional medical associations, as well as individual physician clinical judgment, on questions of appropriate clinical criteria" for gender affirming care. Accordingly, on these matters, the AMA relies on the expertise of relevant national medical specialty associations.

The consensus of the recommendations is that gender-affirming surgical interventions be approached through an individualized, developmentally informed framework. Comprehensive mental health assessment and treatment of any relevant co-occurring conditions, social transition and hormonal therapies are considered before surgical interventions. As with all surgical interventions, decisions regarding gender affirming surgery in minors require individualized assessments of risks, benefits, and alternatives.

Clinical decision-making must ultimately be individualized, with physicians tailoring recommendations, including the type and timing of interventions, to each patient's unique circumstances and clinical context. As such, the AMA "supports shared decision-making between gender-diverse individuals, their health care team, and, where applicable, their families and caregivers," as articulated in AMA Policy H-140.824.

The AMA opposes laws and policies that criminalize, prohibit, or otherwise impede access to gender-affirming care, as stated in AMA Policy H-185.927. This position is consistent with broader AMA policy opposing governmental or third-party interference in medical decision-making, including Policies H-373.995, H-5.989, H-270.959, and H-160.946, all of which affirm the importance of preserving physician clinical judgment and the integrity of the patient-physician relationship.

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38. PROJECT IMG OBSERVER STATUS IN THE HOUSE OF DELEGATES

Reference committee hearing: see report of Reference Committee F.

HOD ACTION: RECOMMENDATION ADOPTED
REMAINDER OF REPORT FILED
See Policy D-600.949

The Board of Trustees has received a request from Project IMG to be considered for Official Observer status in the House of Delegates (HOD) of the American Medical Association (AMA). The Project IMG's request has been considered using the criteria below (Policy G-600.025, "Official Observers in Our AMA House"):

1. The organization and the AMA should already have established an informal relationship and have worked together for the mutual benefit of both;
2. The organization should be national in scope and have similar goals and concerns about health care issues;
3. The organization is expected to add a unique perspective or bring expertise to the deliberations of the HOD; and
4. The organization does not represent narrow religious, social, cultural, economic, or regional interests so that formal ties with the AMA would be welcomed universally by AMA members.

DISCUSSION

As part of its request, Project IMG submitted information on how it has met the criteria for Official Observer status, which is summarized below.

Criterion 1. The organization and the AMA should already have established an informal relationship and have worked together for the mutual benefit of both.

Project IMG has collaborated with the AMA on key events and initiatives, including events in New York and Miami. Most recently, the CEO, Dr. Sebastian Arruarna was a featured speaker at the AMA Distinguish Yourself IMG Summit. This involvement reflects the strong alignment of the AMA's goals of inclusion, education and advancement for international physicians. Project IMG has also worked with AMA to support national advocacy efforts, particularly surrounding the J-1 visa process. There has been involvement with the AMA IMG Section including exchanging critical information and ideas – particularly during the J-1 visa pause and other urgent matters impacting IMGs nationwide.

Criterion 2. The organization should be national in scope and have similar goals and concerns about health care issues.

Project IMG has active chapters in the majority of the U.S. states and mobilizes students and trainees through a three-pronged approach of education, advocacy and service. Project IMG also engages in policy conversations and public discourse to advocate for sustainable immigration pathways and address workforce gaps across the country. In addition, Project IMG actively partners with U.S. hospitals to increase meaningful clinical opportunities for IMGs and collaborates with free clinics nationwide to empower their members to serve underserved communities while gaining vital hands-on experience.

Criterion 3. The organization is expected to add a unique perspective or bring expertise to the deliberations of the HOD.

Project IMG is prepared to maintain a consistent presence with the HOD to help amplify and support the AMA's initiatives and priorities. This presence would also allow Project IMG to gain a broader understanding of issues and solutions across the wider medical field, which it will then share with their members. Project IMG's members offer both national and global perspectives on the status of international medical students and graduates, as well as U.S.-based residents, fellows and practicing physicians. This perspective can make a valuable contribution to policy discussions and healthcare reform efforts that directly shape the future of medicine in the United States.

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Criterion 4. The organization does not represent narrow religious, social, cultural, economic, or regional interests so that formal ties with the AMA would be welcomed universally by AMA members.

Project IMG is a mission-driven collective supporting more than 100,000 International Medical Graduates (IMGs) and medical students from over 120 countries. Although focused on IMGs, Project IMG's membership is completely free and open to anyone – ensuring that their resources, programs and support structures are accessible to all who wish to join.

CONCLUSION

The Board of Trustees appreciates the previous collaboration with Project IMG and their willingness to amplify and support AMA's initiatives and priorities while also bringing a unique perspective to the HOD. Therefore, your Board believes that Project IMG should be recognized as an Official Observer and welcomed to the House in that capacity.

RECOMMENDATION

The Board of Trustees recommends that Project IMG be admitted as an Official Observer in the House of Delegates, and the remainder of this report be filed.

Fiscal Note: Minimal

Appendix - Official Observers to the House of Delegates as of May 2026

Organization	Year Admitted
Accreditation Council for Continuing Medical Education	2025
Ambulatory Surgery Center Association	2005
American Academy of Physician Associates	1994
American Association of Medical Assistants	1994
American Board of Medical Specialties	2014
American Dental Association	1982
American Podiatric Medical Association	2019
Association of periOperative Registered Nurses	2000
Association of State and Territorial Health Officials	1990
Council of Medical Specialty Societies	2008
Federation of State Medical Boards	2000
Federation of State Physician Health Programs	2006
Intealth (ECFMG)	2011
Medical Professional Liability Association (formerly PIAA)	2013
Society for Academic Continuing Medical Education	2003
United States Professional Association for Transgender Health	2024
World Medical Association	2024

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