REPORTS OF THE COUNCIL ON MEDICAL SERVICE

The following reports were presented by Betty Chu, MD, MBA, Chair:

1. COUNCIL ON MEDICAL SERVICE SUNSET REVIEW OF 2016 HOUSE POLICIES

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: RECOMMENDATIONS ADOPTED
REMAINDER OF REPORT FILED

Policy G-600.110, "Sunset Mechanism for AMA Policy," calls for the decennial review of American Medical Association 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 adopts policies, a maximum ten-year time horizon shall exist. A policy will typically sunset after ten years unless action is taken by the House of Delegates to retain it. Any action of our AMA House 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 House of Delegates 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; and (f) The Speakers shall determine the best way for the House of Delegates 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to the HOD or resolution to sunset a policy earlier than its 10-year horizon if it is no longer relevant, has been superseded by a more current policy, or has been accomplished.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 House of Delegates 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 House of Delegates 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 Council on Medical Service 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 #	Title	Text	Recommendation
D-120.949	Ensuring the Safe and Appropriate Use of Compounded Medications	Our AMA will: (1) monitor ongoing federal and state evaluations and investigations of the practices of compounding pharmacies; (2) encourage the development of regulations that ensure safe compounding practices that meet patient and	Retain. Policy is relevant.

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POLICY #	Title	Text	Recommendation
		physician needs; and (3) report back on efforts to establish the necessary and appropriate regulatory oversight of compounding pharmacy practices.	
D-155.995	Containing Catastrophic Care Costs	Our AMA will: (1) in order to ensure that quality of care is not compromised, encourage physicians and the medical profession to become more engaged in the development and implementation of cost-containment policies and strategies, particularly those directed toward high-cost patients; (2) support additional research into the characteristics of the five percent of the patient population with the highest health care costs; (3) support greater evaluation of the use of disease management, case management, pay-for-performance, and end-of-life care programs for high-cost patients, so that their cost-containment impact and projected future savings can be better assessed; and (4) continue to inform the medical profession and the general public regarding issues impacting catastrophic care costs and the complexities therein.	Retain. Policy is relevant.
D-160.924	Hospital Discharge Communications	Our AMA will develop model guidelines for physicians to improve communications to other physicians, hospital staff and patients, and promote these guidelines to payers, hospitals and patients.	Retain. Policy is relevant.
D-160.926	A Guide to Selecting a Physician-Led Integrated System	Our AMA, in collaboration with the Integrated Physician Practice Section and appropriate partners within the House of Medicine, will accomplish the following by the 2017 Annual Meeting: 1. Develop a guide for physicians considering joining or aligning with a physician-led integrated system that addresses, but is not limited to the following: A. various models of integrated systems; B. metrics that help determine the extent to which an integrated system fulfills the definition of, and performs as, an integrated system; C. how to determine an organization's quality commitment/record; D. how to know if a particular system is the right fit; E. what does a physician stand to gain/lose when joining such a system; and 2. The guide should also provide information to physicians in or considering solo and small practice on how they can align through Independent Practice Associations, Accountable Care Organizations, Physician Hospital Organizations, and other models to help them with the imminent movement to risk-based contracting and value-based care.	Sunset. Directive was accomplished.
D-160.928	Hierarchical Condition Category Coding	Our AMA will continue to work with the Centers for Medicare and Medicaid Services to refine risk adjustment in all alternative payment models and	Retain. Policy is relevant.

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POLICY #	Title	Text	Recommendation
		Medicare Advantage plans, particularly to revise risk-adjustment processes, to allow hierarchical condition category (HCC) codes to automatically follow the beneficiary from year-to-year to reflect chronic conditions that will never change.	
D-160.945	Communication Between Hospitals and Primary Care Referring Physicians	Our AMA: (1) advocates for continued Physician Consortium for Performance Improvement? (PCPI) participation in the American College of Physicians (ACP), the Society of General Internal Medicine (SGIM), and the Society of Hospital Medicine (SHM) work to develop principles and standards for care transitions that occur between the inpatient and outpatient settings; (2) advocates for timely and consistent inpatient and outpatient communications to occur among the hospital and hospital-based providers and physicians and the patient's primary care referring physician; including the physician of record, admitting physician, and physician-to-physician, to decrease gaps that may occur in the coordination of care process and improve quality and patient safety; (3) will continue its participation with the Health Information Technology Standards Panel (HITSP) and provide input on the standards harmonization and development process; (4) continues its efforts with The Joint Commission, the Centers for Medicare & Medicaid Services, and state survey and accreditation agencies to develop accreditation standards that improve patient safety and quality; and (5) will explore new mechanisms to facilitate and incentivize communication and transmi ssion of data for timely coordination of care (via telephone, fax, e-mail, or face-to-face communication) between the hospital-based physician and the primary physician.	Retain. Policy is relevant.
D-215.990	AMA Assistance for Members in Matters Pertaining to Physician-Hospital/Health System Relationships	1. As a benefit of membership our AMA will provide assistance, such as information and advice (but not legal opinions or representation), as appropriate to employed physicians, physicians in independent practice, and independent physician contractors in matters pertaining to their relationships with hospitals, health systems, and other similar entities, including, but not limited to, breach of contracts including medical staff bylaws, sham peer review, economic credentialing, and the denial of due process. 2. Our AMA encourages the Federation of Medicine and its members to provide assistance, such as information and advice (but not legal opinions or representation), as appropriate to employed physicians, physicians in independent practice, and	Retain. Policy is relevant.

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POLICY #	Title	Text	Recommendation
		independent physician contractors in matters pertaining to their relationships with hospitals, health systems, and other similar entities, including, but not limited to, breach of contracts including medical staff bylaws, sham peer review, economic credentialing, and the denial of due process.	
D-220.975	The Joint Commission Transparency	1. Our AMA Commissioners to The Joint Commission will be asked to advocate for a truly open and transparent comment process for all proposed changes to TJC standards. 2. It is AMA policy that: (a) all proposed changes to TJC standards resulting from field reviews be published along with clearly stated rationale(s) for each proposed change; (b) all proposed changes to TJC standards be published along with clearly stated identities of entity(ies) external to TJC that suggested the proposed changes to TJC; (c) all proposed changes to TJC standards that are modified by TJC as a result of comments received must provide clearly stated rationale(s) for each modified proposal, to include a clear and thorough analysis of the comment or comments upon which the modification(s) was based; and (d) all proposed changes to TJC standards that are adopted as final by TJC be published along with a clear and thorough analysis of all the field review.	Retain. Policy is relevant.
D-220.976	The Relationship Between The Joint Commission and Physicians	Our AMA will: (1) communicate to The Joint Commission (TJC) the concern regarding the unintended consequences of TJC's standards, and methods of communicating those standards to physicians; (2) advocate with TJC for direct communication to physicians' organizations about standards to be adopted or modified, with at least six months available for open commentary and feedback; (3) advocate that this communication be timely and that it occur in print media as well as through e-mail; (4) advocate that TJC accreditation standards be made available to any licensed physician without hindrance; (5) advocate that TJC establish a process for any physician to provide feedback about TJC programs that affect that physician's practice; and (6) require that AMA TJC Commissioners meet with the Organized Medical Staff Section Governing Council to review TJC standards no less than twice per year.	Retain. Policy is relevant.
D-220.977	The Joint Commission - Evidence-Based Recommendations	Our AMA will: (1) work with The Joint Commission (TJC) to investigate the provision of a cost analysis for each new requirement; and (2) request that TJC provide an	Retain. Policy is relevant.

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POLICY #	Title	Text	Recommendation
		evidence-based evaluation to justify the expenditures for the recommendations it makes.	
D-225.975	De-Linkage of Medical Staff Privileges from Hospital Employment Contracts	Our AMA will develop resources to assist physicians transitioning from employment to independent practice.	Sunset. Directive was accomplished.
D-230.988	Fiduciary Credentialing	Our AMA will: (1) continue to encourage physicians who have experienced what they believe to be inappropriate hospital de-credentialing to contact their state medical association and the Litigation Center of the AMA and the State Medical Societies; and (2) explore the feasibility of participating in legal action designed to address arbitrary and abusive economic profiling of physicians.	Retain. Policy is relevant.
D-285.974	Possible Anti-Competitive and Ethical Implications of Integrated Hospital System Referral Expectations	Our AMA will continue to receive information on and monitor the issue of restrictions on referrals in all health care delivery settings.	Retain. Policy is relevant.
D-290.984	State Plan Amendments for Medicaid	Our AMA will: (1) promote mechanisms that provide the opportunity for public comment and legislative oversight prior to submission of the State Plan Amendments (SPAs) to the Centers for Medicare and Medicaid Services; and (2) serve as a repository of information relating to the outcomes of SPAs in different states, disseminate such information and educate physicians about the impact of proposed changes to Medicaid via SPAs.	Retain. Policy is relevant.
D-315.983	Guiding Principles for the Collection, Use and Warehousing of Electronic Medical Records and Claims Data	Our AMA will continue to monitor the economic implications of the secondary sale and use of non-identifiable, aggregate data.	Retain. Policy is relevant.

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POLICY #	Title	Text	Recommendation
D-330.909	Study the Costs of Administrative and Regulatory Burdens	Our 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 Centers for Medicare & Medicaid Services~~, including but not limited to face-to-face documentation requirements, the Physician Quality Reporting System, and the Meaningful Use program~~.	Retain-in-part; amend by deletion as the policy is no longer limited to the Physician Quality Reporting System or the Meaningful Use program.
D-330.928	Strategies to Strengthen the Medicare Program	Our AMA: (1) will continue to study combining Parts A and B of the Medicare Trust Funds into a single program, and report back, clearly delineating the advantages and disadvantages of this action, including the effect on graduate medical education funding and of adding a means test to Medicare Part A; and (2) encourages the Centers for Medicare and Medicaid Services to explore the use of value-based, targeted benefit design to facilitate a more efficient and meaningful cost-sharing structure that will help align incentives for patients to seek appropriate and effective care.	Retain. Policy is relevant.
D-335.987	Erroneous Guidance by Medicare Carriers and Waiver of Audit and Refund Penalties	1. Our AMA will: (a) ask the Centers for Medicare and Medicaid Services to enforce the requirement that Medicare representatives who have given verbal guidance must immediately confirm that guidance in writing, requiring Medicare carriers to (i) closely monitor carrier representatives' compliance with the rule and (ii) penalize those representatives who do not comply; and (b) urge CMS to eliminate the rule that if a physician incurs a penalty having relied on erroneous guidance from a carrier representative, that penalty cannot be waived unless the physician's initial request was in writing. 2. Whether or not CMS eliminates that rule, our AMA will ask CMS to require Medicare carriers to provide central e-mail and fax units, to which physicians can send all requests for coding and billing clarifications, and from which physicians can receive all carrier responses in "real time."	Retain. Policy is relevant.
D-345.986	Accurate Mental Status Reporting	Our American Medical Association encourages interested national medical specialty societies to develop recommendations regarding mental status information that should be transmitted when patients transition care settings.	Retain. Policy is relevant.

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POLICY #	Title	Text	Recommendation
D-380.997	Private Contracting by Medicare Patients	1. It is the policy of the AMA: (a) that any patient, regardless of age or health care insurance coverage, has both the right to privately contract with a physician for wanted or needed health services and to personally pay for those services; (b) to pursue appropriate legislative and legal means to permanently preserve that patient's basic right to privately contract with physicians for wanted or needed health care services; (c) to continue to expeditiously pursue regulatory or legislative changes that will allow physicians to treat Medicare patients outside current regulatory constraints that threaten the physician/patient relationship; and (d) to seek immediately suitable cases to reverse the limitations on patient and physician rights to contract privately that have been imposed by CMS or the private health insurance industry. ~~**2. Our AMA strongly urge CMS to clarify the technical and statutory ambiguities of the private contracting language contained in Section 4507 of the Balanced Budget Act of 1997.**~~ 3. Our AMA reaffirms its position in favor of a pluralistic health care delivery system to include fee-for-service medicine, and will lobby for the elimination of any restrictions and physician penalties for provision of fee-for-service medicine by a physician to a consenting patient, including patients covered under Medicare.	Retain-in-part; **rescind clause (2)**, as the Centers for Medicare & Medicaid Services has developed extensive regulatory guidelines that have eliminated the technical and statutory ambiguities of the private contracting language contained in Section 4507 of the Balanced Budget Act of 1997.
D-390.974	Modes of Participation in Medicare and Their Impact on the Patient, the Physician, and the US Congress	Our AMA will: (1) continue working to identify politically viable modifications to the statutory language on private contracting that will make opting out a more reasonable choice for practicing physicians; and (2) educate physicians on the different options for participating in the Medicare program and provide our members with the tools and information necessary to analyze the impact on their patients, their practice, an d the US Congress, of their choice of the three modes of relating to the Medicare program by: (a) opting out of Medicare; or (b) caring for Medicare patients in a fee-for-service relationship, making the decision to "accept assignment" on the basis of mutual needs of the patient and the physician; or (c) continuing as a "participating physician" in the Medicare program understanding that the physician is subject to the continued anticipated reductions in direct reimbursement and the ultimate inability to directly negotiate any fees on behalf of their practice. This may give Congress the wrong impression that there is no problem with continued fee reductions.	Retain. Policy is relevant.

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POLICY #	Title	Text	Recommendation
D-390.985	Medicare Balance Billing	Our AMA will work on behalf of physicians to regain the right to balance bill Medicare patients for the full reasonable fees as they determine appropriate.	Retain. Policy is relevant.
D-450.953	Development of Quality Measures with Appropriate Exclusions and Review Processes	Our AMA will provide input on the Severe Sepsis and Sepsis Shock: Management Bundle measure during the National Quality Forum's (NQF) review of the measure in 2017, and ask the Centers for Medicare and Medicaid Services to redesign the measure.	Sunset. Directive was for action at the 2017 NQF meeting.
D-478.971	Electronic Health Records and Meaningful Use	Our AMA: (1) will continue to work with the Centers for Medicare and Medicaid Services and other relevant stakeholders to allow for partial credit for eligible professionals in the Meaningful Use and Merit-Based Incentive payment programs; and (2) will compile and continue to educate physicians on the available guidance related to different types of EHRs, system downtime, and technology failures, including mitigation strategies, continuity training solutions, and contracting solutions.	Retain. Policy is relevant.
D-480.970	Access and Equity in Telemedicine Payments	Our AMA will advocate that the Centers for Medicare & Medicaid Services pay for telemedicine services for patients who have problems accessing physician specialties that are in short supply in areas that are not federally determined ?shortage? areas, if that area can show a shortage of those physician specialists.	Retain. Policy is relevant.
D-60.980	Emergency Medical Services for Children (EMSC) Program	Our AMA (1) recognizes the importance of Emergency Medical Services for Children ((EMS C)); (2) advocates for full funding for the (EMSC) program in Congress; and (3) advocates for continuous passage of (EMSC) reauthorization legislation in Congress.	Retain. Policy is relevant.
D-70.957	Fixed Reimbursement to Physicians for Laboratory Services	Our AMA: (1) encourages physicians to become knowledgeable about the appropriate use of CPT modifier 26 in order to bill the professional component separately from the technical component for the interpretation of laboratory tests and clinical oversight of the laboratory; and (2) will advocate that Medicare and other third party payers provide appropriate coverage for the use of CPT modifier 26, as well as care plan oversight codes and prolonged services codes.	Retain. Policy is relevant.
D-70.958	Blended Payments	Our AMA will work with Congress to make it illegal for insurance companies to unilaterally change payments by “blending” levels.	Retain. Policy is relevant.
D-70.979	Preservation of ~~**Five**~~ Levels of Evaluation and Management Services	Our AMA will communicate to the Centers for Medicare and Medicaid Services and to private payers that the current levels of Evaluation and Management service s should be maintained and not compressed, with appropriate payment for each level.	Retain-in-part; **edit title to remove term “Five,”** as it is no longer accurate.
H-100.950	Addressing the Exploitation of	1. Our AMA will advocate with interested parties for legislative or regulatory measures that require	Retain. Policy is relevant.

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POLICY #	Title	Text	Recommendation
	Restricted Distribution Systems by Pharmaceutical Manufacturers	prescription drug manufacturers to seek Food and Drug Administration and Federal Trade Commission approval before establishing a restricted distribution system. 2. Our AMA supports requiring pharmaceutical companies to allow for reasonable access to and purchase of appropriate quantities of approved out-of-patent drugs upon request to generic manufacturers seeking to perform bioequivalence assays. 3. Our AMA will advocate with interested parties for legislative or regulatory measures that expedite the FDA approval process for generic drugs, including but not limited to application review deadlines and generic priority review voucher programs.	
H-120.928	Pharmacy Use of Medication Discontinuation Messaging Function	Our AMA strongly encourages: (1) all software providers and those pharmaceutical dispensing organizations that create their own software to include the functionality to accept discontinuation message transmittals in their electronic prescribing software products; and (2) all dispensing pharmacies accepting medication prescriptions electronically to activate the discontinuation message transmittal functionality in their electronic prescribing support software.	Retain. Policy is relevant.
H-120.931	Access to Self-Administered Medications	1. Our AMA supports legislation that prohibits health insurance and pharmacy benefit management (PBM) companies from denying early prescription refills for solutions, ointments, gels, creams, nasal sprays, and other formulations that are difficult and/or imprecise to self-administer. 2. Our AMA supports and encourages interested national medical specialty societies and other stakeholders to continue to advocate on the state level and work with health insurance and PBM companies to re-evaluate their refill policies on medications that are difficult and/or imprecise to self-administer to allow for early refills as needed.	Retain. Policy is relevant.
H-155.970	Cost-Cutting Decisions by Third Party Payers	Our AMA strongly opposes, and will take appropriate action as necessary to restrict, third party payer cost-containment strategies that jeopardize patient health and the quality of care.	Retain. Policy is relevant.
H-160.904	Increasing Collaboration Between Physicians and the Public to Address Problems in Health Care Delivery	Our American Medical Association will continue to consider and implement the most strategic and sustainable approaches to stay engaged with physician and non-physician stakeholders essential to our endeavor to improve the delivery of quality medical care.	Retain. Policy is relevant.
H-160.908	Payment Mechanisms for Physician-Led	1. Our AMA advocates that physicians who lead team-based care in their practices receive the payments for health care services provided by the team and establish payment disbursement	Retain. Policy is relevant.

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POLICY #	Title	Text	Recommendation
	Team-Based Health Care	mechanisms that foster physician-led team-based care. 2. Our AMA advocates that payment models for physician-led team-based care should be determined by physicians working collaboratively with hospital and payer partners to design models best suited for their particular circumstances. 3. Our AMA advocates that physicians make decisions about payment disbursement in consideration of team member contributions, including but not limited to: a. Volume of services provided; b. Intensity of services provided; c. Profession of the team member; d. Training and experience of the team member; and e. Quality of care provided. 4. Our AMA advocates that an effective payment system for physician-led team-based care should: a. Reflect the value provided by the team and that any savings accrued by this value should be shared by the team; b. Reflect the time, effort and intellectual capital provided by individual team members; c. Be adequate to attract team members with the appropriate skills and training to maximize the success of the team; and d. Be sufficient to sustain the team over the time frame that it is needed.	
H-160.937	The Promotion of Quality Telemedicine	1. The AMA adopts the following principles for the supervision of nonphysician providers and technicians when telemedicine is used: A. The physician is responsible for, and retains the authority for, the safety and quality of services provided to patients by nonphysician providers through telemedicine. B. Physician supervision (e.g. regarding protocols, conferencing, and medical record review) is required when nonphysician providers or technicians deliver services via telemedicine in all settings and circumstances. C. Physicians should visit the sites where patients receive services from nonphysician providers or technicians through telemedicine, and must be knowledgeable regarding the competence and qualifications of the nonphysician providers utilized. D. The supervising physician should have the capability to immediately contact nonphysician providers or technicians delivering, as well as patients receiving, services via telemedicine in any setting. E. Nonphysician providers who deliver services via telemedicine should do so according to the applicable nonphysician practice acts in the state where the patient receives such services.	Retain. Policy is relevant.

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POLICY #	Title	Text	Recommendation
		F. The extent of supervision provided by the physician should conform to the applicable medical practice act in the state where the patient receives services. G. Mechanisms for the regular reporting, recording, and supervision of patient care delivered through telemedicine must be arranged and maintained between the supervising physician, nonphysician providers, and technicians. H. The physician is responsible for providing and updating patient care protocols for all levels of telemedicine involving nonphysician providers or technicians. 2. The AMA urges those who design or utilize telemedicine systems to make prudent and reasonable use of those technologies necessary to apply current or future confidentiality and privacy principles and requirements to telemedicine interactions. 3. The AMA emphasizes to physicians their responsibility to ensure that their legal and ethical requirements with respect to patient confidentiality and data integrity are not compromised by the use of any particular telemedicine modality. 4. The AMA advocates that continuing medical education conducted using telemedicine adhere to the standards of the AMA's Physician Recognition Award and the Accreditation Criteria of the Accreditation Council for Continuing Medical Education. 5. Our AMA supports the appropriate use of telemedicine in the education of medical students, residents, fellows and practicing physicians.	
H-160.966	Market Forces on Medical Practice	It is the policy of the AMA that (1) the ratcheting down of physician payment rates will not produce appreciable reductions in the rate of health care cost increase, since payment for physicians' services constitutes only about one-fifth of spending for health care; however, it may well reduce access to care as more physicians leave the area, retire, or in other ways change their practices; (2) at the same time, physician-directed peer review mechanisms must take the lead in fostering appropriate utilization of services and encouraging less hospital-intensive patterns of care where indicated; (3) the capture of a dominant or controlling share of the private health insurance market by any one payer can ultimately result in payer control of physicians' total remuneration; such control should be resisted through all legislative means available; (4) physicians must continue to initiate and publicize voluntary programs to accept assignment and/or other special arrangements for lower-income Medicare beneficiaries as a deterrent to legislation mandating assignment or banning balance billing for	Retain. Policy is relevant.

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POLICY #	Title	Text	Recommendation
		all Medicare enrollees regardless of economic status; and (5) it is equally incumbent on those developing state legislative and regulatory proposals to seek the advice of the health care professionals who will be affected by such proposals at the outset; without such input, the state will risk alienating those who provide the care and jeopardizing the health of its residents.	
H-165.851	Options for Implementing and Financing Tax Credits for Individually Selected and Owned Health Insurance	Our AMA supports incremental steps toward financing individual tax credits for the purchase of health insurance, including but not limited to capping the tax exclusion for employment-based health insurance.	Reconcile with Policies H-165.828 and H-165.865.
H-165.887	Development of Health Care Priorities	Our AMA supports efforts to move patients in public programs into the private sector, through the implementation of vouchers or other mechanisms, thereby enabling individual patients to participate in the prioritization of their health care services; and encourages state governments that are investigating the prioritization of health care services provided under Medicaid programs to consider other potential allocation methodologies including variable levels of funding tied to relative health benefit, beneficiary income, or other factors, for such services.	Retain. Policy is relevant.
H-180.968	Third Party Payer Credentialing	It is the policy of the AMA that third party payers should not exclude non-board-certified physicians as a class from participation in their programs, without regard to individual training, experience, and current competence.	Retain. Policy is relevant.
H-185.925	Addressing Discriminatory Health Plan Exclusions or Problematic Benefit Substitutions for Essential Health Benefits Under the Affordable Care Act	1. Our AMA supports improvements to the essential health benefits benchmark plan select ion process to ensure limits and exclusions do not impede access to health care and coverage. 2. Our AMA encourages federal regulators to develop policy to prohibit essential health benefits substitutions that do not exist in a state's benchmark plan and the selective use of exclusions or arbitrary limits that prevent high-cost claims or that encourage high-cost enrollees to drop coverage. 3. Our AMA encourages federal regulators to review current plans for discriminatory exclusions and submit any specific incidents of discrimination through an administrative complaint to Office for Civil Rights.	Retain. Policy is relevant.
H-185.926	Reproductive Health Insurance Coverage	Our AMA supports: (1) insurance coverage for fertility treatments regardless of marital status or sexual orientation when insurance provides coverage for fertility	Retain. Policy is relevant.

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POLICY #	Title	Text	Recommendation
		treatments; and (2) local and state efforts to promote reproductive health insurance coverage rega rdless of marital status or sexual orientation when insurance provides coverage for fertility treatments.	
H-200.998	Tax Credit to Disadvantaged Area Medical Practices	Our AMA actively supports national and state legislation which would grant income tax credits to medical practices established in disadvantaged communities and in areas of critical physician need.	Retain. Policy is relevant.
H-215.966	Evaluating Advertising	1. AMA policy is that organizations conferring titles/awards/rankings on hospitals should adopt the following criteria: a. Significant physician involvement in selection of criteria and methodology. b. Significant physician involvement in screening potential award winners. c. Significant physician involvement in on-site hospital review (if part of the ranking/title/award process). d. Significant physician involvement in the judging process and final selection of award winners. e. Evidenced based performance measures for selection. f. Public transparency and substantive information regarding all aspects including the leadership involved in the criteria, methodology, selection process. g. Disclosure of any conflicts of interest	Retain. Policy is relevant.
H-215.975	Uniform Standards for Not-For-Profit and For-Profit Hospitals	The AMA supports the concept that all hospitals be held to the same standards of care, community service, professional education and commitment to their respective communities.	Retain. Policy is relevant.
H-220.938	The Joint Commission Adherence to its Own Standards	The AMA Board of Trustees directs its Commissioners to The Joint Commission (TJC) to strongly advocate that TJC: (1) consistently enforce its standards regarding unilateral amendment of medical staff bylaws; (2) continue to cite hospitals for unilateral amendment of medical staff bylaws, rules and regulations, which may lead to loss of accreditation if the violation is not rectified within a specified time frame; and (3) cite hospitals for including provisions in their corporate bylaws that allow for the unilateral amendment of medical staff bylaws, rules and regulations, when state statutes do not require the governing body of the hospital to have such authority.	Retain. Policy is relevant.
H-220.975	Medical Staff Comment on The Joint Commission "Field Review of Proposed Standards"	Our AMA believes that all “Field Review of Proposed Standards” that are sent to hospitals should be sent simultaneously to the medical staff of said hospital, with their comments to be returned directly to The Joint Commission for its consideration.	Retain. Policy is relevant.

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POLICY #	Title	Text	Recommendation
H-220.976	Bylaws Approval Time Limit	The AMA supports including a standard in The Joint Commission Accreditation Manual for Hospitals requiring that initial medical staff bylaws and subsequent amendments be approved or disapproved by the hospital governing body within a reasonable period of time specified in the medical staff bylaws and, if the governing body fails to act within the time specified, the proposed changes should be deemed adopted.	Retain. Policy is relevant.
H-220.978	Hospital Medical Staff Representation on the Hospital Governing Body	The AMA supports amending The Joint Commission Leadership Standard LD.01.03.01 to provide for representation at all meetings of the governing body, with vote by one or more medical staff members nominated and elected by the medical staff, consistent with applicable state law.	Retain. Policy is relevant.
H-225.943	Mixed Medical Staffs	Our AMA affirms its unyielding support for the principle that the members of the organized medical staff must work collectively to improve patient care and outcomes, regardless of the employment status or practice setting of each individual member, and through its Organized Medical Staff Section and other appropriate channels, will provide guidance to medical staffs, including but not limited to effective medical staff leadership strategies and relevant updates to the *AMA Physician's Guide to Medical Staff Organization Bylaws*, that facilitate representation of and encourage participation in medical staff activities by community-based and independent physicians.	Retain. Policy is relevant.
H-225.944	Medical Staff Engagement at Critical Access Hospitals	Our AMA encourages all MD/DO(s) on staff at Critical Access Hospitals to contribute to the quality and safety of care provided in those organizations by participating in medical staff activities, including but not limited to credentialing and privileging activities.	Retain. Policy is relevant.
H-225.949	Medical Staff and Hospital Engagement of Community Physicians	1. Our AMA encourages medical staffs to develop medical staff membership categories for physicians who provide a low volume or no volume of clinical services in the hospital ("community physicians"). 2. Our AMA encourages medical staffs and hospitals to engage community physicians, as appropriate, in medical staff and hospital activities, which may include but need not be limited to: (a) medical staff duties and leadership; (b) hospital governance; (c) population health management initiatives; (d) transitions of care initiatives; and (e) educational and other professional and collegial events.	Retain. Policy is relevant.
H-225.984	Hospital Corporate Bylaws	The AMA encourages hospital medical executive committees to: (1) regularly examine the hospital/corporate bylaws, rules and regulations for any conflicts with the medical staff bylaws, rules and regulations or practices; (2) request that their hospital board of trustees/directors notify them of any proposed or impending changes in	Retain. Policy is relevant.

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		the hospital/corporate bylaws; and (3) advise members/applicants of the medical staff of the effect of these hospital/corporate bylaws, rules and regulations.	
H-225.986	Physician Economic Incentive Program	The AMA: (1) opposes physician economic incentives that conflict with patients' welfare; and (2) believe the physician must remain the patient's advocate in the patient's relationship with the hospital.	Retain. Policy is relevant.
H-230.963	Limitations of Membership on Multiple Hospital Medical Staffs	Our AMA: (1) supports the principle that a hospital may not limit a physician's participation or medical staff privileges at the hospital based in whole or in part on the physician's membership or participation at a different hospital or hospital system or on the medical staff membership or participation of a partner, associate or employee of the physician at a different hospital or hospital system; (2) opposes hospitals placing limitations on medical staff privileges or participation at a hospital based in whole or in part on the physician's membership or participation at a different hospital or hospital system or on the medical staff membership or participation of a partner, associate or employee of the physician at a different hospital or hospital system; and (3) opposes hospitals placing limitations on medical staff privileges or participation at a hospital based in whole or in part on the physician (or a partner, associate or employee of the physician) having a financial relationship with another hospital/health system.	Retain. Policy is relevant.
H-230.984	Peer Review of the Performance of Hospital Medical Staff Physicians	The AMA (1) encourages state and local medical associations to establish procedures and committees for monitoring, upon the request of the medical staff, the effectiveness of hospital medical staff peer review; and (2) supports working with the AHA and other appropriate organizations to devise methods to encourage the development of such programs.	Retain. Policy is relevant.
H-230.997	Recertification and Hospital or Health Plan Network Privileges	(1) The fact that a board-certified practitioner fails to undergo the recertification examination shall not be adequate reason to modify or withhold hospital privileges or health plan network status from a physician. (2) Modification or withholding of hospital privileges or health plan network status shall be purely on the basis of assessment of performance.	Retain. Policy is relevant.
H-235.968	Physician Review of Medical Staff Activities	The AMA recommends that hospital medical staffs have a policy that would allow minutes of medical staff committees, except minutes concerning peer review or corrective action information, be made available for review by medical staff members in the medical staff office; and recommends that the	Retain. Policy is relevant.

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		medical executive committee approve all reports, policies and recommendations from medical staff clinical departments and committees and have a process to distribute significant changes to the members of the medical staff.	
H-235.970	Conflict of Interest Issues and Medical Staff Leaders	Our AMA encourages medical staffs to adopt and incorporate into their bylaws medical staff conflict of interest policies that reflect the following principles: 1. Disclosure of potential conflicts. Candidates for election or appointment to medical staff leadership positions should disclose in writing to the medical staff, prior to the date of election or appointment, any personal, professional or financial affiliations or relationships of which they are reasonably aware, including employment or contractual relationships, which could foreseeably result in a conflict of interest with their acting on behalf of the medical staff. Elected or appointed medical staff leaders should disclose potential conflicts in writing to the medical staff whenever they arise. 2. Management of conflicts. When conflicts of interest exist, elected or appointed medical staff leaders should, as appropriate, recuse themselves from the deliberative process and/or abstain from voting on the matter to which the conflict relates. The medical staff should establish a process for disqualification from the deliberative process and/or from voting on the matter at hand for any elected or appointed medical staff leader with an identified conflict who fails to disclose the interest or who fails to recuse himself or herself from the deliberative process and/or from voting on the matter to which the conflict relates, as appropriate.	Retain. Policy is relevant.
H-235.985	Medical Executive Committee Composition	The AMA's policy states that the medical staff shall govern itself by the bylaws, rules and regulations which define the Medical Staff Executive Committee, whose members are selected in accordance with criteria and standards established by the medical staff, consistent with applicable state law.	Retain. Policy is relevant.
H-260.964	Reimbursement for Clinical Lab Work	Our AMA supports the concept that a professional fee should be paid directly to the appropriate physician for clinical laboratory work, regardless of payer source.	Retain. Policy is relevant.
H-260.998	Laboratory Services Contracted by a Physician	Our AMA believes that: (1) laboratories should bill and collect from patients or third-party payers for laboratory services; (2) attending physicians are entitled to fair compensation for professional services rendered; and (3) bills for laboratory services performed by attending physicians should show the location where services were rendered and a description of such services.	Retain. Policy is relevant.

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H-280.951	Quality of Care and Staffing in Nursing Homes	Our AMA will support the policy that staffing levels in nursing homes should appropriately address: (1) the acuity of the patient population; (2) the functional level of the patient and the services provided; (3) the existence of shortages for certain types of staff in some geographic locations and temporary shortages due to events such as employee illness or termination; and (4) the quality, education, and training of staff.	Retain. Policy is relevant.
H-280.953	Physicians Visits Under Medicare Skilled Nursing Facility Prospective Payment System	Our AMA will: (1) work with the Centers for Medicare and Medicaid Services (CMS) and The Joint Commission (TJC) to ensure that physician visits to nursing homes and skilled nursing facilities be based on the physician's determination of appropriate care for each patient; (2) work with CMS to ensure that its Medicare carriers implement these policies in a uniform way; and (3) advocate that physician assessments necessary to comply with both the prospective payment system (PPS) as well as TJC requirements be recognized and reimbursed.	Retain. Policy is relevant.
H-285.941	Managed Care Consensus Bill	The AMA continues to support the enactment of comprehensive legislation that addresses the wide range of patient protection and physician fairness issues, such as disclosure of health plan information to enrollees and prospective enrollees, utilization review and grievance procedures, due process in physician selective contracting decisions, and physician involvement in health plan medical policies.	Retain. Policy is relevant.
H-285.950	Managed Care Organizations' Use of Physicians to Provide Second Opinions to Physicians Providing Emergency Services	The AMA adopts the following principles to guide the use by managed care plans of physicians employed or contracted with to specifically provide second opinions to physicians providing emergency services. The AMA encourages managed care plans to follow these guidelines when employing or contracting with physicians to provide second opinions to physicians providing emergency services. (1) All managed care plans shall disclose to their enrollees and prospective enrollees any plan requirements or the existence of contractual arrangements whereby physicians are required to provide second opinions to physicians providing emergency services regarding the care provided to patients presenting at emergency departments or facilities. (2) The required use of physicians to provide second opinions to physicians providing emergency services regarding the care provided to patients presenting at emergency departments or facilities shall not impede the immediate diagnosis and therapy of acute cardiac, trauma, and other critical patient situations for which delay may result in death or an increase in severity of illness. (3) Any physician with a contractual arrangement to	Retain. Policy is relevant.

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		provide second opinions to physicians providing emergency services regarding the care provided to patients presenting at emergency departments or facilities shall be licensed to practice medicine and actively practicing emergency medicine in the same state in which the second opinion is provided. (4) Any physician with a contractual arrangement to provide second opinions to physicians providing emergency services regarding the care provided to patients presenting at emergency departments or facilities shall have active staff privileges in any facility in which the second opinion is provided. (5) To the degree possible, patients presenting at an emergency department or facility should be involved in the decisions regarding the treatment, referral, and follow-up care for their condition. (6) In the event of disagreements over second opinions, final decisions regarding the treatment, referral, and follow-up care provided to patients presenting at emergency departments or facilities shall be made by the attending emergency physician or other appropriate physicians on staff at the facility.	
H-285.967	Distribution of Premiums Collected by Managed Care Companies	The AMA develop and support appropriate legislation to require managed care plans to publish, on an annual basis, relevant operating and financial information.	Retain. Policy is relevant.
H-285.971	Population Based Practices in Managed Care Systems	The AMA recommends to all managed care plans that they: (1) develop population based programs for prevention, health risk assessments, and health's status improvement; (2) adopt a process to measure clinical quality provided to patients and demonstrate how quality in their system of care is improving; (3) develop programs which assure that communicable and environmentally induced health problems are followed up by physicians within the plan in cooperation with competent health department personnel; and (4) manage these programs in concert with established standards of preventive medicine and public health.	Retain. Policy is relevant.
H-285.983	Organized Medical Staffs in Medical Delivery Systems	The AMA supports expanding the concept of physician governance of medical delivery systems by recommending that: (1) Medical delivery systems establish self-governing medical staffs similar, if not identical, to those in hospitals; (2) The principles of self-governance should include, but not be limited to: (a) the development of medical staff bylaws which cannot be unilaterally changed by the governing board of a medical delivery system; (b) physician election of representatives to the governing board and other appropriate committees of medical delivery systems including credentialing, privileging, quality assurance and utilization review committees; (c) due process protections for physicians credentialed by a	Retain. Policy is relevant.

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		medical delivery system; and (d) full indemnification by medical delivery systems of physicians who, in good faith, serve as members of credentialing, quality assurance and utilization review committees of medical delivery systems; and (3) Policy of the AMA is that the establishment of guidelines, review of decisions, and the adjudication of patient care quality issues in managed care plans must be performed by participating practicing physicians.	
H-290.973	Medicaid Citizenship Documentation	Our AMA strongly advocates that a state Medicaid agency's record of payment for the birth of an individual in a US hospital is satisfactory documentary evidence of both identity and citizenship.	Retain. Policy is relevant.
H-315.972	HIPAA Business Associate Contracting, Domestic and Foreign, and Foreign Outsourcing	1. Our AMA encourages physicians who have entered or who are considering entering a business associate agreement (BAA) to undertake careful due diligence regarding the business associate and to consider with legal counsel the inclusion of contractual provisions such as: a. strong confidentiality clauses; b. required steps to mitigate any harmful effects of wrongful use or disclosure of protected health information (PHI); c. assurance that, upon the contract's termination, all PHI is returned to the covered entity, and no copies are retained by the business associate, except as required for legal or audit purposes; d. indemnification of the covered entity against any losses caused by a business associate; e. the business associate's procurement of specified types of liability insurance which may either protect the covered entity or enable the business associate to meet its indemnity; f. posting a surety bond (a.k.a. performance bond) to ensure faithful performance of the BAA by the business associate; or g. physicians should take care that the original contract should contain provisions addressing the costs involved with the return and maintenance of the PHI at or after the end of the contract term. 2. Our AMA supports legislation and/or regulation requiring all third parties who receive and maintain clinical information from a clinician to make those data available to the clinician in usable form at the end of the business relationship.	Retain. Policy is relevant.
H-320.941	Eliminate Fail First Policy in Addiction Treatment	Our AMA will advocate for the elimination of the “fail first” policy implemented at times by some insurance companies and managed care organizations for addiction treatment.	Retain. Policy is relevant.
H-320.943	Medicare and Insurance Takeback Procedures	Our AMA: (1) will advocate to ensure that when a patient hospitalization is retrospectively found not to meet criteria for inpatient admission, then the take back amount be only the difference between the cost of the admission and the cost of necessary	Retain. Policy is relevant.

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		observation for that patient stay; and (2) will advocate to ensure that, for any care provided to hospital patients who have Medicare, managed Medicare, or commercial insurance, hospitals have the option to rebill denied inpatient claims as outpatient claims, when a physician using clinical judgment makes a prospective decision to admit a patient who is later not found to meet admission criteria.	
H-320.987	Second Opinions When Required by Carrier	The AMA believes that second opinions for medical or surgical services and procedures are best provided by physicians who have the training, experience or skills which provide the necessary information base to assess the need for or advisability of a specific medical or surgical intervention.	Retain. Policy is relevant.
H-320.989	Third Party Utilization Review Programs	Our American Medical Association recommends that hospital medical staffs, prior to approving the written plan for utilization review, ensure the inclusion of provisions that require the hospital to seek formal review and recommendations from the medical staff concerning "any qualified outside organization" that is going to contract with the hospital to perform review activities specified in the plan, prior to entering into the contract.	Retain. Policy is relevant.
H-320.990	Standardization of Mandatory Second Surgical Opinion Programs	The AMA urges third party payers who require second opinions to inform their subscribers so that they understand the requirements of such programs.	Retain. Policy is relevant.
H-320.991	Hospital Preadmission Review/Certification	The AMA believes that the following principle should be applied in evaluating any preadmission review program, so as to minimize any detrimental impacts on quality or accessibility of care: There should be direct and continuing communications to physicians and insured~~s~~ **patients** regarding prior authorization requirements.	Retain-in-part; amend by deletion and addition to make the policy consistent with language used in other AMA policies.
H-330.879	Providers and the Annual Wellness Visit	1. Our AMA supports that the Medicare Annual Wellness Visit (AWV) is a benefit most appropriately provided by a physician or a member of a physician-led health care team that establishes or continues to provide ongoing continuity of care. 2. Our AMA supports that, at a minimum, any clinician performing the AWV must enumerate all relevant findings from the visit and make provisions for all appropriate follow-up care. 3. Our AMA supports that the Centers for Medicare & Medicaid Services (CMS) provide a means for physicians to determine whether or not Medicare has already paid for an AWV for a patient in the past 12 months. 4. Our AMA encourages CMS to educate Medicare enrollees, that, in choosing their primary care physician, they are encouraged to make their AWVs with their primary care physician in order to facilitate continuity and coordination of their care.	Retain. Policy is relevant.

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H-330.880	Virtual Supervision of "Incident to" Services	1. Our AMA supports pilot programs in the Medicare program to enable virtual supervision of "incident to" services that require direct supervision if they are developed with specialty society input and abide by the following principles: A. The physician billing "incident to" must fulfill other requirements of direct supervision of "incident to" services, including first seeing the patient and initiating the course of treatment, and providing subsequent services at a rate that shows active participation in and management of the course of treatment. B. The extent of supervision provided by the physician should conform to the applicable medical practice act in the state where the patient receives services. C. Non-physician practitioners and employees providing "incident to" services must follow existing requirements for the provision of "incident to" services, including abiding by state licensure laws and state medical practice laws and requirements in the state in which the patient receives services. D. The delivery of "incident to" services must be consistent with state scope of practice laws. E. Virtual supervision of "incident to" services must require the supervising physician to be connected through real-time audio and video technology with the room in which the "incident to" service is provided, to ensure that the physician is immediately able to provide assistance and direction during the provision of the service. F. Virtual supervision of "incident to" services must follow evidence-based practice guidelines, to the degree they are available, to ensure patient safety, quality of care and positive health outcomes. G. Physicians providing virtual supervision of "incident to" services should visit the sites in person where patients receive procedures from non-physician practitioners or employees. H. Physicians providing virtual supervision of "incident to" services must establish protocols for arranging for emergency services, including having an agreement with a physician at the site at which "incident to" services are provided, to ensure the provision of immediate assistance. I. Patients receiving "incident to" services that are virtually supervised must have access to the certification, licensure and/or board certification qualifications of the health care practitioners who are providing and supervising the care in advance of their visit. J. Patients receiving "incident to" services that are virtually supervised must have a choice of provider, as is required for all medical services.	Retain. Policy is relevant.

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		2. Our AMA encourages national medical specialty societies to develop best practices and protocols for virtual supervision of "incident to" services, including specifying which services and procedures would not qualify for this practice.	
H-330.899	Medicare Pharmaceutical Benefit	Our AMA utilizes the following principles in evaluating legislative proposals for the addition of a Medicare pharmaceutical benefit: (1) Any pharmaceutical benefit should be fully funded by additional budgetary allocations, separate from existing budget provisions. The benefit should provide for adequate accounting so that drug program expenditures can be tracked separately from all other expenditures. (2) The pharmaceutical benefit should be targeted to reduce hardship for those with low-incomes and those with catastrophic costs. (3) Any legislation should provide a pharmaceutical benefit that is equal across geographic regions. (4) A pharmaceutical benefit should be designed in a way that allows for benefits options under both the traditional Medicare fee-for-service program and any version of the Medicare program that relies on the private marketplace. Different levels of drug benefits for different products would be permissible. (5) A pharmaceutical benefit should include a tiered deductible and co-payment structure that encourages economically responsible behavior. (6) Any pharmaceutical benefit should be designed to prevent adverse selection. (7) Any pharmaceutical benefit should be designed in a manner that prevents interference with clinical decision-making and physician prescribing decisions. (8) Any pharmaceutical benefit should be designed in a manner that minimizes the administrative burden placed on physicians. (9) Any pharmaceutical benefit should be designed in a manner that ensures beneficiary access to local pharmacies, and not be limited to mail order pharmacies. (10) In the implementation of any Medicare drug benefit, employers are highly encouraged to preserve existing coverage, and for Medicare beneficiaries with existing drug coverage, any Medicare benefit should be supplemental to and coordinated with that existing coverage.	Retain. Policy is relevant.
H-330.934	Sharing Demographic Medicare Data with Other Public Entities by CMS	The AMA supports continued provision of aggregate anonymous demographic information to state and local health agencies where its use will promote community health and improve utilization of health care dollars, as long as adequate safeguards to protect individual privacy are preserved.	Retain. Policy is relevant.

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H-330.937	Local Medical Policy of Medical Payers	AMA policy states that when payers apply local medical policies to physicians in remote areas from where the local medical policy was originally developed, this local medical policy must be widely disseminated to the physicians in those areas along with ~~**printed**~~ explanations to the practitioners involved.	Retain-in-part; amend by deletion as printing is no longer the standard and if maintained, it becomes the expectation.
H-340.913	Peer Review by Actively Practicing Physicians	The AMA continues to urge CMS to assure that under the Medicare review process only actively practicing physicians in the same specialty and similar practice settings be allowed to perform Medicare reviews.	Retain. Policy is relevant.
H-345.980	Advocating for Reform in Payment of Mental Health and Substance Use Disorder Services	Our American Medical Association advocates that funding levels for public sector mental health and substance use disorder services not be decreased in the face of governmental budgetary pressures, especially because private sector payment systems are not in place to provide accessibility and affordability for mental health and s ubstance use disorder services to our citizens.	Retain. Policy is relevant.
H-375.964	IOM Report on QIO Program	Our AMA opposes the removal of medical review responsibilities from the QIO scope of work and further opposes conversion of contracts to national or regional contractors.	Retain. Policy is relevant.
H-385.909	The Rights of Patients, Providers and Facilities to Contract for Non-Covered Services	Our AMA will: (1) engage in efforts to convince the Centers for Medicare & Medicaid Services to abstain from inappropriate bundling in situations in which functional and aesthetic considerations should be considered separately; and (2) actively oppose further regulations that would interfere with the rights of patients, providers, and facilities to privately contract for non-covered services.	Retain. Policy is relevant.
H-385.910	Physician Communications and Care Coordination During Patient Hospitalization	Our AMA will continue to advocate that third party payers establish separate physician payments for interprofessional consultative services related to the care of hospitalized patients.	Retain. Policy is relevant.
H-385.924	Support for State Medical Association Economic Research, Development and Planning	The AMA urges state medical associations to establish bureaus or departments of economic research, development and planning to study, develop and disseminate data concerning the economic aspects of medical practice. The AMA continues to assist state associations in collecting such data and to act as a clearinghouse for data so gathered. The AMA encourages state medical associations to designate representatives to deal energetically with third party agencies and programs, utilizing the concept of usual, customary or reasonable charges.	Retain. Policy is relevant.
H-385.991	Balance Billing	Our AMA supports the right of the physician to balance bill a patient for any care given, regardless	Retain. Policy is relevant.

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		of method of payment, where permissible by law or contractual agreement.	
H-390.836	Support for Seamless Physician Continuity of Care	Our AMA encourages physicians who encounter contractual difficulties with Medicare Advantage (MA) plans to contact their Centers for Medicare & Medicaid Services (CMS) Regional office.	Retain. Policy is relevant.
H-390.839	Requiring Secondary and Supplemental Insurers to Medicare to Follow Medicare Payments	Our AMA will support payment by secondary insurers of the balance of the approved Medicare payment in an amount bringing Medicare and secondary payments up to the full allowance of the secondary insurer for services covered by the secondary insurer.	Retain. Policy is relevant.
H-390.854	Freedom of Choice	(1) The AMA will seek appropriate cases to challenge the legality and constitutionality of Medicare restrictions on non-participating physicians' medical practice and on patient freedom of choice by such mechanisms as limitations on balance billing and prohibitions on private "opt out" arrangements between physicians and patients. (2) The AMA will strongly resist such restrictions being extended to other payers in national health care reform legislation.	Retain. Policy is relevant.
H-390.977	Reimbursement for Diagnostic Studies Identified as Surgical Procedures	(1) The AMA supports the concept of separate payment by private and public payers for the services of physicians who perform diagnostic procedures separately and apart from surgical therapy. (2) The AMA supports the concept of one inclusive fee or payment to a physician by private and public payers for diagnostic surgical procedures performed in conjunction with and as a part of surgical therapy and encourages payers to utilize for payment purposes a coding system which can recognize the greater complexity or extent of the service which may be rendered. (3) The AMA urges physicians billing third parties to ensure that all services provided are completely described or coded on the appropriate claim form(s).	Retain. Policy is relevant.
H-405.993	Median Physician Income	The AMA encourages all who prepare reports on physician income to include not simply "mean" (average) data, but also "median" data and quartile distributions, which are far more representative of actual physician income profiles and are better reflections of medical care costs.	Retain. Policy is relevant.
H-406.999	Goal of Health Care Data Collection	The AMA (1) continues to advocate that health care data collected by government and third-party payers be used for education of both consumers and providers; and (2) believes that government, third party payers and self-insured companies should make physician-specific utilization information **from carefully selected studies** available to medical societies.	Retain-in-part; amend by addition to fulfill the intent of Board Report W-A-92, the origin of this policy.
H-410.970	Use of Practice Parameters	Our AMA: (1) urges organizations that have developed practice parameters to recognize	Retain. Policy is relevant.

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		that practice parameters are educational tools, not mechanisms to determine reimbursement or credentialing, to assist physicians in clinical decision making and are not replacements for clinical decision making. Physicians must retain autonomy to vary from practice parameters without retribution in order to provide the quality of care that meets the individual needs of their patients; (2) encourages physicians to be cost conscious and to exercise discretion, consistent with good medical care, when implementing practice parameters; and (3) encourages physician organizations developing practice parameters to include appropriate explanatory disclaimers to ensure that practice parameters are used in a manner that is consistent with AMA policy.	
H-410.997	Practice Parameters and Review Criteria	Our AMA believes that variations from medical practice guidelines and parameters are not, except in very limited circumstances, per se indicators of quality or medical necessity problems. Only where a variation involves provision of a service or procedure deemed by the preponderance of medical opinion to be inappropriate in any clinical situation should it be used as a per se indicator for judgments regarding quality or payment denials. Otherwise, variations from the guidelines and parameters should constitute only a signal for further peer-to-peer considerations relative to quality or payment issues.	Retain. Policy is relevant.
H-450.929	CMS Emergency Department Patient Experience of Care Survey (EDPEC)	Our AMA will monitor the development of ~~**the**~~ Centers for Medicare and Medicaid Services' ~~**E**~~emergency ~~**D**~~department ~~**P**~~patient ~~**E**~~experience of ~~C~~care ~~**(EDPEC)**~~ ~~**S**~~surveys and advocate for fair and reliable reporting that accurately reflects the quality of care provided by physicians and/or hospitals.	Retain-in-part; amend by deletion and addition to reflect the fact that while the initial CMS EDPEC survey has been completed, subsequent surveys are ongoing.
H-450.930	Developing Measures for Good Access to Care	1. Our AMA will collaborate with the appropriate organizations to support specialty-designed measures of access to care that ensure physicians have the measures they need to be successful under the Medicare Access and Chip Reauthorization Act (MACRA). 2. Our AMA encourages the Centers for Medicare and Medicaid Services (CMS) to use specialty society-developed access to care measures for the Clinical Practice Improvement incentives rather than CMS-generated measures of access.	Retain. Policy is relevant.
H-450.937	Medical Care Outside the United States	1. Our AMA advocates that employers, insurance companies, and other entities that facilitate or incentivize medical care outside the US adhere to the following principles: A. Medical care outside of the US must be voluntary.	Retain. Policy is relevant.

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		B. Financial incentives to travel outside the US for medical care should not inappropriately limit the diagnostic and therapeutic alternatives that are offered to patients, or restrict treatment or referral options. C. Patients should only be referred for medical care to institutions that have been accredited by recognized international accrediting bodies (e.g., the Joint Commission International or the International Society for Quality in Health Care). D. Prior to travel, local follow-up care should be coordinated and financing should be arranged to ensure continuity of care when patients return from medical care outside the US. E. Coverage for travel outside the US for medical care must include the costs of necessary follow-up care upon return to the US. F. Patients should be informed of their rights and legal recourse prior to agreeing to travel outside the US for medical care. G. Access to physician licensing and outcome data, as well as facility accreditation and outcomes data, should be arranged for patients seeking medical care outside the US. H. The transfer of patient medical records to and from facilities outside the US should be consistent with HIPAA guidelines. I. Patients choosing to travel outside the US for medical care should be provided with information about the potential risks of combining surgical procedures with long flights and vacation activities. 2. Our AMA supports efforts that allow for the reporting and tracking of quality and safety issues associated with medical procedures performed abroad.	
H-450.941	Pay-For-Performance, Physician Economic Profiling, and Tiered and Narrow Networks	1. Our AMA will collaborate with interested parties to develop quality initiatives that exclusively benefit patients, protect patient access, do not contain requirements that permit third party interference in the patient-physician relationship, and are consistent with AMA policy and Code of Medical Ethics, including Policy H-450.947, which establishes the AMA's Principles and Guidelines for Pay-for-Performance and Policy H-406.994, which establishes principles for organizations to follow when developing physician profiles, and that our AMA actively oppose any pay-for-performance program that does not meet all the principles set forth in Policy H-450.947. 2. Our AMA strongly opposes the use of tiered and narrow physician networks that deny patient access to, or attempt to steer patients towards, certain physicians primarily based on cost of care factors. 3. Our AMA pledges an unshakable and uncompromising commitment to the welfare of our	Retain-in-part; **rescind clause (4)**, as time frame for reporting directive has passed. Additionally, in 2018 the AMA published a thorough guide, including model contract language, titled: Evaluating Pay-for-Performance Contracts.

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		patients, the health of our nation and the primacy of the patient-physician relationship free from intrusion from third parties. ~~**4. Because there are reports that pay-for-performance programs may pose more risks to patients than benefits, our AMA will prepare an annual report on the risks and benefits of pay-for-performance programs, in general and specifically the largest programs in the country including Medicare, for the House of Delegates over the next three years, beginning at the 2007 Interim Meeting. This report should shall clearly delineate between private pay-for-performance programs and voluntary public pay-for-reporting and other related quality initiatives.**~~ 5. Our AMA will continue to work with other medical and specialty associations to develop effective means of maintaining high quality medical care which may include physician accountability to robust, effective, fair peer review programs, and use of specialty-based clinical data registries. 6. As a step toward providing the Centers for Medicare and Medicaid Services (CMS) with data on special populations with higher health risk levels and developing variable incentives in achieving quality, our AMA will continue to work with CMS to encourage and support pilot projects, such as the Physician Quality Reporting Initiative (PQRI), by state and specialty medical societies that are developed collaboratively to demonstrate effective incentives for improving quality, cost-effectiveness, and appropriateness of care. 7. Our AMA will advocate that physicians be allowed to review and correct inaccuracies in their patient specific data well in advance of any public release, decreased payments, or forfeiture of opportunity for additional compensation.	
H-450.943	Effects of Pay-for-Performance on Minority Health Disparities	Our American Medical Association urges that physicians with expertise in eliminating racial and ethnic health disparities be involved in the design, implementation and evaluation of pay-for-performance programs.	Retain. Policy is relevant.
H-450.999	Practice Evaluation	(1) Our AMA urges state and local medical societies to consider developing public information programs to inform consumers about existing quality assurance activities. (2) Our AMA encourages increased use of office or hospital outpatient facilities, and use of these facilities for diagnostic testing prior to hospitalization whenever medically feasible, and where quality of service can be assured.	Retain. Policy is relevant.
H-460.896	Stem Cell Tourism	Our AMA (a) encourages the study of appropriate guidance for physicians to use when advising patients who seek to engage in stem cell tourism and how to guide them in risk assessment, (b) encourages	Retain. Policy is relevant.

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POLICY #	Title	Text	Recommendation
		further research on stem cell tourism, and (c) urges physicians to educate themselves on these issues.	
H-475.991	Postoperative Care - Responsibility and Reimbursement	Our AMA: (1) continues to support repeal of the federal law which allows reimbursement to optometrists for the unsupervised/independent provision of postoperative care; and (2) reaffirms its position that physicians performing surgery have an ethical and professional responsibility to continue the care of their individual patients through the post-surgical recovery and healing period, or to arrange coordination of such care, especially in those situations where there is a reasonable expectation that another physician will provide postoperative surgical care.	Retain. Policy is relevant.
H-475.996	Revision of AMA Surgical Screening Criteria	The AMA (1) urges national medical specialty societies to review all criteria sets in use within the QIO program to determine whether sections applicable to the practice of their members are in need of revision and, if they are, to develop recommendations for change; (2) encourages state medical societies to organize specialty specific liaison activities between specialty groups and their respective QIOs in order to address particular issues that may arise concerning the development or application of criteria; and (3) supports continued efforts to collect information on screening criteria sets and to evaluate the process by which they are being applied.	Retain. Policy is relevant.
H-480.953	Interoperability of Medical Devices	Our AMA believes that intercommunication and interoperability of electronic medical devices co uld lead to important advances in patient safety and patient care, and that the standards and protocols to allow such seamless intercommunication should be developed fully with these advances in mind. Our AMA also recognizes that, as in all technological advances, interoperability poses safety and medico-legal challenges as well. The development of standards and production of interoperable equipment protocols should strike the proper balance to achieve optimum patient safety, efficiency, and outcome benefit while preserving incentives to ensure continuing innovation.	Retain. Policy is relevant.
H-480.968	Telemedicine	The AMA: (1) encourages all national specialty societies to work with their state societies to develop comprehensive practice standards and guidelines to address both the clinical and technological aspects of telemedicine; (2) will assist the national specialty societies in their efforts to develop these guidelines and standards; and urges national private accreditation organizations (e.g., URAC and JCAHO) to require that medical care organizations which establish ongoing arrangements for medical care delivery from remote sites require practitioners at those sites to meet no less stringent credentialing	Retain. Policy is relevant.

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POLICY #	Title	Text	Recommendation
		standards and participate in quality review procedures that are at least equivalent to those at the site of care delivery.	
H-70.914	Opposing Coverage Decisions Based Solely on ICD-10 Code Specificity	Our AMA opposes limitations in coverage for medical services based solely on diagnostic code specificity.	Retain. Policy is relevant.
H-70.918	Medicare Evaluation and Management Medical Decision Making Guidelines	It is AMA policy that: (1) all Medicare contractors disclose any Medical Decision Making tool or ~~**score sheet**~~ **algorithm** used in audits; (2) all Medicare contractors have a **clearly defined** process to resolve conflicts of interpretation on Medical Decision Making ~~tools and/or score sheets~~ between practicing physicians and contractor clinical auditors; and (3) any Medical Decision Making tool or ~~**score sheet**~~ **algorithm** must be based on the ~~**factors for arriving at complexity, as defined in**~~ **instructions for Medical Decision Making as** outlined in CPT Guidelines that accompany the CPT ~~**Book**~~ **Code Set**.	Retain-in-part; amend by deletion and addition to update this policy to align with current CPT guidelines.
H-70.958	Medicare ICD-10 Coding Requirements	Our AMA will: (1) request that the Centers for Medicare & Medicaid Services ensure that its Medicare carriers fully understand and implement the distinction between coding to the "highest level of specificity" within a code category, and that coding for the condition(s) to the "highest degree of certainty" for that visit. For this purpose, symptoms, signs, abnormal test results or other reason for the visit are appropriate and acceptable diagnoses; and (2) will use all appropriate vehicles to communicate to physicians the correct method to report ICD-10-CM codes to describe diagnoses and other reasons for the physician-patient encounter.	Retain. Policy is relevant.
H-70.960	Documentation Requirements for Physician Care Plan Oversight	The AMA will (1) continue to work with CMS so that CPT codes 99375 and 99376, for Care Plan Oversight, are recognized for payment to all physicians; (2) the AMA CPT Editorial Panel will consider revising the Care Plan Oversight codes to more accurately reflect medical practice; (3) will work with CMS to develop documentation requirements that are more consistent with standard medical practice and are not time based; and (4) the CPT Editorial Panel will continue to monitor CMS's implementation of documentation requirements.	Sunset; policy obsolete with advent of the Chronic Care Management (99490, 99491; 99437, 99439) and Complex Chronic Care Management (99487, 99489) CPT codes.
H-75.984	Increasing Availability and Coverage for Immediate Postpartum Long-Acting Reversible Contraceptive Placement	1. Our AMA: (a) recognizes the practice of immediate postpartum and post pregnancy long-acting reversible contraception placement to be a safe and cost effective way of reducing future unintended pregnancies; and (b) supports the coverage by Medicaid, Medicare, and private insurers for immediate postpartum long-acting reversible contraception devices and placement, and that these be billed separately from the obstetrical global fee.	Retain. Policy is relevant.

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POLICY #	Title	Text	Recommendation
		2. Our AMA encourages relevant specialty organizations to provide training for physicians regarding (a) patients who are eligible for immediate postpartum long-acting reversible contraception, and (b) immediate postpartum long-acting reversible contraception placement protocols and procedures.	
H-85.957	Encouraging Standardized Advance Directives Forms Within States	Our AMA encourages each state society to develop a standardized form of advance directives for use by physicians and other health care providers as a template to discuss end-of-life care with their patients.	Retain. Policy is relevant.

2. STUDY OF THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM (FEHBP)

Informational report; no reference committee hearing.

HOUSE ACTION: FILED

At the 2025 Annual Meeting, the American Medical Association (AMA) House of Delegates (HOD) adopted Policy D-185.906, "Study of the Federal Employee Health Benefit Plan [sic] (FEHBP)," which asks the following:

> Our AMA will conduct a thorough study of the FEHBP to understand the successes and failures, strengths and weaknesses of the program and determine how the FEHBP compares with AMA policy H-165.881 to see whether it might be an appropriate model to achieve private and public health system reform, with a report back to the A-26 Meeting of our House of Delegates.

Under Policy H-165.881, our AMA will continue to actively pursue strategies for expanding patient choice in the private sector by advocating for greater choice of health plans by consumers, equal-dollar contributions by employers irrespective of an employee's health plan choice, and expanded individual selection and ownership of health insurance where plans are truly accountable to patients. This report, which is presented as information to the HOD, discusses the FEHBP and its advantages, limitations, and consistency with AMA health reform policy.

BACKGROUND

The FEHBP provides health insurance coverage to approximately 8.2 million civilian federal workers, retirees, and their dependents, or roughly 2.4 percent of the U.S. population.[1] As such, it is the largest employer-sponsored insurance (ESI) program in the country.[2] Established in 1960, in an era when many large private employers had begun offering health benefits, the intent of the FEHBP was to provide better benefits to federal employees, help them understand and compare plan options, and organize annual enrollment.[3]

Administered by the U.S. Office of Personnel Management (OPM), the FEHBP is governed by federal law that authorizes OPM to contract with qualified health insurers to offer a variety of plan types, primarily including fee-for-service (FFS) plans (most of which have a preferred provider organization [PPO] component), health maintenance organization (HMO) plans, and high-deductible health plans.[4] Similar to other private health plans, FEHBP offerings must comply with Affordable Care Act (ACA) benefits rules and requirements regarding minimum essential benefits, prohibitions on annual and lifetime limits, and other consumer protections enshrined in the 2010 law. Even so, the FEHBP is subject to fewer Department of Health and Human Services regulations than ACA marketplace, Medicare, or Medicaid plans and likewise receives less attention from Congress, interest groups, and health policy stakeholders.[5]

The basic rules of the FEHBP are outlined in federal statute and regulations, which give OPM relatively broad authority to administer the program and contract with plans.[6] In a typical cycle, OPM sends a "call letter" to insurers in the spring and then meets with each carrier to negotiate premiums, benefits, and payments for the next plan year.[7] The administrative structure of the FEHBP has been described as "diffuse," in that OPM works in coordination with the many health plans with which it contracts as well as more than a hundred federal agency employment offices.[8]

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Enrollment in the FEHBP is managed by federal agency personnel offices that oversee participation in accordance with OPM rules and procedures. The intent is to help workers enroll in coverage; unlike other federal health programs, OPM as the administrator does not engage in public purchasing or provider rate setting.[9]

Like other types of ESI, both the federal government and enrollees contribute towards the costs of FEHBP coverage. The federal government's share of premiums, known as the "fair share" formula and governed by statute, is intended to keep federal contributions consistent, regardless of the plan selected by an employee.[10] Generally, the government pays about 72 percent of the average premium across all plans (sometimes more, sometimes less) and will pay no more than 75 percent of a particular plan's premium.[11]

Premiums are designed to cover health care costs, plans' administrative expenses and profits, and OPM's administrative costs.[12] In reviewing health plans to be offered under the FEHBP, OPM considers the ability of plans to provide reasonable access to and choice of primary and specialty medical care throughout the service area. Participating health plans must be open to all workers, and no one can be denied coverage due to pre-existing conditions. OPM policy states that all participating carriers must be committed to the following:

1. Ensuring enrollees have access to good health care benefits;
2. Striving to keep premiums affordable;
3. Ensuring enrollees have access to quality provider networks;
4. Providing competitive health care choices for consumers;
5. Strengthening information for consumers so they can be more involved and responsible for their own health care decisions;
6. Being well managed and financially secure;
7. Providing efficient and effective contract administration;
8. Ensuring the timely and accurate submission of actuarial data and financial accounting information;
9. Maintaining compliance with laws, regulations, contract requirements and administrative guidance at all times; and
10. Guaranteeing that enrollee and government resources are protected.[13]

Importantly, eligibility for the FEHBP is limited to civilian federal employees, federal retirees, White House staff, and cabinet members. Per the ACA, members of Congress and their staffs are required to purchase coverage through an ACA exchange in order to receive a government contribution. Similar to other ESI programs, FEHBP-eligible individuals can enroll themselves and their family members in FEHBP plans within 60 days of being hired; during an open enrollment period; or within a specific timeframe of experiencing a qualified live event, such as a marriage, divorce or the birth or adoption of a new baby.[14] According to OPM, the FEHBP enrollee population reflects the demographics of the federal workforce: the median age of active employees is 47; approximately 42 percent of enrollees in the FEHBP and Postal Service Health Benefits Program are over the age of 50; and around 11 percent are younger than 30. When retiree demographics are considered together with the active workforce, the average age of FEHBP enrollees is around 60.[15]

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Advantages of the FEHBP

Policy D-185.906 directed the AMA to study the successes and strengths of the FEHBP, which we describe as "advantages." For decades, the FEHBP has been viewed by many as a highly successful program. When compared to other types of coverage, its advantages include the following:

Robust, structured choice of plans: The FEHBP provides a broad range of plan options to enrollees, generally between 10 and 20 plans in each geographic market,[16] and—in 2026—offers a total of 132 plan options from 47 participating insurers.[17] Despite having a catalogue of available plans that is more robust than plan choices available at many private workplaces, only about five percent of FEHBP enrollees opt to change plans in a given year.[18] Moreover, the FEHBP has become more concentrated over the years such that, in 2015, Blue Cross Blue Shield (BCBS) had become the largest carrier for FEHBP enrollees in 98 percent of all U.S. counties.[19] This concentration translates to decreased competition and gives BCBS plans considerable influence when it comes to pricing of FEHBP plans. Of note, in 2025 approximately two-thirds of federal workers were enrolled in BCBS plans.[20]

Comprehensive benefits package and patient protections: Most FEHBP plans offer comprehensive coverage, including preventive services at no cost when received from a preferred provider. Notably, GLP-1 medications are

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currently covered by FEHBP. Additionally, there are no waiting periods or coverage restrictions based on pre-existing conditions.

Generous federal contributions: Federal contributions towards FEHBP plans are not based on employee income. Rather, the federal government pays 72 to 75 percent of the average premium across all plans with employees responsible for the remainder. In comparison, according to KFF's Employer Health Benefits Survey (which includes data from both public and private employers) in 2025 employers contributed on average 84 percent of single coverage premiums and 74 percent of family plan premiums.[21]

Continuity of coverage: Unlike most private employer plans, the FEHBP provides continuity of coverage to federal workers and retirees. FEHBP enrollees are able to maintain their coverage when transitioning to other federal jobs/agencies, and can continue FEHBP coverage into retirement. Because many private employers no longer offer retiree health coverage, continuity of coverage into retirement should be considered a particularly valuable FEHBP perk.

Less attention from Congress, regulators: Unlike other federal health programs, the FEHBP is somewhat insulated from policymakers and stakeholders and receives less attention from Congress and regulators than other federal health programs. In Congress, the program falls under the jurisdiction of the House Oversight and Accountability Committee and Senate Committee on Homeland Security and Government Affairs instead of the health and tax committees that oversee most Congressional health care matters.

Limitations of the FEHBP

Limitations of the FEHBP include the following:

High and Increasing costs: The main shortcoming of the FEHBP is that its health coverage is expensive, and costs are rising. In 2026, employees and retirees are expected to contribute 12.3 percent more, on average, towards their premiums after incurring a 13.5 percent increase in premium contributions in 2025.[22] The average premium increase overall in 2026 is 10.2 percent, down from 11.2 percent in 2025, while the federal contribution increased 9.2 percent in 2026, down from 10.1 percent in 2025.[23] The program's recent double-digit increases may generally be higher than premium cost increases at many private firms, whose average premium contributions vary by firm size, industry, and other factors.

OPM has stated that premium increases this year are due in part to an aging workforce; the use of expensive prescription medications, especially GLP-1 drugs; and increased behavioral health spending. [24,25] Health policy experts have also highlighted higher hospital prices as a contributor.[26] OPM states that it routinely compares FEHBP premium costs to other large employers, although detailed benchmarking was not included in its benefits highlights for the current plan year. In last year's benefits highlights, OPM asserted that the FEHBP's overall average premium increase (11.2 percent) was similar to premium increases at comparable large employers, citing the California Public Employees' Retirement System —the second largest purchaser of public employee health benefits (after the federal government)—which saw average premiums increase by 10.8 percent.[27] OPM also cited the Large Employer Health Strategy Survey, conducted by the Business Group on Health, which found that large employers projected an average premium increase of eight percent for plan year 2025.[28]

Limited eligibility: An obvious but important drawback of the FEHBP as a reform model is its eligibility parameters, which limit enrollment to federal employees and retirees and their dependents, thus ensuring the overall stability of its risk pool.

Choice overload: Too much choice and not enough information to help guide enrollee decision-making may make it difficult for some federal employees to understand how different plans could impact their costs and access to care. Choice overload has also been cited as a challenge in other insurer markets, including ACA exchanges.

Susceptibility to changes in administration priorities: Given the White House's oversight of federal agencies, including OPM, the FEHBP may be more susceptible to changes intended to align the program with administration priorities. For example, coverage for some gender-affirming care for people of all ages was removed from the FEHBP following an executive order by President Trump.[29]

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ROLE OF THE FEHBP IN HEALTH REFORM EFFORTS

Various health reformers have pointed to the FEHBP as a model almost since its inception, although considerations of the program were more frequent during the pre-ACA era and less so in recent years. Of note, proposals from across the political spectrum have been based in part on the FEHBP's framework, including the *Healthy Americans Act*—proposed in 2007 and 2009 by Senators Wyden and Bennett to establish universal health care—and the *FEHBP for All Act*, first introduced in 2011 by Representative Darrell Issa to repeal the ACA and open up the FEHBP to everyone. Importantly, the Issa bill kept the traditional FEHBP program intact to prevent adverse selection from negatively affecting the risk pool.

The FEHBP as a Model for National Health Insurance

In the 1990s, calls for the public to be able to purchase the same health coverage as members of Congress, who prior to the ACA were typically enrolled in the FEHBP, led to an array of proposals to open the FEHBP to the public and treat it as national health insurance. Back then, the FEHBP was widely praised as providing excellent coverage at low administrative cost. Not surprisingly, federal employees and their unions vehemently opposed such legislation, which they believed would significantly increase their premium costs. Moreover, the complexities involved in implementing such proposals became apparent when, for example, the OPM director at the time commented that the FEHBP is "a wonderful working model, but it cannot be instantly duplicated."[30] More modest proposals to open the FEHBP to uninsured people and/or small businesses were also debated, and President Clinton's health package—released in 1995—included a provision allowing small businesses to buy into the program.[31]

The FEHBP as a Model for Restructuring Medicare

Also in the 1990s, several proposals to restructure the Medicare program based in part on the FEHBP were considered by various stakeholders because, at that time, the FEHBP was viewed as more successful than Medicare at controlling spending while offering robust choice and achieving high participant satisfaction.[32] In 1995, Stuart Butler and a colleague from the Heritage Foundation proposed reforming Medicare by adopting the FEHBP's choice and competition features and by, among other things, transforming it from an entitlement to a defined contribution program (though the FEHBP is not strictly a defined contribution model) and providing vouchers that enrollees could put towards a private plan of their choosing.[33] A few years later, a provision in the Balanced Budget Act of 1997, called Medicare+Choice, established Medicare Part C by authorizing the participation of private plans, thus launching the initial phase of what is now known as Medicare Advantage (MA).[34] The Medicare Modernization Act of 2003 further modified plan payments in Part C and established the Part D prescription drug program, which also incorporated the FEHBP's "managed competition" structure.[35,36]

The FEHBP as a Model for the ACA, Public Option Proposals

The idea of the FEHBP as a model for national health insurance was also debated in the years leading up to passage of the ACA, although some analysts cautioned against opening it up to non-federal workers in order to prevent disrupting the program's stable risk pool. In the end, President Obama rejected calls to open the FEHBP to the public in favor of carefully-designed insurance exchanges.[37]

The ACA also adopted some protections that had previously been provided to FEHBP enrollees, such as the prohibition on coverage restrictions based on health status. In 2009, a spinoff of the FEHBP that would authorize OPM with overseeing national health plans (outside of the FEHBP) was discussed as a potential replacement for the public option that was included in legislation passed by the House of Representatives. However, neither a public option nor an FEHBP spinoff-type option was included in the Senate bill or final ACA package.

Leveraging health plan FEHBP participation to address counties lacking individual market insurers (known as bare counties) was a key component of a bipartisan proposal to improve the ACA in 2017. This proposal would have required, as a condition of continued participation in the FEHBP, the two largest FEHBP insurers in a county to offer at least one silver plan through the federal exchange in all counties that would otherwise be bare.

In an effort to build upon the ACA's existing structure, a new coverage option for exchanges that would allow the public to enroll in the FEHBP has also been suggested.[38] Perhaps due to feasibility and/or cost concerns as well as existing FEHBP eligibility restrictions, such proposals have not gained much traction. Instead, most proposals put

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forward in Congress to establish a public option on ACA exchanges have been tied to Medicare or Medicaid payment rates in order to keep costs down, since the intent of a public option is to offer good coverage that costs less than other competing plans. Likewise, at the time this report was written, none of the states implementing a public option had adopted an approach that would allow the public to enroll in either the FEHBP or state employee health plan. Instead, public option laws in Washington, Colorado, and Nevada aim to lower premiums and decrease overall health costs by either capping provider payments (Washington), establishing premium reduction targets (Nevada), or both—setting premium targets with the authority to reduce provider payments if the targets are not met (Colorado).[39] Several other states have considered various public option proposals and may, in the future, explore leveraging their state's employee benefits plan to increase available exchange plan offerings.

AMA POLICY

Longstanding policy (Policy H-165.846) has supported using federal guidelines, such as those under the FEHBP, as a standard for assessing meaningful health insurance coverage. As previously noted, Policy H-165.881 states that our AMA will continue to actively pursue strategies for expanding patient choice in the private sector by advocating for greater choice of health plans by consumers, equal-dollar contributions by employers irrespective of an employee's health plan choice, and expanded individual selection and ownership of health insurance where plans are truly accountable to patients. Additional policies referencing the FEHBP include:

- Policy H-165.825, which supports requiring the largest two FEHBP insurers in counties that lack a marketplace plan to offer at least one silver-level marketplace plan as a condition of FEHBP participation. To clarify, this policy would not allow individuals to buy-in to FEHBP plans. Rather, individuals in otherwise bare counties would have the choice of at least two silver plans that abide by ACA requirements, offered by the two largest FEHBP insurers in their county.

- Policy H-180.961, which encourages the National Association of Insurance Commissioners to develop standards and a uniform disclosure format applicable to health plans and policies offered in the general insurance market, taking into consideration the benefit definitions and disclosure format used by plans participating in the FEHBP.

Policies addressing ESI, including Policies H-165.828 and H-165.843, are also relevant to the FEHBP as it is the largest ESI provider in the country. For decades, AMA policy has advocated for the promotion of individually selected and owned health insurance using refundable and advanceable tax credits that are inversely related to income so that patients with the lowest incomes receive the largest credits (e.g., Policies H-165.920 and H-165.865). Additional AMA health reform policies relevant to this report include:

- Policy H-165.838, which states that insurance coverage options offered in a health insurance exchange should be self-supporting; have uniform solvency requirements; not receive special advantages from government subsidies; include payment rates established through meaningful negotiations and contracts; not require provider participation; and not restrict enrollees' access to out-of-network physicians. This policy further commits the AMA to achieving health reforms that include numerous components, including health insurance coverage for all Americans; insurance market reforms that expand choice of affordable coverage and eliminate denials for pre-existing conditions; and assurance that health care decisions will remain in the hands of patients and their physicians, not insurance companies or government officials.

- Policy H-165.823, which advocates for a pluralistic health care system—which may include a public option—that focuses on increasing equity and access, is cost-conscious, and reduces burden on physicians. This policy establishes standards for supporting a public option and for supporting auto-enrollment in health insurance coverage.

- Policy H-165.985, which reaffirms core AMA health reform principles, including free market competition; freedom of patients to select and change physicians or health plans; freedom of physicians to choose whom they will serve, to establish their fees at a level which they believe fairly reflect the value of their services, and to participate or not participate in a particular plan or method of payment; and full and clear information to consumers on the provisions and benefits offered by alternative medical care and health benefit plans, so that the choice of a source of medical care delivery is an informed one.

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DISCUSSION

Although the FEHBP has often been cited as a model for providing robust health plan competition and choice at reasonable cost, the Council finds that expanding the program broadly is not a viable strategy for increasing coverage and patient choice. Proposals incorporating the FEHBP in health system reforms have diminished in recent years, possibly due to the availability of exchange plan coverage under the ACA and/or because the FEHBP is less competitive and more costly than it once was. In comparing the FEHBP to other types of coverage, the Council found that the structure of the FEHBP does not substantially differ from the ACA marketplace or large employer plans, though the catalog of FEHBP plan options may be larger in some areas, its risk pool may be more stable than that of the ACA market, and FEHBP coverage may be continued into retirement. Unlike the 1960s when the FEHBP was created, most health plans must now meet certain standards and requirements, which has narrowed the differences between the FEHBP and other coverage types.

FEHBP consumer protections and benefit packages are generally comprehensive, as evidenced by the FEHBP's coverage of GLP-1 medications for obesity; however, they are not necessarily more generous than some large private employer offerings. In terms of cost, true comparisons between the FEHBP and other types of coverage would require detailed analysis at the local level; however, the Council points to recent double-digit increases in federal worker premium costs. Of note, the Council also recognizes that significant federal workforce reductions since 2025 may impact the FEHBP as soon as next year in ways that are not yet understood. For example, it is not clear how the FEHBP risk pool will be affected and whether some carriers may opt to exit the program in areas like Washington, DC that have experienced substantial decreases in staffing.

The Council believes that the FEHBP is largely consistent with Policy H-165.881 as well as AMA policies emphasizing pluralism, choice, competition, and other essential health reform principles. In particular, the FEHBP provides a broad array of competing plan options and a standardized employer contribution, both of which encourage consumer choice and plan competition. That said, we do not necessarily view the FEHBP as the most promising solution to achieving universal coverage, primarily due to its limited eligibility and rising costs. Additionally, premium contributions for federal workers are not tied to their household incomes; rather, the federal government pays between 72 and 75 percent of worker premiums, amounts that do not increase or decrease based on income. This feature of the FEHBP could be viewed as inconsistent with AMA policy advocating for the use of tax credits that are inversely related to income, so that patients with the lowest incomes receive the largest credits.

After studying the FEHBP as a reform model and hearing from a program expert, the Council concluded that opening up the FEHBP to the public would seem unwise in that it would severely disrupt the program's stable risk pool, which has been one of the keys to its success over the years. Though an expanded FEHBP would provide generous coverage and a robust choice of plans, FEHBP plans are relatively expensive and the costs of an expanded or open program would be high, potentially making it less affordable. That said, future reforms may continue to adopt certain features of the FEHBP, just as the ACA, MA, and Part D programs have done.

The Council also underscores that AMA Policy H-165.846—first adopted in 1997 and most recently reaffirmed in 2019—supports using the FEHBP as a standard for assessing meaningful coverage. We emphasize that this is only one such standard, and that the principles and guidelines embedded throughout the AMA's large compendium of policy form the basis by which the AMA will continue to evaluate and engage in advocacy around a broad array of health reform approaches, including proposals that may build upon the FEHBP or incorporate some of its features.

CONCLUSION

Having decided against recommending new AMA policy supportive of expanding eligibility for the FEHBP to non-federal workers—which would threaten that program's sustainability—the Council did not identify gaps in existing AMA policy that would preclude assessment of future reform proposals that are based in part or in full on the FEHBP. Therefore, the Council makes no policy recommendations at this time.

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Council on Medical Service Report 2-A-26
Study of the Federal Employees Health Benefits Program (FEHBP)
Policy Appendix

Expanding Choice in the Private Sector H-165.881
Our American Medical Association (AMA) will continue to actively pursue strategies for expanding patient choice in the private sector by advocating for greater choice of health plans by consumers, equal-dollar contributions by employers irrespective of an employee's health plan choice and expanded individual selection and ownership of health insurance where plans are truly accountable to patients. (BOT Rep. 23, A-97; Reaffirmed BOT Rep. 6, A-98; Reaffirmation A-02; Reaffirmed: CMS Rep. 4, A-12; Reaffirmation: A-19)

Adequacy of Health Insurance Coverage Options H-165.846
1. Our AMA supports the following principles to guide in the evaluation of the adequacy of health insurance coverage options:
   A. Any insurance pool or similar structure designed to enable access to age-appropriate health insurance coverage must include a wide variety of coverage options from which to choose.
   B. Existing federal guidelines regarding types of health insurance coverage (e.g., Title 26 of the US Tax Code and Federal Employees Health Benefits Program [FEHBP] regulations) should be used as a reference when considering if a given plan would provide meaningful coverage.
   C. Provisions must be made to assist individuals with low-incomes or unusually high medical costs in obtaining health insurance coverage and meeting cost-sharing obligations.
   D. Mechanisms must be in place to educate patients and assist them in making informed choices, including ensuring transparency among all health plans regarding covered services, cost-sharing obligations, out-of-pocket limits and lifetime benefit caps, and excluded services.
2. Our AMA advocates that the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program be used as the model for any essential health benefits package for children.

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3. Our AMA: (a) opposes the removal of categories from the essential health benefits (EHB) package and their associated protections against annual and lifetime limits, and out-of-pocket expenses; and (b) opposes waivers of EHB requirements that lead to the elimination of EHB categories and their associated protections against annual and lifetime limits, and out-of-pocket expenses. (CMS Rep. 7, A-07; Reaffirmation I-07; Reaffirmation A-09; Reaffirmed: Res. 103, A-09; Reaffirmation I-09; Reaffirmed: CMS Rep. 3, I-09; Reaffirmed: CMS Rep. 2, A-11; Appended: CMS Rep. 2, A-11; Reaffirmed in lieu of Res. 109, A-12; Reaffirmed: CMS Rep. 1, I-12; Reaffirmed: CMS Rep. 3, A-13; Reaffirmed in lieu of Res. 812, I-13; Reaffirmed: CMS Rep. 6, I-14; Reaffirmed: CMS Rep. 6, I-15; Appended: CMS Rep. 04, I-17; Reaffirmed in lieu of: Res. 101, A-19)

Medical Care for Patients with Low Incomes H-165.855
It is the policy of our American Medical Association that:

1. states be allowed the option to provide coverage to their Medicaid beneficiaries who are nonelderly and nondisabled adults and children with the current Medicaid program or with premium tax credits that are refundable, advanceable, inversely related to income, and administratively simple for patients, exclusively to allow patients and their families to purchase coverage through programs modeled after the state employee purchasing pool or the Federal Employee Health Benefits Program (FEHBP) with minimal or no cost-sharing obligations based on income. Children qualified for Medicaid must also receive Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program benefits and have no cost-sharing obligations.
2. in order to limit patient churn and assure continuity and coordination of care, there should be adoption of 12-month continuous eligibility across Medicaid, Children's Health Insurance Program, and exchange plans.
3. to support the development of a safety net mechanism, allow for the presumptive assessment of eligibility and retroactive coverage to the time at which an eligible person seeks medical care.
4. tax credit beneficiaries should be given a choice of coverage, and that a mechanism be developed to administer a process by which those who do not choose a health plan will be assigned a plan in their geographic area through auto-enrollment until the next enrollment opportunity. Patients who have been auto-enrolled should be permitted to change plans any time within 90 days of their original enrollment.
5. state public health or social service programs should cover, at least for a transitional period, those benefits that would otherwise be available under Medicaid, but are not medical benefits per se.
6. as the nonelderly and nondisabled populations transition into needing chronic care, they should be eligible for sufficient additional subsidization based on health status to allow them to maintain their current coverage.
7. our American Medical Association encourages the development of pilot projects or state demonstrations, including for children, incorporating the above recommendations.
8. our AMA should encourage states to support a Medicaid Physician Advisory Commission to evaluate and monitor access to care in the state Medicaid program and related pilot projects. (CMS Rep. 1, I-03; Reaffirmed in lieu of Res. 105, A-06; Reaffirmation I-07; Modified: CMS Rep. 1, A-12; Reaffirmed in lieu of Res. 101, A-13; Reaffirmed: CMS Rep. 02, A-16; Reaffirmation: A-18;Reaffirmed: Joint CMS/CSAPH Rep. 1, I-21; Reaffirmed: CMS Rep. 3, A-22; Reaffirmed: CMS Rep. 5, I-23)

Ensuring Marketplace Competition and Health Plan Choice H-165.825
Our AMA will: (1) support health plans offering coverage options for individuals and small groups competing on a level playing field, including providing coverage for pre-existing conditions and essential health benefits; (2) oppose the sale of health insurance plans in the individual and small group markets that do not guarantee: (a) pre-existing condition protections and (b) coverage of essential health benefits and their associated protections against annual and lifetime limits, and out-of-pocket expenses, except in the limited circumstance of short-term limited duration insurance offered for no more than three months; and (3) support requiring the largest two Federal Employees Health Benefits Program (FEHBP) insurers in counties that lack a marketplace plan to offer at least one silver-level marketplace plan as a condition of FEHBP participation. (CMS Rep. 03, A-18; Reaffirmed: CMS Rep. 01, I-20)

Defining Levels of Health Insurance Coverage H-180.961
Our AMA strongly encourages the National Association of Insurance Commissioners to develop standards and a uniform disclosure format applicable to health plans and policies offered in the general insurance market, taking into consideration the benefit definitions and disclosure format used by plans participating in the Federal Employees Health Benefits Plan program; and supports the enactment of federal and/or state legislation requiring the use by health plans of standardized uniform disclosure formats that have had appropriate input by medical organizations. (CMS Rep. 9, A-97; Reaffirmed: CMS Rep. 2, I-01; Reaffirmation I-07; Reaffirmed: CMS Rep. 01, A-17)

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Health Insurance Affordability H-165.828

1. Our AMA supports modifying the eligibility criteria for premium credits and cost-sharing subsidies for those offered employer-sponsored coverage by lowering the threshold that determines whether an employee's premium contribution is affordable to the level at which premiums are capped for individuals with the highest incomes eligible for subsidized coverage in Affordable Care Act (ACA) marketplaces.
2. Our AMA supports legislation or regulation, whichever is relevant, to fix the ACA's "family glitch," thus determining the eligibility of family members of workers for premium tax credits and cost-sharing reductions based on the affordability of family employer-sponsored coverage and household income.
3. Our AMA encourages the development of demonstration projects to allow individuals eligible for cost-sharing subsidies, who forego these subsidies by enrolling in a bronze plan, to have access to a health savings account (HSA) partially funded by an amount determined to be equivalent to the cost-sharing subsidy.
4. Our AMA supports capping the tax exclusion for employment-based health insurance as a funding stream to improve health insurance affordability, including for individuals impacted by the inconsistency in affordability definitions, individuals impacted by the "family glitch" and individuals who forego cost-sharing subsidies despite being eligible.
5. Our AMA supports additional education regarding deductibles and cost-sharing at the time of health plan enrollment, including through the use of online prompts and the provision of examples of patient cost-sharing responsibilities for common procedures and services.
6. Our AMA supports efforts to ensure clear and meaningful differences between plans offered on health insurance exchanges.
7. Our AMA supports clear labeling of exchange plans that are eligible to be paired with a Health Savings Account (HSA) with information on how to set up an HSA.
8. Our AMA supports the inclusion of pregnancy as a qualifying life event for special enrollment in the health insurance marketplace.
9. Our AMA supports that the ACA eligibility firewall not apply to individuals offered employer-sponsored coverage whose household incomes are at or below 200 percent of the federal poverty level, so they can receive federal premium tax credits and cost-sharing assistance if they opt to enroll in a marketplace health plan as an affordable alternative to their employer-based plan.
10. Our AMA supports incrementally lifting the ESI firewall with continual monitoring and consideration of insurance marketplace stability, if and only if there is documentation that marketplace insurance pays sufficiently to ensure physician practice sustainability, and other relevant parameters, with the goal of maximizing the number of individuals able to freely choose the health insurance plan that is best for themselves and their families.
11. Our AMA supports any incremental lifting of the firewall must be paired with a pause to review the relevant parameters, and the ability to pause permanently, or reverse if disruptive effects are detected.
12. Our AMA advocates that physician payments by health insurers participating in the ACA marketplace be sustainable, reflect the full cost of practice and the value of the care provided, include inflation-based updates, and pay fair and equitable rates. (CMS Rep. 8, I-15; Reaffirmed in lieu of: Res. 121, A-16; Reaffirmation: A-17; Reaffirmed: CMS Rep. 09, A-19; Reaffirmed: CMS Rep. 02, A-19; Reaffirmed in lieu of: Res. 101, A-19; Reaffirmed: CMS Rep. 01, I-20; Reaffirmed: CMS Rep. 2, I-20; Modified: CMS Rep. 3, I-21; Appended: Res. 701, I-21; Reaffirmed: Res. 826, I-24; Appended: CMS Rep. 02, A-25)

Trends in Employer-Sponsored Health Insurance H-165.843

Our AMA encourages employers to:

a. promote greater individual choice and ownership of plans;
b. implement plans to improve affordability of premiums and/or cost-sharing, especially expenses for employees with lower incomes and those who may qualify for affordable care act marketplace plans based on affordability criteria, while promoting meaningful coverage and the application of vital consumer and provider protections, such as prompt pay and network adequacy requirements;
c. provide employees with user-friendly information regarding their eligibility for subsidized ACA marketplace plans based on their offer of employer-sponsored insurance;
d. provide employees with information regarding available health plan options, including the plan's cost, network breadth, and prior authorization requirements, which will help them choose a plan that meets their needs;
e. offer information and decision-making tools to assist employees in developing and managing their individual health care choices;
f. support increased fairness and uniformity in the health insurance market; and
g. promote mechanisms that encourage their employees to pre-fund future costs related to retiree health care and long-term care. (CMS Rep. 4, I-07; Reaffirmed: CMS Rep. 01, A-17; Modified: CMS Rep. 02, A-25)

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Individual Health Insurance H-165.920
Our AMA:
(1) affirms its support for pluralism of health care delivery systems and financing mechanisms in obtaining universal coverage and access to health care services;
(2) recognizes incremental levels of coverage for different groups of the uninsured, consistent with finite resources, as a necessary interim step toward universal access;
(3) actively supports the principle of the individual's right to select a health insurance plan and actively support ways in which the concept of individually selected and individually owned health insurance can be appropriately integrated, in a complementary position, into the Association's position on achieving universal coverage and access to health care services. To do this, our AMA will:
(a) Continue to support equal tax treatment for payment of health insurance coverage whether the employer provides the coverage for the employee or whether the employer provides a financial contribution to the employee to purchase individually selected and individually owned health insurance coverage, including the exemption of both employer and employee contributions toward the individually owned insurance from FICA (Social Security and Medicare) and federal and state unemployment taxes;
(b) Support the concept that the tax treatment would be the same as long as the employer's contribution toward the cost of the employee's health insurance is at least equivalent to the same dollar amount that the employer would pay when purchasing the employee's insurance directly;
(c) Study the viability of provisions that would allow individual employees to opt out of group plans without jeopardizing the ability of the group to continue their employer sponsored group coverage; and
(d) Work toward establishment of safeguards, such as a health care voucher system, to ensure that to the extent that employer direct contributions made to the employee for the purchase of individually selected and individually owned health insurance coverage continue, such contributions are used only for that purpose when the employer direct contributions are less than the cost of the specified minimum level of coverage. Any excess of the direct contribution over the cost of such coverage could be used by the individual for other purposes;
(4) will identify any further means through which universal coverage and access can be achieved;
(5) supports individually selected and individually-owned health insurance as the preferred method for people to obtain health insurance coverage; and supports and advocates a system where individually-purchased and owned health insurance coverage is the preferred option, but employer-provided coverage is still available to the extent the market demands it;
(6) supports the individual's right to select a health insurance plan and to receive the same tax treatment for individually purchased coverage, for contributions toward employer-provided coverage, and for completely employer provided coverage;
(7) supports immediate tax equity for health insurance costs of self-employed and unemployed persons;
(8) supports legislation to remove paragraph (4) of Section 162(l) of the US tax code, which discriminates against the self-employed by requiring them to pay federal payroll (FICA) tax on health insurance premium expenditures;
(9) supports legislation requiring a "maintenance of effort" period, such as one or two years, during which employers would be required to add to the employee's salary the cash value of any health insurance coverage they directly provide if they discontinue that coverage or if the employee opts out of the employer-provided plan;
(10) encourages through all appropriate channels the development of educational programs to assist consumers in making informed choices as to sources of individual health insurance coverage;
(11) encourages employers, unions, and other employee groups to consider the merits of risk-adjusting the amount of the employer direct contributions toward individually purchased coverage. Under such an approach, useful risk adjustment measures such as age, sex, and family status would be used to provide higher-risk employees with a larger contribution and lower-risk employees with a lesser one;
(12) supports a replacement of the present federal income tax exclusion from employees' taxable income of employer-provided health insurance coverage with tax credits for individuals and families, while allowing all health insurance expenditures to be exempt from federal and state payroll taxes, including FICA (Social Security and Medicare) payroll tax, FUTA (federal unemployment tax act) payroll tax, and SUTA (state unemployment tax act) payroll tax;
(13) advocates that, upon replacement, with tax credits, of the exclusion of employer-sponsored health insurance from employees' federal income tax, any states and municipalities conforming to this federal tax change be required to use the resulting increase in state and local tax revenues to finance health insurance tax credits, vouchers or other coverage subsidies; and
(14) believes that refundable, advanceable tax credits inversely related to income are preferred over public sector expansions as a means of providing coverage to the uninsured.
(15) Our AMA reaffirms our policies committed to our patients and their individual responsibility and freedoms consistent with our United States Constitution. (BOT Rep. 41, I-93; CMS Rep. 11, I-94; Reaffirmed by Sub. Res. 125

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and Sub. Res. 109, A-95; Amended by CMS Rep. 2, I-96; Amended and Reaffirmed by CMS Rep. 7, A-97; Reaffirmation A-97; Reaffirmed: CMS Rep. 5, I-97; Res. 212, I-97; Appended and Amended by CMS Rep. 9, A-98; Reaffirmation I-98; Reaffirmation I-98; Res. 105 & 108, A-99; Reaffirmation A-99; Reaffirmed: CMS Rep. 5 and 7, I-99; Modified: CMS Rep. 4, CMS Rep. 5, and Appended by Res. 220, A-00; Reaffirmation I-00; Reaffirmed: CMS Rep. 2, I-01; Reaffirmed CMS Rep. 5, A-02; Reaffirmation A-03; Reaffirmed: CMS Rep. 1 and 3, A-02; Reaffirmed: CMS Rep. 3, I-02; Reaffirmed: CMS Rep. 3, A-03; Reaffirmation I-03; Reaffirmation A-04; Consolidated: CMS Rep. 7, I-05; Modified: CMS Rep. 3, A-06; Reaffirmed in lieu of Res. 105, A-06; Reaffirmation A-07; Appended and Modified: CMS Rep. 5, A-08; Modified: CMS Rep. 8, A-08; Reaffirmation A-10; Reaffirmed: CMS Rep. 9, A-11; Reaffirmation A-11; Reaffirmed: Res. 239, A-12; Appended: Res. 239, A-12; Reaffirmed: CMS Rep. 6, A-12; Reaffirmed: CMS Rep. 9, A-14; Reaffirmed in lieu of: Res. 805, I-17; Modified: Speakers Rep. 02, I-24)

3. IMPROVING PATIENT ACCESS TO PHARMACIES AND MEDICATIONS IN PHARMACY DESERTS

Reference committee hearing: see report of Reference Committee A.

HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS
REMAINDER OF REPORT FILED
See Policies D-110.987, H-120.911, H-120.912 and H-120.989

Resolution 113, "Improving Patient Access to Pharmacies and Medications in Pharmacy Deserts," was introduced by the Ohio delegation at the 2025 Annual Meeting and was referred. It asks the following:

> RESOLVED, that our American Medical Association (AMA) support efforts to expand telepharmacy as a potential solution to pharmacy deserts; and be it further;
>
> RESOLVED, that our AMA advocate for equitable reimbursement rates for pharmaceuticals between Medicare, Medicaid, and private insurers to ensure sustainable pharmacy operations in rural and underserved areas; and be it further;
>
> RESOLVED, that our AMA study and address the impact of preferred pharmacy networks on patient access to pharmacy services, particularly in pharmacy deserts, with attention to supporting independent pharmacies.

This report reviews the state of pharmacies and pharmacy access in the United States, economic issues faced by pharmacies, and solutions to improve pharmacy access. Additionally, it provides an overview of related AMA policies and offers a number of recommendations.

BACKGROUND

Pharmacies are key to ensuring that patients have access to the medications prescribed by their physicians. For many people, pharmacies are their most frequent contact with the health care system, as evidence shows that patients visit pharmacies 1.5-2 times more frequently than other health care providers.[1] However, over the last 15 years, pharmacies have been closing at an alarming rate. Between 2010 and 2021, 29 percent of all pharmacies across America closed.[2] In 2024, 2,200 pharmacies closed, meaning an average of six pharmacies closed each day.[3] As an example of the magnitude of the issue, in 2025, Rite Aid, a major pharmacy retailer across the United States, filed its second bankruptcy in two years and ceased all operations. This resulted in approximately 2,200 Rite Aid pharmacies closing between the initial bankruptcy filing in May 2023 and October 2025.[4]

These closures highlight an overarching trend among not only chain pharmacies, but also local/independent pharmacies. Estimates show that independent pharmacies make up about 35 percent of all pharmacies nationally and meet the needs of over 15 million Americans.[5] These pharmacies are also closing rapidly, approximately one per day.[5] Historically, independent community pharmacies have closed at a higher net rate than chain pharmacies. However, in recent years more independent pharmacies have also been opening, which has lowered their net closure rate. This more recent trend may indicate that independent pharmacies have a higher "churn rate," meaning that while they may open more frequently, they are unable to stay in business and end up closing or selling to a chain. Notably, while there

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is an increase in independent pharmacies opening, they do not seem to be opening in communities that are low-income or which currently lack access to pharmacies.[6,7] This is particularly important as research demonstrates that individuals who live in rural areas, are 65 years or older, or live in a low-income household are more likely to rely on independent pharmacies for access to prescriptions.[8] As these pharmacies often lack the bargaining power that bigger chain pharmacies have, they may struggle to stay open, exacerbating the access problems within vulnerable communities.[7]

As a result of these closures, pharmacy deserts have been growing. While there is no single universally accepted definition of a pharmacy desert, the term generally refers to communities that do not have easy access to a pharmacy. The term was originally coined in 2014 and relied on census tracts to identify communities that had a "high poverty rate" and no pharmacies within one mile in urban areas or 10 miles in rural areas.[9] In 2025, researchers expanded on this definition by introducing a pharmacy vulnerability index. This index takes a slightly different approach in identifying deserts, defining them as areas where the travel time to the nearest pharmacy is longer than the travel time to the nearest supermarket, accounting for the region and urbanicity levels.[10] Importantly, geographic distance is not the only issue that many patients face in accessing pharmacies, as lack of public transportation and limited pharmacy hours can greatly exacerbate access issues.[3,9] This vulnerability index led to the concept of "keystone pharmacies," or pharmacies that if closed would create a pharmacy desert. Based on this definition, nearly 18 percent of the United States population currently lives in pharmacy deserts and another nearly nine percent live in areas served by a keystone pharmacy.[10] Individuals who reside in rural communities are disproportionately represented when assessing communities served by keystone pharmacies, while pharmacy deserts seem to be equally distributed across urbanicity when incorporating national population statistics.[9,10] Thus, while more rural communities are at risk to become pharmacy deserts, the problem also exists in some urban and suburban communities.

In both suburban and urban settings, individuals living in pharmacy deserts are more likely to be a part of a racial and/or ethnic minority.[8,9] When controlling for setting (urban vs rural), predominately Black and Hispanic communities faced the largest decline in pharmacies, with nearly five percent fewer pharmacies than non-predominately Black/Hispanic communities.[11] However, in rural settings, White individuals are more likely to reside in a pharmacy desert or in areas served by a keystone pharmacy. This is likely explained by the fact that more White individuals live in rural areas. Regardless of the racial makeup of the community, pharmacies in communities with poverty rates higher than 20 percent had significantly higher risks of pharmacy closure.[10,11] Further, many communities considered pharmacy deserts are also considered medically underserved, meaning they do not have adequate access to physicians or non-physician practitioners, which exacerbates the issue.[10,11] Pharmacy deserts are not just an issue of convenience, as patients living in them are less likely to be able to access their medications and as a result, unable to access their treatments.[9,10] While not driven solely by pharmacy access issues, they likely contribute to medication nonadherence which results in avoidable health care spending, including millions of dollars due to unnecessary hospitalizations each year.[12] Further, disparities among racial and ethnic communities are prevalent across both access and utilization of prescription medications. Since these disparities are not entirely explained by access to medical professionals, health insurance coverage, or medication cost, researchers posit that this additional driving factor to this disparity may be pharmacy deserts.[13,14]

PHARMACY ECONOMICS

Prior to the modern insurance paradigm, pharmacy economics were straightforward, as pharmacists acquired the goods and set prices based on supply and demand. Pharmacies buy a drug at a price set by the drug manufacturer and the consumer purchases it with the markup determined by the pharmacy. However, with the advent of prescription drug insurance, the patient-pharmacist connection became less direct as payers were inserted in the middle, shifting pharmacist focus to volume to keep pharmacies economically viable.[15] The inception of the Medicare Modernization Act in 2003, which created Medicare Part D and the contemporary business model used by pharmacy benefit managers (PBMs), further complicated pharmacy reimbursement and what was necessary to stay in business.[15] Payment paradigms become increasingly complicated when payers, PBMs, and discount programs are involved in the transaction.[16,17] If a patient is utilizing insurance, the plan typically pays for the bulk of a covered drug at the set reimbursement rate with the pharmacy, usually negotiated by a PBM. Often the patient is responsible for some out-of-pocket (OOP) payment that is paid directly to the pharmacy. In theory, the combination of the patient OOP payment and the payer reimbursement should cover the drug and dispensing costs for the pharmacy. However, in practice, pharmacy reimbursement does not fully cover acquisition and operating costs.[17] Moreover, another concerning issue arises when a non-integrated pharmacy deals with a PBM that is vertically integrated as it can result in anticompetitive practices.[18,19] Several mergers and acquisitions across the pharmacy and PBM/payer markets, as well as insurers creating their own PBMs, have led to large vertically integrated firms operating across these three product markets.[20]

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Estimates show that five of the six largest PBMs are vertically integrated with both insurers and pharmacies, indicating high concentration in PBM markets.[19,21] Research shows that nearly 80 percent of prescription claims are processed by the three largest PBMs.[17,18]

Furthermore, not only are the largest PBMs vertically integrated with insurers, but these firms also often either own or have preferred network agreements with a significant number of pharmacies.[17,18,19] Preferred pharmacy networks are similar to "in-network providers" in concept. PBMs negotiate an agreement with a pharmacy or pharmacy chain on behalf of insurers for discounted rates for beneficiaries.[21] This can be beneficial for patients if they have access to pharmacies that are within the preferred network. Patients who utilize these pharmacies can save money on their prescription costs. For example, among Medicare Part D plans, preferred pharmacies can reduce patient spending by two percent.[21] However, preferred pharmacy networks can limit patient choice and, in cases when patients are unable to access a preferred pharmacy, lead to higher OOP costs.[21] Since PBMs have a large share of market power, downward pressure is put on non-integrated pharmacies, lowering reimbursement rates. Often exacerbating the closures of small, independent pharmacies as they cannot sustain the reduction in reimbursement or patients when they are redirected to preferred network pharmacies.[19,22]

Even pharmacies in preferred networks can experience financial strain emanating from inadequate reimbursement rates. In many cases, on behalf of insurers, PBMs have significantly reduced pharmacy reimbursement rates, sometimes resulting in pharmacies dispensing medications at a deficit.[23,24] Additionally, pharmacies are often hit with Direct and Indirect Renumeration (DIR) fees.[23] These fees are retroactive and result from a payer attempting to recoup a portion of their payment after a transaction is completed. This can be harmful for any pharmacy, but it is particularly problematic for small or independent pharmacies that do not have the same funding or volume as larger retail chains. While there have been some recent reform efforts from the Centers for Medicare & Medicaid Services (CMS) related to DIR fees, the solutions presented have not been comprehensive and do not address all payer types.[24] Further, programs like 340B, intended to make drugs more affordable for patients, can make it difficult for non-340B pharmacies to compete. Specifically, 340B program hospital and clinic pharmacies can purchase medication for a price much lower than most other pharmacies can offer, which they can then sell at rates significantly lower than non-340B pharmacies or at more favorable markups.[21]

While the process of reimbursement does not dramatically differ between a vertically integrated pharmacy and an independent pharmacy, the results vary greatly. Smaller, independent pharmacies are generally not vertically integrated with PBMs and/or payers, and thus lack the bargaining power to negotiate and are often excluded from preferred pharmacy networks.[23,25] As a result, independent pharmacies often receive worse reimbursement rates and/or a loss of patients as PBMs and payers steer patients towards vertically integrated and preferred pharmacy networks.[23,25] These issues have led to significant losses in gross margins for pharmacies.[23] Gross margins are the total revenue of a business minus the cost of the goods that are sold. These margins fund business growth and innovation. Research shows that even though pharmacies are dispensing more prescriptions toward increasing revenue, gross margins are decreasing.[23] For example, Walgreens experienced a 33 percent decrease between 2015 and 2024 in gross margins per 30-day prescription. Additionally, non-prescription drug purchases, which can bolster margins, also decreased seven percent. This drop in gross margins is a direct result of PBM and payer reimbursement rates becoming increasingly tighter.[23] As a result, it has become increasingly difficult to run a financially successful pharmacy. For more information on drug pricing and PBMs, please reference CMS Report 5-A-19: The Impact of Pharmacy Benefit Managers on Patients and Physicians; CMS Report 4-I-19: Additional Mechanisms to Address High and Escalating Pharmaceutical Prices; CMS Report 6-A-25: Prescription Medication Price Negotiation; and CMS Report 6-A-24: Economics of Prescription Medication Prior Authorization.

POTENTIAL SOLUTIONS

Pharmacy-Based Solutions

There are a number of potential pharmacy-based solutions that could work towards improving pharmacy access and, since no solution will independently fix the entirety of the problem, it is important to explore them together. One such potential solution, particularly in existing pharmacy deserts, is the expansion of telepharmacy, which generally consists of a remote pharmacist providing traditional services, such as prescription review, prescription verification, and patient consultation, via the internet.[26] Individuals who do not have convenient access to a pharmacy or may not be able to travel to a pharmacy could benefit most from telepharmacy services. In practice, telepharmacy has shown promise in addressing access issues and reducing operating costs, as they operate with increased efficiency.[27] This has

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shown improved patient outcomes and medication adherence while reducing unnecessary medical visits and hospitalizations.[28]

To better address the needs for more emergent prescriptions, some settings have begun to implement remote dispensing. This type of dispensing is often included as a method of telepharmacy but is unique in that there is an immediacy in dispensing.[29] In remote dispensing set ups, a pharmacist at a central location will supervise dispensing at a number of remote sites. Patients have the ability to speak with the pharmacist to verify the prescription, review drug utilization, and complete any necessary drug counseling. Pharmacy technicians will typically be on-site and manage the physical portions of dispensing. This means that patients have access to medications immediately, which can be crucial if a patient has acute care needs.[29] Some providers or payers have even recently begun to implement prescription kiosks or "drug vending machines," that are enabled by remote dispensing.[30,31] These kiosks allow clinicians to send prescriptions for shelf-stable medications for both acute and chronic care needs and, upon dispensing, patients have the ability to engage pharmacists via videoconferencing built into the kiosk.[30,31]

Further, mail order pharmacy services are another potential part of the solution. While similar to telepharmacy and remote dispensing, mail order pharmacy services do not always entail real-time interaction between the patient and pharmacists.[32] These services are typically operated through a patient's PBM and mail prescriptions directly to the patient's home. While there can be variety in medications provided, the vast majority of mail order prescriptions are sent as a 90-day supply, thus making this method of delivery most appropriate for well-managed chronic conditions and/or maintenance medications and not as useful for acute prescription needs, like an antibiotic.[32]

While there are clear potential benefits to the expansion of telepharmacy, remote dispensing, and mail-order pharmacy services, there are also significant barriers. Communities that are more likely to be in a pharmacy desert are also less likely to have access to reliable broadband as there are significant disparities in access to broadband in rural communities and in majority Black and Hispanic neighborhoods.[33,34] Additionally, the necessary technological investment, both initially and ongoing, can be overwhelming for many pharmacies. Telepharmacy services require significant technological infrastructure and security which is complex and can be prohibitively expensive.[28] Of note, while not a required aspect, many of these solutions include an enhanced clinical role for pharmacists.[27] The AMA has long opposed scope of practice expansions that would allow pharmacists to practice medicine—which includes making a diagnosis or prescribing medications—without appropriate physician supervision.[35]

In both mail order and telepharmacy services, there can be issues with both communication and promptness of medication delivery. Specifically, a patient may not be able to fill some prescriptions via telepharmacy or mail order. If the pharmacies are not accurately communicating, the dispensing pharmacist may not have adequate information to do a full medication utilization review.[34,36] This could lead to missing patient education on potential drug interactions or adverse drug interactions that could have been prevented had full information been available.[34,36] Further, there can be complications with patients receiving the medication in a timely manner. Research shows that in a significant number of cases; patients have to wait several days between the telepharmacy consultation and receipt of the medication and mail order prescriptions typically take about a week to be delivered. This could be a significant issue if a patient needs medication to treat an acute condition. For example, patients prescribed antibiotics are often unable to wait days or a week for the prescription without significant consequences to their health. Likewise, delivery delays can impact medication adherence when chronic medications are delayed to the point where patients run out of their medications. Importantly, some newer delivery models are able to deliver medications in one to two days, so it is possible that this delivery window will continue to be reduced.[36] Pharmacists surveyed also voiced significant concern that not only could this delay result in incorrect medication usage, but medications could be damaged or inaccurate when delivered via mail or should a patient not have a secure location to receive mail. Further, this delivery method is significantly more complicated for medications that are temperature or light sensitive.[36] This could be partially addressed by the aforementioned medication kiosks that allow for immediate dispensing, but this would only be an option for shelf-stable medications. Due to these issues, telepharmacy and mail order pharmacy services may not be a safe or viable solution for situations when a drug has specific instructions and/or need to be accessed rapidly, but could serve communities struggling to access non-emergent pharmacy services.[34,36]

Legislative & Regulatory Solutions

At a minimum, pharmacies must be reimbursed in a manner that allows them to remain open and accessible in communities across the United States. It is essential that payers reimburse pharmacies in a manner that is fair and covers the actual costs of obtaining and dispensing the medication. Similar to physician practices that dispense

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medications, it is not possible for pharmacies to provide medications at a deficit and remain financially viable.[23] To ensure that reimbursement is fair and equitable, it will be important to address the role of PBMs and vertical integration between payers, PBMs, and pharmacies/pharmacy chains. While the dissolution of existing integration is exceptionally challenging, it may be beneficial to work towards the prevention of further integration. A January 2026 Congressional hearing highlighted the importance of this issue and came with assurances from Congress that oversight on this issue would continue. The Consolidated Appropriations Act of 2026, signed into law in early February 2026, includes provisions that will work to regulate PBMs and promote a more sustainable environment for pharmacies.[37] Further, at the end of January 2026, the Department of Labor proposed a new rule that would require increased transparency in PBM practices. Specifically, the new rule, if implemented, would require that PBMs disclose rebates and payments from drug manufacturers, any compensation received when the drug cost paid by the insurer exceeds the pharmacy reimbursement, and any payments recouped from pharmacies connected to drugs dispensed in the PBM managed plan.[38] Along with this rule, a February 2026 Federal Trade Commission (FTC) settlement with vertically integrated PBMs, demonstrated additional commitments to not only transparency, but also providing more reasonable reimbursement to pharmacies.

While PBM regulation is essential to improving pharmacy reimbursement, and as a result improving pharmacy access, some states have begun to implement innovative new payment methods. For example, in 2022, Ohio Medicaid worked to revamp the system all together. After an investigation showed that two major PBMs charged patients $224 million more than they paid the pharmacies, the state ended its working relationship between Medicaid and multiple PBMs.[39] Instead, Ohio Medicaid contracted its own PBM, Ohio Medicaid's Single Pharmacy Benefit Manager (SPBM).[40] As a part of this program the state mandates dispensing fees based on surveys sent to pharmacists that are designed to determine the actual cost of dispensing and ensure reimbursement covers the full cost. Additionally, the implementation of the Ohio SPBM has allowed the state to better oversee the PBM and prevent untoward business practices that may occur.[39,40] In the first two years of its implementation, the SPBM overhaul has boosted pharmacy dispensing fees by over 1,200 percent and has reportedly saved $140 million.[41] While this model does seem to hold promise, it has not been without opposition. PBMs and associated groups have tied up many of the most promising aspects of the Ohio legislation and regulation in extensive legal battles that were ongoing at the time this report was written. Further, some state legislators and regulators have called the initial results of this program into question and voiced potential concern with data privacy in the SPBM.[41,42] Additionally, the feasibility to implement a similar program on a national level is complicated by the fact that Medicaid programs vary greatly between states.[42] Further, implementation in the Medicare or commercial markets would likely face significantly greater legal challenges. While the SPBM as implemented in Ohio may not be the perfect solution, most agree that it has seemed to make significant improvements and should be considered as a model option.[42] Other states have begun to implement legislation that works to mitigate some of the issues that are faced by pharmacies. For example, Alabama SB 252 increased Medicaid reimbursement rates and set a standard per-prescription dispensing fee. Further, Illinois HB 1697 and California SB 41 work to eliminate spread pricing and practices designed to steer patients towards PBM affiliated pharmacies.

Incentive Based Solutions

In addition to regulatory or legislative solutions, some states have worked to provide pharmacies serving underserved communities with monetary support via grants. For example, Illinois offers the Pharmacy Support Program to pharmacies serving underserved areas in an effort to improve access to pharmacies and pharmacy services. Further, private organizations and associations have stepped in to provide support and funds for pharmacies operating in pharmacy deserts. For example, the National Community Pharmacists Association announced the Rural Pharmacy Ownership Accelerator, which is a program designed to prepare pharmacy owners to open and operate pharmacies in rural areas.[43] The American Pharmacist Association has offered a variety of grants that have, among other things, offered seed money for pharmacists to open or expand practice in underserved communities.[44] Additionally, some PBMs have begun to offer programs to support independent pharmacies operating in underserved areas. For example, the Sustaining Pharmacy Access and Rural Care (SPARC) Program was recently launched by LucyRx, an independent PBM that boasts increased transparency from competitors. The SPARC program works to increase reimbursement rates, expand community services, and advocate for legislative reforms.[45] While this program could be beneficial for pharmacies in that it provides enhanced reimbursement rates, core tenants of the program work to expand pharmacist scope of practice to both prescribe and to provide preventive care. Although these tenants of the program conflict with AMA policy, the program's increased reimbursement to independent pharmacies serving underserved communities demonstrates a potential solution coming from the private sector.[45]

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It also may be advantageous to implement incentive programs to support pharmacies in pharmacy deserts. Similar to programs designed to attract physicians to practice in medically underserved communities, these programs could provide some kind of supplemental payment for pharmacies operating in these areas.[2] While this would require a substantial investment from state and/or federal governments, it could be transformative for pharmacies serving these communities. Grants or programs that provide financial support have the potential to assist pharmacies in remaining open, however it is important to qualify that these types of solutions will not remedy the issue in the long-term.

Across all potential solutions, it is important to remember that no single solution will be successful in isolation. To make significant improvements in pharmacy access, it will be essential to ensure that solutions are designed and implemented holistically and in tandem. Additionally, it is important to ensure that pharmacy and pharmacist organizations and associations lead efforts to improve pharmacy access. While the AMA should continue to offer support, these organizations are experts in pharmacy and pharmacy practice and AMA efforts should be integrated with their solutions.

AMA POLICY AND ADVOCACY

To support alternative dispensing methods, Policy H-120.989 outlines AMA support for mail service pharmacies as a legitimate alternative and outlines the criteria that should be met to ensure that these pharmacies remain beneficial for patients. Policy H-120.936 supports the establishment of national guidelines that work towards safe and timely delivery of medications via the mail. Policy H-120.962 expands these guidelines to ensure that mail order pharmacies remain accessible and affordable for patients and do not charge egregious additional fees. Policy H-120.940 ensures that mail order and online pharmacies adequately communicate with electronic prescribing systems and do not interfere with physician prescribing. Additionally, Policy H-120.956 focuses on internet prescribing and outlines not only efforts to ensure that these platforms are accessible to physicians and advantageous to patients but also to support appropriate pharmaceutical bodies in accreditation.

In addition to mail and internet-based pharmacies, the AMA has extensive policy to ensure that patients have access to the medications prescribed by their physician without interference from payers or PBMs. Policies H-110.991, H-110.990, and H-110.959 are all designed to ensure that patients have timely and affordable access to the medications as prescribed by their physician. Policy H-120.943 outlines AMA efforts to ensure that patients have access not only to affordable medications, but also quantities that are adequate and do not face arbitrary limits. To combat harmful PBM practices, Policies D-120.988, H-120.924, and H-110.963 limit PBM and payer intrusion in prescription access, increase transparency, and hold these bodies accountable should patient harm occur. Policy H-125.986 outlines the importance of ensuring that payment for prescriptions is adequate to cover the full cost of prescription medications for both pharmacies and physicians/physician practices. Policy D-160.920 outlines efforts to track and work against the vertical integration between payers, PBMs, and pharmacies. This policy outlines efforts to communicate concerns and advocate for change with federal and state legislators and regulators. To further combat poor PBM practices, Policy H-110.957 outlines AMA opposition to spread pricing and discusses efforts to prohibit it on a federal and state level. Policy D-110.987 focuses on efforts to increase transparency in PBM practices, specifically in relation to patient impact and pharmacy payment. To support the aforementioned policies, the AMA also advocates for improved medication access and against PBM harms via the grassroots site TruthinRx. This campaign works to educate and influence patients, physicians, and legislators about harmful payer and PBM practices/policies. Additionally, efforts have been made at the state and federal levels to advocate for legislation to limit PBM and payer harmful practices. The AMA supported these federal PBM reforms as well as the health policy wins included in the Consolidated Appropriations Act of 2026.

Finally, the AMA has policies designed to ensure that pharmacists do not practice beyond the scope of their training. Policy H-35.961 outlines the inappropriateness of pharmacists working to verify the medical rationale or diagnosis behind a treatment/prescription. Policy D-35.987 outlines AMA efforts to monitor and oppose pharmacist scope of practice expansions that constitute the practice of medicine, for which pharmacists are not trained. To further combat these scope expansions, the AMA Advocacy Resource Center has worked to block and mitigate a significant number of bills in states across the country.

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DISCUSSION

Pharmacy access is key to ensuring patients have access to the full spectrum of health care. However, across the country millions of Americans are living in areas deemed pharmacy deserts or areas served only by a keystone pharmacy. This can have significant downstream impacts on patient health outcomes and introduce stress on the health care system as a whole. When patients are unable to fill their medications, they are unable to adhere to treatment plans prescribed by their physician. As a result, patients have increased risk of poor health outcomes and are more likely to experience increases in the severity or onset of new health issues. Pharmacies are closing at a rapid rate, an issue that is even more severe in rural areas and communities of color. Individuals living in majority-minority communities are more likely to rely on independent pharmacies, which are closing in these communities. Although there are some promising numbers in terms of how many pharmacies, especially independent pharmacies, are opening these new businesses tend not to open in underserved areas.

Pharmacy access is adversely impacted due to a combination of poor reimbursement rates, PBM interference, and increasingly stringent preferred pharmacy networks. Pharmacies, even those that are a part of a large chain, have seen significant drops in gross revenue over the last several years. Even though pharmacy volume may be increasing, the rates of reimbursement are so low that the gross revenue continues to decrease. While this trend is seen in large pharmacy chains, it is even more significant for smaller and independent pharmacies. These pharmacies lack the market power to be able to negotiate reimbursement rates and are often excluded from preferred pharmacy networks. As a result, prices are higher for patients and pharmacy margins are shrinking. To combat these issues, the Council recommends the adoption of two new policies. First, the Council recommends policy that supports efforts to ensure pharmacy reimbursement across payer types covers the actual cost of obtaining and dispensing each prescription. Second, the Council recommends that policy be adopted to ensure preferred in-person pharmacy network adequacy. In line with existing network adequacy policy, this policy would work to ensure that a minimum preferred network standard be enforced across payers and bolster independent pharmacy inclusion when possible. In conjunction, these two policies could work to support existing pharmacies in continuing ongoing operations.

In an effort to improve pharmacy access, innovative alternative delivery and practice methods, and legislative and regulatory changes have been implemented or proposed. These dispensing methods allow patients to have access to a pharmacist via telecommunication and receive their medication either by mail or in-person. Some health systems have even begun to implement these practices in kiosk or “vending machine” form for shelf stable medications. These practices build on existing mail order dispensing where patients are sent drugs, typically maintenance medications, via the mail. Although these methods are promising, there is some concern with pharmacy communication, medication management, and prescription accuracy. However, with appropriate guardrails, the Council believes that these dispensing methods could work in conjunction with other strategies to decrease the number of pharmacy deserts. Accordingly, the Council recommends the adoption of new policy that recognizes these dispensing methods, supports their coverage, and outlines appropriate guardrails. These guidelines ensure that pharmacists practice in their defined scope, medications are delivered timely, accurately, and without major cost increases, and that existing community pharmacies are not displaced. Further, the Council recommends the reaffirmation of Policy H-120.989, which outlines appropriate guidelines for mail order pharmacies and recognizes their legitimacy as a component to improving pharmacy access.

In addition to alternative dispensing methods, governmental and non-governmental organizations have implemented changes and made investments to support improvements to pharmacy access. States have taken the opportunity to implement regulatory and legislative changes dictating fairer reimbursement rates, dispensing fees that cover actual costs, and the reining in of PBMs. The federal government has introduced legislation and regulations that target PBMs in an effort to promote their transparency. Some states along with private organizations and associations have also stepped in to provide grants and support to pharmacists operating pharmacies in deserts. To support these, and future innovative efforts, the Council recommends the adoption of new policy that not only encourages innovation, but also the associated regulatory changes necessary to implement them. To limit anticompetitive practice by PBMs or payers, the Council recommends the adoption of new policy that supports fair market competition in order to support the financial health of full-service independent/community pharmacies. Finally, to further address PBM interference, the Council recommends the reaffirmation of Policy D-110.987, which outlines AMA efforts to advocate for active regulation of PBMs, with a particular focus on increasing transparency and regulation.

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RECOMMENDATIONS

The Council on Medical Service recommends that the following recommendations be adopted in lieu of Resolution 113-A-25, and the remainder of the report be filed:

1. Our American Medical Association (AMA) supports efforts to ensure that pharmacy reimbursement by all payers covers the actual cost of obtaining and dispensing the medication, including necessary staffing and operational costs with sufficient margin to ensure pharmacy viability.
2. Our AMA supports the establishment and enforcement of a minimum preferred pharmacy network adequacy standard requiring all health plans to contract with sufficient numbers of pharmacies, including, independent and/or physician-owned pharmacies, such that patient medications or medical products are accessible without unreasonable travel or delay.
3. Our AMA recognizes telepharmacy and remote dispensing as avenues to improve access to prescription medications and supports their expansion and encourages payer coverage when the following criteria are met:
    a. Services are provided by pharmacists within a clearly defined scope of practice that does not constitute the practice of medicine without appropriate physician supervision.
    b. Medications are delivered to patients accurately and in a timely manner.
    c. Communication between pharmacy systems is maintained to ensure an accurate medication list so that patients are educated on all their medications with key safety information.
    d. Patients are not subjected to increased cost-sharing or major shipping and handling fees to receive their medications.
    e. Existing community pharmacies are not displaced.
    f. Patients and physicians are able to opt out of telepharmacy and remote dispensing.
4. Our AMA supports the development of innovative programs designed to improve access to pharmacies and the appropriate regulatory changes to allow for these programs to be implemented while ensuring high-quality, physician-led care in alignment with AMA policy.
5. Our AMA supports practices by payers/insurers or pharmacy benefit managers (PBMs) that promote fair market competition, patient access and choice of pharmacy, and supports the financial viability of full-service independent/community pharmacies.
6. That our AMA reaffirm Policy H-120.989, which recognizes mail order pharmacy services as legitimate method for drug distribution and outlines its appropriate use.
7. That our AMA reaffirm Policy D-110.987, which outlines AMA advocacy and support for PBM regulation.

Fiscal Note: Minimal

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Council on Medical Service Report 3-A-26
Improving Patient Access to Pharmacies and Medications in Pharmacy Deserts
Policy Appendix

Mail Service Pharmacy H-120.989

1. Our American Medical Association (AMA) believes that MSP is an established alternative method of distributing drugs in the United States.
2. Our AMA believes that controlled studies in the 1970s support the fact that MSPs are less vulnerable to drug diversion than retail pharmacies. Although numerous concerns about lack of safety and drug diversion have been expressed in trade publications and newsletters, documented controlled data regarding these concerns are minimal. There is no evidence of lack of safety in the peer-reviewed controlled-study literature. Presently, the practice of obtaining drugs from mail service pharmacies appears to be relatively safe.
3. Our AMA believes that mail service pharmacy for prescription drugs is probably most appropriate for patients who have a well-established diagnosis, who have long-term chronic illnesses, whose disease is relatively stable and in whom the dose and dosage schedule is well regulated, who are isolated because of geographic or personal reasons, who have a drug history profile on record, who have been adequately informed about their medication, and who continue to see their physician regularly. Certainly, MSP is not best utilized for medications that are to be used acutely. Further, there must be assurance that generic substitution occur only by order of the prescribing physician.
4. Our AMA believes that any purported price savings from the use of MSP is difficult to assess, since studies are generally limited to regional and limited patient populations.
5. Our AMA believes that physicians have the responsibility to prescribe reasonable amounts of prescription medications based on the diagnosis and needs of their patients. Physicians must not be influenced by purely economic reasons, but they must take into account the patient's ability to pay and be aware of the guidelines recommended by particular health benefit programs for drugs.
(BOT Rep. I, I-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CSAPH Rep. 3, A-07; Reaffirmed: BOT Rep. 8, A-11; Reaffirmed: CSAPH Rep. 1, A-21)

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Improve Safety of Mail-Ordered Medication H-120.936
Our American Medical Association supports the establishment of national guidelines for mail-order pharmacies to ensure that medications reach patients in a safe and timely manner with full potency, and that when medication is damaged or loses potency during shipment, it should be replaced by the pharmacy at no cost to the patient. (Res. 917, I-14; Reaffirmed: CSAPH Rep. 01, I-24)

National Mail Order Pharmacy Practices H-120.962
1. Our American Medical Association insists that mail-order pharmacy companies respect the prescribing authority of physicians and dispense prescription medications only in the amounts prescribed; and recommends that mail order pharmacy companies charge only a reasonable and small shipping and handling fee per shipment in order not to encourage patients to request amounts of medications greater than those warranted by their physician's best judgment.
2. Our AMA opposes charging patients more than one co-pay for multiple prescriptions of the same or varying doses of a long-term medication within a 90-day period when evidence-based medicine dictates that less than 90-day prescriptions should be written during the initialization and dose stabilization of a newly prescribed long-term medication or during change in dosing of a long-term medication currently being taken. (Sub. Res. 506, I-96; Reaffirmed: CSAPH Rep. 3, A-06; Appended: Res. 121, A-07; Reaffirmed: BOT Rep. 8, A-11; Reaffirmation A-14; Modified: CSAPH Rep. 01, A-24)

Mail Order Pharmacies and Interface with Current Pharmacy Hubs H-120.940
1. Our American Medical Association (AMA) will work with mail order pharmacies to make sure that such pharmacies adopt interfaces with current pharmacy hubs and physician electronic prescribing systems at no cost to physicians.
2. Our AMA will advocate for penalties and/or incentives for mail order pharmacies to encourage the adoption of a functional system to automate the prescribing process through interfaces with physicians electronic prescribing systems. (Res. 708, A-10; Reaffirmed: BOT Rep. 8, A-11; Reaffirmed: CSAPH Rep. 1, A-21)

Internet Prescribing H-120.956
1. Our AMA supports the use of the Internet as a mechanism to prescribe medications with appropriate safeguards to ensure that the standards for high quality medical care are fulfilled.
2. Our AMA will work with state medical societies in urging state medical boards to ensure high quality medical care by investigating and, when appropriate, taking necessary action against physicians who fail to meet the local standards of medical care when issuing prescriptions through Internet web sites that dispense prescription medications.
3. Our AMA will work with the Federation of State Medical Boards and others in endorsing or developing model state legislation to establish limitations on Internet prescribing.
4. Our AMA will continue to work with the National Association of Boards of Pharmacy and support their digital pharmacy accreditation program so that physicians and patients can easily identify legitimate Internet pharmacy practice sites.
5. Our AMA will work with federal and state regulatory bodies to close down Internet web sites of companies that are illegally promoting and distributing (selling) prescription drug products in the United States.
6. Our AMA will keep pace with changes in technology by continually updating standards of practice on the Internet. (BOT Rep. 35, A-99; Reaffirmed: BOT Rep. 3, I-04; Reaffirmed: Sub. Res. 522, A-05; Modified: CSAPH Rep. 1, A-15; Modified: CSAPH Rep. 01, A-25)

Price of Medicine H-110.991
Our AMA: (1) advocates that pharmacies be required to list the full retail price of the prescription on the receipt along with the co-pay that is required in order to better inform our patients of the price of their medications; (2) will pursue legislation requiring pharmacies, pharmacy benefit managers and health plans to inform patients of the actual cash price as well as the formulary price of any medication prior to the purchase of the medication; (3) opposes provisions in pharmacies' contracts with pharmacy benefit managers that prohibit pharmacists from disclosing that a patient's co-pay is higher than the drug's cash price; (4) will disseminate model state legislation to promote drug price and cost transparency and to prohibit "claw backs"; (5) supports physician education regarding drug price and cost transparency, manufacturers' pricing practices, and challenges patients may encounter at the pharmacy point-of-sale; and (6) work with relevant organizations to advocate for increased transparency through access to meaningful and relevant information about medication price and out-of-pocket costs for prescription medications sold at both retail and mail order/online pharmacies, including but not limited to Medicare's drug-pricing dashboard.

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(CMS Rep. 6, A-03; Appended: Res. 107, A-07; Reaffirmed in lieu of: Res. 207, A-17; Appended: Alt. Res. 806, I-17; Reaffirmed: BOT Rep. 14, A-18; Appended: CMS Rep. 07, A-18; Reaffirmation: A-19; Appended: Res. 126, A-19)

Cost Sharing Arrangements for Prescription Drugs H-110.990
Our AMA:
1. believes that cost-sharing arrangements for prescription drugs should be designed to encourage the judicious use of health care resources, rather than simply shifting costs to patients;
2. believes that cost-sharing requirements should be based on considerations such as: unit cost of medication; availability of therapeutic alternatives; medical condition being treated; personal income; and other factors known to affect patient compliance and health outcomes;
3. supports the development and use of tools and technology that enable physicians and patients to determine the actual price and patient-specific out-of-pocket costs of individual prescription drugs, taking into account insurance status or payer type, prior to making prescribing decisions, so that physicians and patients can work together to determine the most efficient and effective treatment for the patient's medical condition;
4. supports public and private prescription drug plans in offering patient-friendly tools and technology that allow patients to directly and securely access their individualized prescription benefit and prescription drug cost information; and
5. believes payers should not establish a higher cost-sharing requirement exclusively for prescription drugs approved for coverage under a medical exceptions process. (CMS Rep. 1, I-07; Reaffirmation A-08; Reaffirmed: CMS Rep. 1, I-12; Reaffirmed in lieu of Res. 105, A-13; Reaffirmed in lieu of: Res. 205, A-17; Reaffirmed in lieu of: Res. 207, A-17; Reaffirmed: CMS Rep. 07, A-18; Appended: CMS Rep. 2, I-21; Reaffirmed: Res. 113, A-23; Appended: CMS Rep. 01, A-23)

Prescription Medication Price Negotiation H-110.959
1. Our AMA supports efforts to ensure that patients have affordable access to medications.
2. Our AMA encourages all payers, both public and private, in efforts to establish a reasonable and affordable cap on patient out-of-pocket prescription drug spending in a manner that does not increase patient premiums.
3. Our AMA opposes drug payment methodologies that result in physician practices being paid at less than the cost of acquisition, inventory, storage, and administration of relevant drugs and other necessary related clinical services. (CMS Rep. 06, A-25)

Adequate Prescription Medication Supply H-120.943
1. Our AMA urges health plans to: (a) define a month's supply as a minimum of 31 days and three month's supply as a minimum of 93 days, so that patients are not shorted on their one-month or three-month supply of prescription drugs; and (b) allow prescription refills to provide the appropriate number of doses for the time period specified by the physician.
2. Our AMA will advocate and support advocacy at the state and federal levels against arbitrary prescription limits that restrict access to medically necessary treatment by limiting the dose, amount or days of the first or subsequent prescription for patients with pain related to a cancer or terminal diagnosis. (Res. 510, A-07; Reaffirmed: CMS Rep. 04, A-16; Appended: Res. 918, I-16)

Inappropriate Actions by Pharmacies and Pharmacy Benefit Managers D-120.988
Our AMA, in cooperation with pharmacy benefit managers, pharmacy companies, and other drug retailing organizations, shall develop model procedures that physicians may use when prescribing off-formulary pharmaceuticals that are medically indicated and that these procedures be in compliance with the Health Insurance and Portability and Accountability Act of 1996. (Res. 528, A-02; Reaffirmation I-04; Reaffirmation A-06; Reaffirmed: CSAPH Rep. 01, A-16)

Evaluating Actions by Pharmacy Benefit Manager and Payer Policies on Patient Care H-120.924
Our AMA will: (1) urge the National Association of Boards of Pharmacy, Federation of State Medical Boards (FSMB), and National Association of Insurance Commissioners (NAIC) to support having national pharmacy chains, health insurance companies, and pharmacy benefits managers (PBMs) testify at state-level public hearings by state medical/pharmacy boards and state departments of insurance, on whether the pharmacy chains, health insurance companies, and PBMs' policies to restrict the prescribing/dispensing of opioid analgesics are in conflict with state insurance laws or state laws governing the practice of medicine and pharmacy; and (2) oppose specific dose or duration

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limits on pharmacologic therapy that are not supported by medical evidence and clinical practice. (BOT Rep. 17, A-18; Reaffirmed: 235, I-18)

Third-Party Pharmacy Benefit Administrators H-110.963
1. Our American Medical Association recommends that third-party pharmacy benefit administrators that contract to manage the specialty pharmacy portion of drug formularies be included in existing pharmacy benefit manager (PBM) regulatory frameworks and statutes, and be subject to the same licensing, registration, and transparency reporting requirements.
2. Our AMA will advocate that third-party pharmacy benefit administrators be included in future PBM oversight efforts at the state and federal levels. (Res. 820, I-22; Reaffirmed: CMS Rep. 06, A-24)

Pharmaceutical Benefits Management Companies H-125.986
Our AMA:
(1) encourages physicians to report to the Food and Drug Administration's (FDA) MedWatch reporting program any instances of adverse consequences (including therapeutic failures and adverse drug reactions) that have resulted from the switching of therapeutic alternates;
(2) encourages the Federal Trade Commission (FTC) and the FDA to continue monitoring the relationships between pharmaceutical manufacturers and PBMs, especially with regard to manufacturers' influences on PBM drug formularies and drug product switching programs, and to take enforcement actions as appropriate;
(3) pursues congressional action to end the inappropriate and unethical use of confidential patient information by pharmacy benefits management companies;
(4) states that certain actions/activities by pharmacy benefit managers and others constitute the practice of medicine without a license and interfere with appropriate medical care to our patients;
(5) encourages physicians to routinely review their patient's treatment regimens for appropriateness to ensure that they are based on sound science and represent safe and cost-effective medical care;
(6) supports efforts to ensure that reimbursement policies established by PBMs are based on medical need; these policies include, but are not limited to, prior authorization, formularies, and tiers for compounded medications; and
(7) encourages the FTC and FDA to monitor PBMs' policies for potential conflicts of interests and anti-trust violations, and to take appropriate enforcement actions should those policies advantage pharmacies in which the PBM holds an economic interest.
(BOT Rep. 9, I-97; Appended: Res. 224, I-98; Appended: Res. 529, A-02; Reaffirmed: Res. 533A-03; Reaffirmation I-08; Reaffirmation A-10; Reaffirmed: Alt. Res. 806, I-17; Modified: Res. 242, A-18; Reaffirmed: CMS Rep. 08, A-19; Reaffirmed: CMS Rep. 06, A-24)

Opposing Pharmacy Benefit Manager Spread Pricing H-110.957
1. Our AMA opposes the use of spread pricing by Pharmacy Benefit Managers (PBMs).
2. Our AMA will advocate for federal and state legislation and regulation that prohibits the use of spread pricing by PBMs.
3. Our AMA supports policies requiring PBMs to use transparent, pass-through pricing models that ensure fair and consistent reimbursement to pharmacies, physicians, and patients. (Res. 121, A-25)

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

Health Insurance Company Purchase by Pharmacy Chains D-160.920
Our AMA will: (1) continue to analyze and identify the ramifications of the proposed CVS/Aetna or other similar merger in health insurance, pharmacy benefit manager (PBM), and retail pharmacy markets and what effects that these ramifications may have on physician practices and on patient care; (2) continue to convene and activate its AMA-state medical association and national medical specialty society coalition to coordinate CVS/Aetna-related advocacy activity; (3) communicate our AMA's concerns via written statements and testimony (if applicable) to the U.S. Department of Justice (DOJ), state attorneys general and departments of insurance; (4) work to secure state level hearings on the merger; and (5) identify and work with national antitrust and other legal and industry experts and allies. (BOT Action in response to referred for decision Res. 234, I-17)

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Evaluation of the Expanding Scope of Pharmacists' Practice D-35.987

1. Our American Medical Association will re-evaluate the expanding scope of practice of pharmacists in America and develop additional policy to address the proposed new services provided by pharmacists that may constitute the practice of Medicine.
2. Our AMA will continue to collect and disseminate state specific information in collaboration with state medical societies regarding the current scope of practice for pharmacists in each state; studying if and how each state is addressing these expansions of practice.
3. Our AMA will develop model state legislation to address the expansion of pharmacist scope of practice that is found to be inappropriate or constitutes the practice of medicine, including but not limited to the issue of interpretations or usage of independent practice arrangements without appropriate physician supervision and work with interested states and specialties to advance such legislation.
4. Our AMA opposes federal and state legislation allowing pharmacists to independently prescribe or dispense prescription medication without a valid order by, or under the supervision of, a licensed doctor of medicine, osteopathy, dentistry or podiatry.
5. Our AMA opposes federal and state legislation allowing pharmacists to dispense medication beyond the expiration of the original prescription.
6. Our AMA opposes the inclusion of Doctors of Pharmacy (PharmD) among those health professionals designated as a "Physician" by the Centers for Medicare & Medicaid Services. (Res. 219, A-11; Appended: Res. 218, A-12; Reaffirmed: BOT Rep. 9, A-22)

4. EXPANDING MEDICARE COVERAGE OF MEDICAL NUTRITION THERAPY

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: RECOMMENDATIONS ADOPTED
REMAINDER OF REPORT FILED
See Policies H-150.910, H-160.906, H-385.905 and H-400.972

Resolution 116, "Medicare Coverage of Registered Dietician and Certified Nutrition Support Specialist Visits Beyond Type 2 Diabetes and Renal Disease," was introduced by the Senior Physicians Section at the 2025 Annual Meeting and was referred. It asks the following:

> RESOLVED, that our American Medical Association (AMA) support legislation for Medicare coverage for registered dietitian or certified nutrition support specialist visits referred by physicians for conditions such as obesity, pancreatic insufficiency, hyperlipidemia, irritable bowel syndrome, small intestinal bacterial overgrowth, gout, and allergies, recognizing that other significant chronic conditions can also benefit from tailored dietary interventions; and be it further;
>
> RESOLVED, that our AMA specify that payment for registered dietician or certified nutrition support specialist services should be made separately from Medicare physician services (i.e. outside the Medicare physician fee schedule) to avoid having a negative impact on the conversion factor that would impact payment for all physician services.

This report discusses the Medicare Physician Fee Schedule (MPFS), provides a summary of medical nutrition therapy (MNT) Medicare coverage, and includes several policy recommendations.

BACKGROUND

Since 1992, Medicare payment for physicians' services has been valued through the MPFS.[1] Payment rates are based on resources required to furnish services, which are assigned relative value units (RVUs) under the Resource-Based Relative Value Scale (RBRVS) considering three types of inputs: clinician work, practice expense, and professional liability insurance.[2] Annual updates to the MPFS include statutorily-required updates to the conversion factor under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).[3]

Under current law, the projected cost of all changes to the MPFS must be budget neutral and may not raise or lower total Medicare spending by more than $20 million per year.[4] Thus, the evaluated change of RVUs or the introduction

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of new services are accompanied by offsets to the fees for other services.[5,6] The budget neutrality requirement is a provision of the Social Security Act which dates to the founding of the RBRVS legislation and has not been updated since passage. The Centers for Medicare & Medicaid Services administers the statute's budget neutrality requirement with a percentage adjustment.[7] The actual payment rate for each service is determined by multiplying its value under the RBRVS by a conversion factor.[8] Budget neutrality adjustments are accomplished by raising or lowering that conversion factor. If new services or higher payments are added to the MPFS, an offsetting cut (a negative adjustment) must be made to other service payments to keep total spending balanced.[9] Beginning in 2026, there will be two separate conversion factors: one for qualifying alternative payment model (APM) participants (QPs) and one for physicians and practitioners who are not QPs.[10] QPs are those that meet thresholds for participation in an Advanced APM – features that ensure accountability for quality and cost of care.[11]

MEDICAL NUTRITION THERAPY

Medical nutrition therapy (MNT) is a form of treatment that utilizes nutrition education and behavioral counseling to prevent or manage a medical condition.[12] A Registered Dietitian Nutritionist (RDN), credentialed by the Commission on Dietetic Registration (CDR), collaborates with an individual and, in some cases, members of their medical team to identify health needs and personal goals. RDNs must hold at least a master's degree, complete an Accreditation Council for Education in Nutrition and Dietetics accredited program with specific coursework, and finish 1,000 hours of supervised practice in health care facilities, community agencies, or food service corporations. Additionally, an RDN must pass a national registration exam administered by the CDR. Further, many states require licensure to practice and ongoing professional development to maintain credentialling. The RDN can act as part of a medical team, in various practice settings, such as hospitals, physician offices, private practice and other health care facilities. An RDN can build a nutrition plan that maximizes micro- and macronutrient intake while optimizing health status.[13,14,15,16] MNT typically has four steps: nutrition assessment, nutrition diagnosis, plan, and monitoring and evaluation.[17] The tailored personalized nutrition plan includes: 1) dietary changes, 2) education, 3) supplements, and 4) advanced nutrition support which includes, in severe cases, tube feeding (enteral) or intravenous nutrition (parenteral). MNT also comes in two types – standard MNT and diabetic self-management training – which may be offered either alone or together. For patients with diabetes, MNT is usually most effective when the practitioner delivers both types together.

MNT can provide significant benefits by offering personalized nutrition plans to improve chronic disease management (e.g., diabetes, heart disease, obesity, kidney disease, cancer), reduce symptoms, lower health risks, improve lab markers (e.g., blood sugar, lipids, blood pressure), boost energy, support weight management, and decrease overall health care costs by reducing hospitalization and medications.[18] MNT can also nourish a patient's body when the digestive system is not working effectively or efficiently. MNT can help a patient learn ways to build physical activity into their daily routine, take an active role in their health care, and overcome barriers to nutritious eating. Twenty-five systematic reviews published between 2017 and 2024 indicate that MNT is likely effective in improving a range of health outcomes in adults with pre-diabetes, type 1 diabetes, type 2 diabetes, obesity, pre-hypertension, hypertension, dyslipidemia, chronic kidney disease, head and neck cancer, and chronic obstructive pulmonary disease compared with no MNT or standard care.[19]

Current systematic reviews demonstrate that MNT interventions provided by RDNs may be clinically effective for adults with overweight or obesity, malnutrition , and chronic obstructive pulmonary disease.[20] Additionally, in a pooled analysis, MNT interventions lowered low-density lipoprotein cholesterol, total C, triglycerides, fasting blood glucose, hemoglobin A1c, and body mass index (BMI) compared to a control group.[21] Cost effectiveness and economic savings of MNT for dyslipidemia showed improved quality-adjusted life years and cost savings from reduced medication use.[22] It was concluded that multiple MNT sessions by an RDN are clinically effective and cost beneficial in patients with dyslipidemia and cardiometabolic risk factors.[23]

While there are benefits to MNT, there are also potential disadvantages. For instance, MNT is a time burden with high drop-out rates for patients engaging in therapy.[24] Relatedly, while telehealth has grown in use overall, face-to-face visits tend to be the most widely used mode of service for MNT and can pose a burden for patients, RDNs, and clinical operations.[25] Furthermore, though nurses, community health workers, and primary care physicians can play a significant role in the nutritional counseling of patients, it is not always the case that they are involved. In many states, MNT can be provided without the supervision or order (prescription) of a physician, making it difficult for patients to receive integrated care.

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There are also broader concerns about access to effective, safe, and integrated MNT. Currently, there is only consistent insurance coverage for nutrition care for adults with type 2 diabetes and chronic kidney disease in outpatient settings.[26] Though evidence indicates that MNT can improve outcomes, practitioners may hesitate to refer clients due to high out-of-pocket costs. The lack of coverage for MNT may be a detriment to clients with lower incomes who may have more health issues, but who are less likely to be able to afford nutrition care.[27] Shortages of health care workers, including RDNs, are also a widespread concern, particularly in areas that are rural or lack sufficient resources.[28] Additionally, a lack of appropriate coverage for services may lead hospitals to have too few RDNs on staff, leading to more patients being served per RDN and less effective care as a result.

MEDICARE COVERAGE OF MEDICAL NUTRITION THERAPY

Medicare covers MNT for patients who meet certain eligibility criteria, such as those with diabetes, kidney disease, and post-36 months after a kidney transplant.[29] Services included are nutrition assessments, therapy, counseling, and follow-up visits.[30] Medicare does not provide coverage for MNT for patients with pancreatic insufficiency, hyperlipidemia, irritable bowel syndrome, small intestinal bacterial overgrowth, gout, and allergies. However, Medicare provides coverage for medically necessary diagnosis and treatment, which can include physician visits, diagnostic tests, screenings, prescription medications, and procedures for each of the outlined conditions. While Medicare does not cover MNT for patients with obesity, it does cover obesity screenings and behavioral counseling for those with a BMI of thirty or greater.[31] Medicare covers behavioral therapy if a primary care physician or other primary care practitioner provides the counseling in a primary care setting, where personalized prevention plans can be coordinated with other care. Intensive Behavioral Therapy (IBT) is a structured counseling program, primarily for obesity, that uses behavioral techniques (e.g., cognitive behavioral therapy, goal setting, dietary advice) with a health care provider (e.g., physician, dietitian, therapist) to promote lasting weight loss through diet, exercise, and mindset changes.[32] IBT focuses on changing habits and thoughts around food and activity, offering support and strategies for healthier lifestyles.[33] Studies surrounding IBT have been shown to be effective in inducing a 10 percent weight loss, which is sufficient to significantly improve health. While weight loss maintenance was shown to be difficult for most participants, long-term outcomes have the potential to be improved through various methods, including prolonging contact between patients and providers or combining lifestyle modification with pharmacotherapy.[34]

As previously discussed, the projected cost of all changes to the MPFS must be budget neutral and may not raise or lower total Medicare spending by more than $20 million per year. Therefore, additional coverage of MNT for patients with the conditions listed above would necessitate offsets to the fees for other services. Furthermore, paying for additional coverage for Medicare beneficiaries outside the MPFS may not be advisable as it could create access challenges for Medicare beneficiaries, disrupt coordination in team-based and value-based care models, and introduce uncertainty around payment authorization, valuation, and operational implementation. Finally, paying for these services outside of the MPFS could set a precedent affecting other non-physician providers currently paid through the MPFS.

AMA ADVOCACY & RESOURCES

In statements to the U.S. Senate Committee on Health, Education, Labor and Pensions, Subcommittee on Primary Health & Retirement Security, and the U.S. House of Representatives Committee on Ways and Means, Subcommittee on Health, the AMA expressed support for expanded coverage and access to intensive behavioral and nutritional interventions including MNT. In these statements, the AMA urged Congress to expand Medicare coverage for MNT to include additional diet-related health conditions beyond diabetes and renal disease. In a 2021 letter to the Centers for Medicare & Medicaid Services on the 2022 MPFS rule, the AMA commented on the importance of requiring registered dieticians and nutritional professionals to report back to the physician at the onset of the therapy and periodically during the course of treatment.

AMA POLICY

Policy D-440-954 broadly outlines the role that the AMA will take in the study, prevention, and treatment of obesity, which includes increasing public insurance of and payment for the full spectrum evidence-based adult and pediatric obesity treatment, working with national medical specialty societies and state medical associations to address out-of-date restrictions prohibiting physicians from treating obesity, and advocating for patient access to and physician payment for the full continuum of evidence-based obesity treatment modalities (such as behavioral, pharmaceutical, psychosocial, nutritional, and surgical interventions).

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Policy H-150.953 urges physicians and managed care organizations and other third-party payers to recognize obesity as a complex disorder and all payers to ensure coverage parity for evidence-based treatment of obesity, including FDA-approved medications without exclusions or additional carve-outs.
Policy H-390.849 states that the AMA will advocate for the development and adoption of physician payment reforms that adhere to its outlined principles, opposes bundling of payments in ways that limit medically necessary care, and supports payment methodologies that redistribute Medicare payments among providers based on outcomes. Additionally, Policy H-390.849 highlights that the AMA will continue to monitor health care delivery and physician payment reform activities and provide resources to help physicians understand and participate in these initiatives.

Policy H-385.905 supports legislation that ensures Medicare physician payment is sufficient to safeguard beneficiary access to care, replaces or supplements budget neutrality in MIPS with incentive payments, or implements positive annual physician payment updates.

Policy H-400.972 broadly outlines the AMA policy on and recommended principles guiding Medicare physician payment reform.

Policy H-160.906 defines the role that physicians should have within team-based health care as well as guidelines and a model in the development of physician-led team-based health care.

DISCUSSION

The Council acknowledges the value of visits with and treatment from an RDN, especially for patients who are aging or those who have chronic health conditions. At the same time, the Council understands the scope of practice concerns surrounding MNT and the central role that physicians must play in such treatments. Accordingly, the Council supports the use of MNT – delivered by a RDN, as defined in §1861(v)(2) of the Social Security Act and credentialed by the CDR and in ongoing collaboration with the patient's physician. Furthermore, while the Council supports expanded coverage for these services, it should be accompanied by physician oversight of care teams consistent with Policy H-160.906, which defines the role that physicians have within team-based health care and provides guidelines and a model in the development of physician-led team-based health care.

On balance, and consistent with previous AMA statements and advocacy efforts, the Council supports expansion of Medicare coverage and access to intensive behavioral and nutritional interventions including medical nutrition therapy for diet-related health conditions exempted from budget neutrality. The Council recognizes that expansion of nutritional services impacts the MFPS but believes the value of this therapy warrants its inclusion. At the same time, the Council acknowledges the negative impacts of budget neutrality on payment and encourages reform of the MFPS to eliminate this effect. As outlined in the AMA Medicare Basics Series, the threshold required by budget neutrality unfairly restricts payment for physicians as well as access to care for patients. Therefore, the Council recommends reaffirming Policy H-385.905, which supports legislation that ensures Medicare physician payment is sufficient to safeguard beneficiary access to care, replacing or supplement budget neutrality in the Merit-based Incentive Payment System (MIPS) with incentive payments, or implementing positive annual payment updates. We also acknowledge that broader reform of the MPFS is important and, as such, recommend reaffirming Policy H-400.972, which outlines the AMA policy on and recommended principles guiding Medicare physician payment reform.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 116-A-25 and the remainder of the report be filed:

1. That our American Medical Association (AMA) recognize the benefits and support the use of medical nutrition therapy (MNT) – delivered by a Registered Dietitian Nutritionist, as defined in §1861(v)(2) of the Social Security Act and credentialed by the Commission on Dietetic Registration and in ongoing support with the patient's physician – for the purpose of managing and treating chronic health conditions for which there is evidence of efficacy.
2. That our AMA support the expansion of Medicare coverage and exemption from budget neutrality for evidence-based intensive behavioral and nutritional interventions, including medical nutrition therapy(MNT).
3. That our AMA reaffirm Policy H-160.906, which defines the role that physicians should have within team-based health care as well as guidelines and a model in the development of physician-led team-based health care.

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4. That our AMA reaffirm Policy H-385.905, which supports legislation that ensures Medicare physician payment is sufficient to safeguard beneficiary access to care, replaces or supplements budget neutrality in Merit-based Incentive Payment System with incentive payments, or implements positive annual physician payment updates.
5. That our AMA reaffirm Policy H-400.972, which outlines the AMA policy on and recommended principles guiding Medicare physician payment reform.

Fiscal Note: Minimal

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Council on Medical Service Report 4-A-26
Expanding Medicare Access to Medical Nutrition Therapy (MNT)
Policy Appendix

Obesity as a Major Public Health Problem H-150.953

1. Our American Medical Association (AMA) will urge physicians as well as managed care organizations and other third-party payers to recognize obesity as a complex disorder involving appetite regulation and energy metabolism that is associated with a variety of comorbid conditions.
2. Our AMA will work with appropriate federal agencies, medical specialty societies, and public health organizations to educate physicians about the prevention and management of overweight and obesity in children and adults, including education in basic principles and practices of physical activity and nutrition counseling; such training should be included in undergraduate and graduate medical education and through accredited continuing medical education programs.
3. Our AMA will urge federal support of research to determine:
    a. the causes and mechanisms of overweight and obesity, including biological, social, and epidemiological influences on weight gain, weight loss, and weight maintenance;
    b. the long-term safety and efficacy of voluntary weight maintenance and weight loss practices and therapies, including surgery;
    c. effective interventions to prevent obesity in children and adults; and
    d. the effectiveness of weight loss counseling by physicians.
4. Our AMA will encourage national efforts to educate the public about the health risks of being overweight and obese and provide information about how to achieve and maintain a preferred healthy weight.
5. Our AMA will urge physicians to assess their patients for overweight and obesity during routine medical examinations and discuss with at-risk patients the health consequences of further weight gain; if treatment is indicated, physicians should encourage and facilitate weight maintenance or reduction efforts in their patients or refer them to a physician with special interest and expertise in the clinical management of obesity.
6. Our AMA will urge all physicians and patients to maintain a desired weight and prevent inappropriate weight gain.
7. Our AMA will encourage physicians to become knowledgeable of community resources and referral services that can assist with the management of overweight and obese patients.
8. Our AMA will urge the appropriate federal agencies to work with organized medicine and the health insurance industry to develop coding and payment mechanisms for the evaluation and management of obesity.
9. Our AMA will urge all payers to ensure coverage parity for evidence-based treatment of obesity, including FDA-approved medications without exclusions or additional carve-outs.

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(SA Rep. 6, A-99; Reaffirmation A-09; Reaffirmed: CSAPH Rep. 1, A-09; Reaffirmation A-10; Reaffirmation I-10; Reaffirmation A-12; Reaffirmed in lieu of Res. 434, A-12; Reaffirmation A-13; Reaffirmed: CSAPH Rep. 3, A-13; Reaffirmation: A-19; Appended: Res. 806, I-23)

Physician Payment Reform H-390.849

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

(CMS Rep. 6, A-09; Reaffirmation A-10; Appended: Res. 829, I-10; Appended: CMS Rep. 1, A-11; Appended: CMS Rep. 4, A-11; Reaffirmed in lieu of Res. 119, A-12; Reaffirmed in lieu of Res. 122, A-12; Modified: CMS Rep. 6, A-13; Reaffirmation I-15; Reaffirmation: A-16; Reaffirmed in lieu of: Res. 712, A-17; Reaffirmed: BOT Action in response to referred for decision: Res. 237, I-17; Reaffirmation: A-19; Reaffirmed: BOT Action in response to referred for decision Res. 111, A-19; Reaffirmed: BOT Action in response to referred for decision Res. 132, A-19; Reaffirmed: Res. 212, I-21; Reaffirmed: Res. 240, A-22; Reaffirmation: A-22; Modified: CMS Rep. 04, A-23; Reaffirmed: Res. 214, A-23; Reaffirmation: A-23; Reaffirmed in lieu of: Res. 225, A-25; Reaffirmed: Res. 226, A-25)

Merit-based Incentive Payment System (MIPS) Update H-385.905

Our American Medical Association supports legislation that ensures Medicare physician payment is sufficient to safeguard beneficiary access to care, replaces or supplements budget neutrality in MIPS with incentive payments, or implements positive annual physician payment updates.
(BOT Rep. 13, I-20; Reaffirmed: Res. 212, I-21; Reaffirmed: Res. 220, I-24)

Physician Payment Reform H-400.972

1. It is the policy of our American Medical Association to take all necessary legal, legislative, and other action to redress the inequities in the implementation of the RBRVS, including, but not limited to:
    a. Reduction of allowances for new physicians.
    b. The non-payment of EKG interpretations.

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   c. Defects in the Geographic Practice Cost Indices and area designations.
   d. Inappropriate Resource-Based Relative Value Units.
   e. The deteriorating economic condition of physicians' practices disproportionately affected by the Medicare payment system.
   f. The need for restoration of the RBRVS conversion factor to levels consistent with the statutory requirement for budget neutrality.
   g. The inadequacy of payment for services of assistant surgeons.
   h. The loss of surgical-tray benefit for many outpatient procedures (Reaffirmed by Rules & Credentials Cmt., A-96);
2. Seek an evaluation of:
   a. Stress factors (i.e., intensity values) as they affect the calculation of the Medicare Payment Schedule, seeking appropriate, reasonable, and equitable adjustments.
   b. Descriptors (i.e., vignettes) and other examples of services used to determine RBRVS values and payment levels and to seek adjustments so that the resulting values and payment levels appropriately pertain to the elderly and often infirm patients.
3. Evaluate the use of the RBRVS on the calculation of the work component of the Medicare Payment Schedule and to ascertain that the concept for the work component continues to be an appropriate part of a resource-based relative value system.
4. Seek to assure that all modifiers, including global descriptors, are well publicized and include adequate descriptors.
5. Seek the establishment of a reasonable and consistent interpretation of global fees, dealing specifically with preoperative office visits, concomitant office procedures, and/or future procedures.
6. Seek from CMS and/or Congress an additional comment period beginning in the Fall of 1992.
7. Seek the elimination of regulations directing patients to points of service.
8. Support further study of refinements in the practice cost component of the RBRVS to ensure better reflection of both absolute and relative costs associated with individual services, physician practices, and medical specialties, considering such issues as data adequacy, equity, and the degree of disruption likely to be associated with any policy change.
9. Take steps to assure that relative value units in the Medicare payment schedule, such as nursing home visits, are adjusted to account for increased resources needed to deliver care and comply with federal and state regulatory programs that disproportionately affect these services and that the Medicare conversion factor be adjusted and updated to reflect these increased overall costs.
10. Support the concepts of HR 4393 (the Medicare Geographic Data Accuracy Act of 1992), S 2680 (the Medicare Geographic Data Accuracy Act of 1992), and S 2683 (Medicare Geographic Data Accuracy Act) for improving the accuracy of the Medicare geographic practice costs indices (GPCIs) and work with CMS and the Congress to assure that GPCIs are updated in as timely a manner as feasible and reflect actual physician costs, including gross receipt taxes.
11. Request that CMS refine relative values for particular services on the basis of valid and reliable data and that CMS rely upon the work of the AMA/Specialty Society RVS Updating Committee (RUC) for assignment of relative work values to new or revised CPT codes and any other tasks for which the RUC can provide credible recommendations.
12. Pursue aggressively recognition and CMS adoption for Medicare payment schedule conversion factor updates of an index providing the best assurance of increases in the monetary conversion factor reflective of changes in physician practice costs, and to this end, to consider seriously the development of a ”shadow” Medicare Economic Index.
13. Continue to implement and refine the Payment Reform Education Project to provide member physicians with accurate and timely information on developments in Medicare physician payment reform.
14. Take steps to assure all relative value units contained in the Medicare Fee Schedule are adjusted as needed to comply with ever-increasing federal and state regulatory requirements.

(Sub. Res. 109, A-92; Reaffirmed: I-92; Reaffirmed by CMS Rep. 8, A-95 and Sub. Res. 124, A-95; Reaffirmation A-99 and Reaffirmed: Res. 127, A-99; Reaffirmation A-02; Reaffirmation A-06; Reaffirmation I-07; Reaffirmed: BOT Rep. 14, A-08; Reaffirmation A-09; Reaffirmed: CMS Rep. 01, A-19; Reaffirmed: Res. 212, I-21; Reaffirmed: Res. 802, I-24)

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Addressing Adult and Pediatric Obesity D-440.954

1. Our American Medical Association will:
    a. Assume a leadership role in collaborating with other interested organizations, including national medical specialty societies, the American Public Health Association, the Center for Science in the Public Interest, and the AMA Alliance, to discuss ways to finance a comprehensive national program for the study, prevention, and treatment of obesity, as well as public health and medical programs that serve vulnerable populations.
    b. Encourage state medical societies to collaborate with interested state and local organizations to discuss ways to finance a comprehensive program for the study, prevention, and treatment of obesity, as well as public health and medical programs that serve vulnerable populations.
    c. Continue to monitor and support state and national policies and regulations that encourage healthy lifestyles and promote obesity prevention.
2. Our AMA, consistent with H-440.842, Recognition of Obesity as a Disease, will work with national specialty and state medical societies to advocate for patient access to and physician payment for the full continuum of evidence-based obesity treatment modalities (such as behavioral, pharmaceutical, psychosocial, nutritional, and surgical interventions).
3. Our AMA will work with interested national medical specialty societies and state medical associations to increase public insurance coverage of and payment for the full spectrum of evidence-based adult and pediatric obesity treatment.
4. Our AMA will:
    a. work with state and specialty societies to identify states in which physicians are restricted from providing the current standard of care with regards to obesity treatment.
    b. work with interested state medical societies and other stakeholders to remove out-of-date restrictions at the state and federal level prohibiting healthcare providers from providing the current standard of care to patients affected by obesity.
5. Our AMA will leverage existing channels within AMA that could advance the following priorities:
    - Promotion of awareness amongst practicing physicians and trainees that obesity is a treatable chronic disease along with evidence-based treatment options.
    - Advocacy efforts at the state and federal level to impact the disease obesity.
    - Health disparities, stigma and bias affecting people with obesity.
    - Lack of insurance coverage for evidence-based treatments including intensive lifestyle intervention, anti-obesity pharmacotherapy and bariatric and metabolic surgery.
    - Increasing obesity rates in children, adolescents and adults.
    - Drivers of obesity including lack of healthful food choices, over-exposure to obesogenic foods and food marketing practices.
6. Our AMA will conduct a landscape assessment that includes national level obesity prevention and treatment initiatives, and medical education at all levels of training to identify gaps and opportunities where AMA could demonstrate increased impact.
7. Our AMA will convene an expert advisory panel once, and again if needed, to counsel AMA on how best to leverage its voice, influence and current resources to address the priorities listed in item 5 above.

(BOT Rep. 11, I-06; Reaffirmation A-13; Appended: Sub. Res. 111, A-14; Modified: Sub. Res. 811, I-14; Appended: Res. 201, A-18; BOT Action in response to referred for decision: Res. 415, A-22; Modified: Res. 818, I-22)

Models / Guidelines for Medical Health Care Teams H-160.906

1. Our 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.

2. Our AMA supports the following elements that should be considered when planning a team-based care model according to the needs of each physician practice:

Patient-Centered:
a. The patient is an integral member of the team.
b. A relationship is established between the patient and the team at the onset of care, and the role of each team member is explained to the patient.
c. Patient and family-centered care is prioritized by the team and approved by the physician team leader.

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d. Team members are expected to adhere to agreed-upon practice protocols.
e. Improving health outcomes is emphasized by focusing on health as well as medical care.
f. Patients' access to the team, or coverage as designated by the physician-led team, is available twenty-four hours a day, seven days a week.
g. Safety protocols are developed and followed by all team members.

Teamwork:
h. Medical teams are led by physicians who have ultimate responsibility and authority to carry out final decisions about the composition of the team.
i. All practitioners commit to working in a team-based care model.
j. The number and variety of practitioners reflects the needs of the practice.
k. Practitioners are trained according to their unique function in the team.
l. Interdependence among team members is expected and relied upon.
m. Communication about patient care between team members is a routine practice.
n. Team members complete tasks according to agreed-upon protocols as directed by the physician leader.

Clinical Roles and Responsibilities:
o. Physician leaders are focused on individualized patient care and the development of treatment plans.
p. Non-physician practitioners are focused on providing treatment within their scope of practice consistent with their education and training as outlined in the agreed upon treatment plan or as delegated under the supervision of the physician team leader.
q. Care coordination and case management are integral to the team's practice.
r. Population management monitors the cost and use of care, and includes registry development for most medical conditions.

Practice Management:
s. Electronic medical records are used to the fullest capacity.
t. Quality improvement processes are used and continuously evolve according to physician-led team-based practice assessments.
u. Data analytics include statistical and qualitative analysis on cost and utilization, and provide explanatory and predictive modeling.
v. Prior authorization and precertification processes are streamlined through the adoption of electronic transactions.

(CMS Rep. 6, A-14; Reaffirmed: CMS Rep. 07, A-16; Reaffirmed: CMS Rep. 05, A-17)

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5. INCLUSION OF DISCOUNTED PRESCRIPTION MEDICATION IN PATIENT COST-SHARING

Reference committee hearing: see report of Reference Committee A.

HOUSE ACTION: RECOMMENDATIONS ADOPTED
REMAINDER OF REPORT FILED
See Policy H-110.955

Resolution 710, "Requiring Insurances to Apply Discounted Cost Medication to the Patient's Deductible," was introduced by the New York delegation at the 2025 Interim Meeting and was referred. It asks the following:

> RESOLVED, that our American Medical Association (AMA) advocate for legislation or other appropriate means to ensure that all payment made by patients for prescription medications outside of their insurance coverage (such as pharmaceutical discount programs) count towards that patient's annual deductible and out of pocket maximum.

In response, this report reviews patient cost-sharing, patient assistance programs, and their impact on patients and physicians. Further, it provides an overview of related AMA policies and offers a recommendation for new House of Delegates (HOD) policy.

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BACKGROUND

Cost-sharing is broadly defined as the portion of health care costs that a patient pays out-of-pocket (OOP). These costs are typically inclusive of deductibles, coinsurance, and copayment ("copay").[1] Deductibles are the amount that a beneficiary must pay before the insurance plan covers the costs of care. While specific amounts vary plan to plan, once a deductible is met the patient is then only responsible for a copay or coinsurance.[2] Plans that have lower deductibles typically have higher monthly premiums and plans with higher deductibles typically have lower monthly premiums. Some plans have separate deductibles for prescription drugs and often family plans include separate individual and family deductibles.[2] In addition to deductibles, many plans have an OOP maximum, which is the most a beneficiary would have to pay for covered services annually.[3] With passage of the Affordable Care Act (ACA), the vast majority of payers are required to cover preventive services fully, even prior to a deductible being met.[4] After a beneficiary's deductible is met, OOP costs are typically defined as either coinsurance or a copay.[2] Coinsurance is defined as the percentage of a covered service paid by the patient while a copay is a fixed amount paid by the patient.[5,6]

Importantly, there are several costs for which patients are responsible that are not included in deductible nor OOP maximum calculations. Specifically, payments made in relation to monthly premiums, out-of-network provider fees, non-covered treatments, over the counter medications, costs that exceed payer set allowable amounts, and some prescription discount programs are often not included in a plan's calculation of patient cost-sharing.[2,3] Out-of-network care can often incur increased OOP spending, with variation from plan to plan as to what services, or how much of a service is covered out-of-network. In an effort to control costs, most plans also have an OOP maximum or limit. Typically, care that is not billed initially to the insurance company is also excluded, such as medications or physician services paid with cash.

There is significant variability, especially among private payers, in the actual set amounts for each type of cost-sharing. Among ACA Marketplace plans, the average deductible for a single individual is just under $3,000. However, there is significant variation with some plans offering deductibles as low as $80 for low-income beneficiaries who qualify, to nearly $7,500 for bronze plans.[6] Although there is variation between states, the average deductible for a single person who has coverage through an Employer Sponsored Insurance (ESI) plan is just over $2,000.[7] Both Marketplace and ESI plans typically have a copay between $20-$40 for primary care visits and $40-$100 for specialty care visits once a deductible is met. When these plans include coinsurance, this rate typically averages around 20 percent.[8] For marketplace and ACA-compliant ESI plans, OOP maximums cannot exceed $10,600 per person or $21,200 per family. While more uncommon in private health insurance plans, Medicare sets deductibles and OOP maximums separately for prescription drug and non-drug related costs. Medicare Part D, which covers prescription drugs, has an annual OOP maximum of $2,100 and a prescription drug deductible of $615 as established by the Inflation Reduction Act.[9] Medicare Part D coinsurance and copay rates vary based on drug costs (e.g., generic drugs typically have lower patient OOP costs than brand name drugs).[10,11] While Medicaid OOP costs vary by state, federal regulation currently caps total OOP spending at no more than five percent of a family's annual income and includes exemptions for certain groups, like young children and pregnant individuals, and situations, like emergency care and family planning.[12] For prescription medications, among Medicaid beneficiaries making less than 150 percent of the Federal Poverty Limit, copays cannot exceed eight dollars.[12] For a more detailed breakdown of these costs and how they are typically collected, please reference CMS Report 2-I-23.

PATIENT ASSISTANCE PROGRAMS

In the United States, prescription medications are often tied to significant OOP costs for patients. Research has shown that nearly a quarter of adults with insurance reported a necessary prescription was either not covered or required a "very high" copay.[13] For individuals with chronic conditions, like diabetes, cancer, arthritis, or HIV, this can be especially problematic as generic drugs are often not available for these diagnoses. While the biologic and specialty drug market has increased access to name-branded drugs, patients often incur exceptionally high costs to obtain them.[14] Although this is an issue cited across all insurance types, Medicare beneficiaries reported the issue more frequently than those with other types of insurance coverage.[13,14] This often results in cost-related nonadherence, meaning patients delay or skip, refilling a prescription and/or take smaller doses. Patients who are unable to adhere to their treatment plans are more likely to experience poor health outcomes, harmful side effects, and/or unsuccessful treatment outcomes.[15] Current estimates show that about 15 percent of patients demonstrate cost-related nonadherence behaviors.[15] As a result of challenges with OOP costs, patient assistance programs (PAPs) have become relatively

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common. These programs can be offered through the government, drug manufacturers, non-profit organizations, and/or as discount or coupon cards.

For individuals who are beneficiaries of government funded insurance plans, there are PAPs offered by state and federal governments when medications are prohibitively expensive. For example, Medicare beneficiaries who meet certain annual income and resource limits qualify for the "Extra Help" or Low-Income Subsidy which limits OOP payments beyond the larger Medicare limits.[16] To qualify for this program, individuals must be dual-eligible and enrolled in a Medicaid drug coverage plan, make less than $2,015 per month, and have total assets below $18,090. Individuals who are also enrolled in Medicaid, Supplemental Security Income, or a Medicare Savings Program automatically qualify. For these beneficiaries, all generic drugs have an associated copay of just over $5 and all name-brand drugs have a copay of just under $13. If beneficiaries also qualify for Medicaid, these copays can be as low as $1.60 for generics and $4.90 for name-brand drugs.[17] In addition to federal programs, nearly every state has a program designed to cover the cost of prescriptions not covered by Medicare Part D plans. In addition, most states have State Pharmaceutical Assistance Programs (SPAPs). These programs are designed to reduce the cost of medication related spending for targeted populations, often those who have an income under a set level, are under/uninsured, have a specific diagnosis, and/or those over 65 years of age.[18] For example many, but not all, states have a specific program designed to ensure that individuals with HIV/AIDS are able to access the necessary medications. Additional SPAPs are designed to center around seniors who are unable to access medications, while others are more general and apply to broader populations. For example, Alabama has one SPAP designed to assist in accessing HIV/AIDs medications (Alabama AIDS Drugs Assistance Program) and another designed to support seniors (SenioRx) who cannot afford their medications.[18]

Beyond SPAPs, 13 states offer some kind of discount program that is often available to a wider population. Some states, such as Arizona, offer discount cards to any state resident via CoppeRx/Arizona Rx, while other states have more specified requirements. For example, California's Discount Program is exclusive to Medicare recipients and Vermont's program, Health Vermonters, is exclusive to those who meet an income threshold and do not have prescription coverage.[18] Oregon and Washington State combined their drug assistance programs into ArrayRx, formerly the Northwest Prescription Drug Consortium, which not only provides a discount card program to residents in those states, but also pure-pass through pharmacy benefit manager (PBM) services and a group purchasing organization.[19] The initial joint efforts of Washington and Oregon allowed for the program to increase its investments and impacts, which has been furthered with the more recent inclusion of Arizona, Connecticut, Nevada. Estimates from this program's discount card show that patients who utilize these cards save between 18 and 80 percent when filling their prescription at a retail pharmacy.[18,19] In February 2026, the federal government launched TrumpRx, which is described as offering the "cheapest prices in the world" for the negotiated drugs. As of the launch of the website, 43 medications were included with intentions to grow this number.[20] While this website has been publicized as a major cost saver for patients who need the included medications, initial reviews are mixed.[20,21] First, the site does not allow patients to utilize their health insurance, meaning that for individuals with prescription drug coverage, the level of savings may be limited. Second, approximately half of the drugs included on the site have generic alternatives that are less expensive than the name brand drugs.[21,20,21,22]

While successful government assistance programs can be exceptionally helpful for those who qualify, many people do not meet the qualifications. Therefore, private organizations and companies have stepped in to offer assistance. Many drug manufacturers, especially those of very high-cost drugs, offer PAPs. In addition, drug manufacturers and companies have developed business models to provide direct-to-consumer dispensing, avoiding PBMs and retail pharmacies at a lower cost, but also require forgoing the use of insurance. Although some programs are only offered to patients who are uninsured or underinsured, other programs are open to all recipients of a drug.[23] These programs can be in the form of copay assistance, discounts to the price of the medication, and/or offsetting of associated costs like transportation or infusion services. However, in many cases patients must navigate an application process that is often demanding.[23,24] Even so, for some patients these programs provide the only means to access their prescription(s). In addition to the aforementioned manufacturer-based programs, many non-profit organizations exist designed to help patients access their medications, often in relation to a specific diagnosis or family of diagnoses.[24] For example, the Patient Access Network (PAN) Foundation works to provide grants to patients with a variety of diagnoses that are considered chronic, rare, and/or life-threatening.[25]

In addition to both government and non-governmental assistance programs, coupon or discount cards have grown in accessibility and popularity across the country. These cards are primarily based on three types of discounts: manufacturer, pharmacy-specific, and prescription coupon. Manufacturer discount cards are submitted by the patient

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to the pharmacy and the manufacturer then pays the difference between the patient payment and actual cost. For example, if a patient paid $50 when using the discount card on a medication that typically costs $100 OOP, the manufacturer would reimburse the pharmacy the remaining $50.[26] Pharmacy-specific discount cards are unique to a pharmacy and generally allow patients to pay a lower price on a medication, typically a generic medication, but do not work in conjunction with insurance coverage. While these types of cards are particularly beneficial to uninsured patients, they also can be beneficial to those with insurance coverage, as it is not uncommon for the discounted rate to be less than the copay or coinsurance rate for a patient who is fully insured.[26] Prescription discount (or coupon) cards are similar but apply to multiple pharmacies. These cards are driven by private, for-profit companies that negotiate with PBMs to secure discounts on specific medications. When these cards, such as GoodRx, America's Pharmacy, or SingleCare, are used a portion of the transaction is split between the PBM and card company, and the remainder goes to the pharmacy in the form of payment.[26,27] With the widespread use of discount cards and coupons, many payers became concerned that their benefit designs would be altered and profits lessened. As a result, some plans made changes to how OOP costs are calculated, often not counting patient payments made via coupons or discount cards toward annual cost sharing in order to maintain benefit designs and profits.[27,28] Further, some plans utilize copay accumulators to maximize their profits. In these systems, when a patient relies on a coupon to afford medications, the value is not included toward the OOP costs. Therefore, when the coupon is exhausted and/or expires, the patient is subjected to paying the full deductible along with a copay/coinsurance. In this system, the payer ends up with the majority of the benefit from the coupon, as they are able to shift many of the costs back to the patient. Alternatively, payers may implement a copay maximizer program. These programs apply the coupon evenly across the year, meaning that the patient may be responsible for a smaller monthly copay in addition to the coupon. This can be problematic as plan beneficiaries that utilize copay maximizers often do not meet their annual deductible and may end up spending more on health care costs.[27,28] This is particularly problematic for patients with high-deductible health plans (HDHP) as they are much less likely to meet the deductible.[27]

As a result of increasing PAP availability, Alternative Funding Programs (AFPs) have grown significantly. AFPs are designed to assist beneficiaries in navigating the PAP application process and are relied upon when a plan sponsor, such as an employer, does not want to pay for an expensive drug. Specifically, ESI plans preemptively determine that a medication, typically a high-cost specialty prescription, is "non-essential" and as a result they are removed from the formulary making the patient "un/underinsured" for that medication and AFPs step in to assist patients in negotiating the PAP process. While these programs may seem to be beneficial to patients, AFPs can result in significant ethical concerns and impact patients negatively.[29] Specifically, there have been concerns raised that the use of AFPs may conflict with consumer protection laws/regulations via the ACA, the Employee Retirement Income Security Act, and/or the Health Insurance Portability and Accountability Act. For example, under the ACA, prescription drugs are considered an essential health benefit (EHB) and, as a result, they must be covered. By deeming a prescription "non-essential," there is some concern that the ACA EHB clause is violated. Further, there is significant concern that these programs are exploiting PAPs and causing ethical issues by incorrectly labeling patients as "underinsured" when their health plan pushes them into using an AFP.[29] This could lead to not only patients who are truly un/underinsured not being able to receive support but may unduly burden patients who are not deemed eligible for support even with assistance from the AFP. A full overview of AFPs can be found in this AMA issue brief.[29]

LEGISLATION AND REGULATION

To address the issues raised by copay accumulator programs, some states have implemented legislation and/or regulation to require health plans to include reductions in OOP expenses for prescription drugs in cost-sharing calculations.[30] States vary in their requirements but generally necessitate that insurance plans include a combination of third-party payments, financial assistance, discounts, and/or product vouchers in cost-sharing totals. However, many states have faced challenges in implementing these laws due to conflicts with HDHP requirements and health savings account (HSA) eligibility. Specifically, there is concern that the credit for financial assistance, prior to meeting a deductible, could cause a beneficiary to be ineligible to contribute to their HSA. In other words, to maintain HSA eligibility, beneficiaries must meet a statutory deductible before discounts or coupons can be applied to cost-sharing calculations.[30,31] States have generally managed to work around this requirement by broadening legislation language or allowing for exceptions to ensure that those with HDHP/HSA plans are not ruled ineligible.[30]

As of the writing of this report, 25 states, the District of Columbia, and Puerto Rico have laws aimed at addressing copay accumulator adjustments by insurers and PBMs. While states vary in the specifics of their legislation, many focus on a basic requirement for all payments to be included in copay calculations. In most states, the requirements apply to all state regulated plans, meaning that some plans may be exempt. For example, Illinois, via the Managed

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Care Reform and Patient Rights Act, requires that any state regulated health plan must count third party payments, financial assistance, discounts, product vouchers, or any other reduction in OOP expenses on prescription drugs toward cost-sharing totals.[32] Kentucky law prohibits state regulated payers and PBMs from excluding payments via coupons, discounts, or vouchers when calculating cost-sharing. The law does allow for the use of copay accumulators when a generic alternative is available with an exception if the prescriber deems the brand-name drug is medically necessary or approved by insurance.[33,34] Texas requires that health plans and PBMs apply any third-party payment, financial assistance, discount, product voucher, or other reduction in OOP expenses be included in calculations for deductibles, copays, cost-sharing responsibility, or OOP maximum. Further, Texas law shares the Kentucky exemption when a name-brand drug is medically necessary or approved by insurance.[34]

At the federal level, the Centers for Medicare & Medicaid Services (CMS) released a 2021 rule that allowed health plans to use accumulator adjustments but deferred to states for regulation. However, this rule was challenged in 2023 and it was determined that copay accumulators are only permissible among CMS-regulated plans if allowed by state regulations and for name branded drugs that have a generic alternative.[35] An additional CMS final rule clarified that among ACA Marketplace plans, drugs that are considered EHBs have a limit on annual cost sharing protected by ACA consumer protections.[36] While not yet released, the Department of Labor and the Department of Health and Human Services have indicated plans to release rules outlining similar standards that will apply to broader health plans and self-insured group plans.[35]

AMA POLICY AND ADVOCACY

The AMA has existing policy on copay accumulators, as Policy D-110.986 outlines AMA intent to develop model state legislation and support federal and state efforts to ban co-pay accumulator policies. As a result of this policy, the AMA has joined the All Co-pays Count coalition and adopted their model legislation. This model legislation is available to all states and is endorsed by over 30 organizations and advocacy groups. The model legislation outlines the issue and ensures that OOP spending is included in cost-sharing calculations. Related Policy H-125.977 advocates that OOP expenses be calculated toward Medicare Part D coverage gap calculations and that assistance programs be available to all individuals regardless of insurance type or coverage. Policy D-110.982 goes further and supports advocacy on the "ethical dilemma" that is presented when patients are able to obtain medication or equipment at a price lower than their insurance offers due to discount cards or cash prices. In addition, Policy D-110.983 outlines educational efforts on AFPs and the negative impacts they have and advocacy to limit AFPs via regulation or legislation. Of note, when legislation supporting the inclusion of these discounted OOP payments in cost-sharing calculations was introduced, the AMA expressed its support (House Testimony, Senate Testimony, House Letter).

In addition to policies oriented towards cost-sharing/copays and OOP spending, the AMA has extensive policy designed to improve the affordability of prescription drugs. Policies H-110.980 and H-110.987 demonstrate efforts to ensure that patients have access to affordable medications. These policies discuss AMA standards for drug affordability, process transparency, and patient access. Policy H-110.986 discusses AMA support for adding value metrics into drug prices. In conjunction with the aforementioned policies that address all payer types, Policy D-330.954 specifically focuses on managing prescription drug prices in Medicare and outlines support for price negotiation. Along with aforementioned D-110.986, Policies D-120.988 and D-120.934 target PBMs and the need for increased regulation and transparency. Specifically, Policy D-120.934 outlines AMA steps to ensure that PBMs do not prevent physicians from appropriately treating patients and Policy D-120.988 details prevention of appropriate treatment by PBMs. Combined with its grassroots advocacy campaign TruthinRx, the AMA has sent a significant number of letters to legislators, regulators, and payers working to regulate PBMs and make prescription drugs affordable. Finally, the AMA voiced support for the PBM regulations passed in the Consolidated Appropriations Act of 2026.

DISCUSSION

Patient OOP spending is typically utilized to calculate cost-sharing amounts. For example, patients will usually need to spend a certain amount OOP to achieve their deductible amount. Once met, the payer will pay a larger share of the accrued health care costs. While this generally remains the same with prescription drug spending, the introduction of PAPs has complicated the process. PAPs can take a wide variety of forms and may be sponsored by governmental and non-governmental organizations. Due to the high, and rising costs of prescription drugs in the United States, patients continue to search for methods to make their medications more affordable. For those who qualify, government and private programs can help to reduce costs. For others, drug manufacturer discounts and support programs can assist

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in affordability. However, these programs often have specific eligibility qualifications that many do not meet, and as a result many have begun to utilize coupons/discount cards.

While PAPs are generally beneficial to patients, payers and PBMs may employ these programs for their own financial gains. Further, the utilization of these discount cards has complicated cost-sharing calculations, as much of this spending now happens outside of insurance. For example, some accumulator adjustment programs allow for health insurers and/or PBMs to duplicate payments, in a sense "double dipping," by accepting compensation or reimbursement from both the PAP and the patient's OOP spending. While not all insurance companies or PBMs participate in this practice, it seems to be becoming more widespread and is harmful to patients. To take further advantage of the situation, AFPs have begun to materialize. These programs are often viewed as predatory and harmful to not only the patients that they directly serve, but also to those patients who may not be able to access the PAPs. Additionally, these AFPs may circumvent federal and state legislation and regulation. To combat the payer and PBM tactics and ensure that patient cost-sharing calculations are based on actual OOP spending, some states have recently moved to implement legislation, the impact of which has yet to be seen. To support these efforts, the Council recommends the adoption of new policy that supports that all OOP spending submitted to the payer by the patient, or on behalf of the patient, be included in calculations for cost-sharing.

RECOMMENDATION

The Council on Medical Service recommends that the following recommendation be adopted in lieu of Resolution 710-A-25, and the remainder of the report be filed:

1. Our American Medical Association supports efforts to ensure that all payers and pharmacy benefit managers include any out-of-pocket prescription drug spending related to a covered benefit submitted by the patient, or on behalf of the patient, in cost-sharing, and/or out-of-pocket spending calculations.

Fiscal Note: Minimal

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Council on Medical Service Report 5-A-26
Inclusion of Discounted Prescription Medication in Patient Cost-Sharing
Policy Appendix

Co-Pay Accumulators D-110.986
Our AMA will develop model state legislation regarding Co-Pay Accumulators for all pharmaceuticals, biologics, medical devices, and medical equipment, and support federal and state legislation or regulation that would ban co-pay accumulator policies, including in federally regulated ERISA plans. (Res. 205, I-19; Appended: Res. 212, I-20)

Non-Formulary Medications and the Medicare Part D Coverage Gap H-125.977
1. Our American Medical Association will advocate for the inclusion of out of pocket, non-formulary, prescription medication expenses in calculating a patient's contributions toward the Medicare Part D coverage gap, after which coverage resumes.
2. Our AMA will advocate for economic assistance, including coupons (and other discounts), for patients, whether they are enrolled in government health insurance programs, enrolled in commercial insurance plans, or are uninsured. (Res. 826, I-14; Reaffirmation I-15; Reaffirmation: I-17; Reaffirmation: A-22)

Ethical Pricing Procedures that Protect Insured Patients D-110.982
1. Our American Medical Association advocates for policies that limit the cost of a medications or durable medical equipment to an insured patient with coverage to the lower range of prices that a non-covered patient can achieve at cash price either before or after application of a non-manufacturer's free discount card (such as GoodRx).
2. Our AMA will write a letter to lawmakers and other pertinent stakeholders describing the ethical dilemma of the medication pricing process and how it adversely affects insured patients. (Res. 012, A-24)

Alternative Funding Programs D-110.983
Our American Medical Association will educate employers, benefits administrators, and patients on alternative funding programs (AFPs) and their negative impacts on patient access to treatment and will advocate for legislative and regulatory policies that would address negative impacts of AFPs. (Res. 707, A-24)

Additional Mechanisms to Address High and Escalating Pharmaceutical Prices H-110.980
1. Our American Medical Association will advocate that the use of arbitration in determining the price of prescription drugs meet the following standards to lower the cost of prescription drugs without stifling innovation:
    a. The arbitration process should be overseen by objective, independent entities.
    b. The objective, independent entity overseeing arbitration should have the authority to select neutral arbitrators or an arbitration panel.
    c. All conflicts of interest of arbitrators must be disclosed and safeguards developed to minimize actual and potential conflicts of interest to ensure that they do not undermine the integrity and legitimacy of the arbitration process.
    d. The arbitration process should be informed by comparative effectiveness research and cost-effectiveness analysis addressing the drug in question.
    e. The arbitration process should include the submission of a value-based price for the drug in question to inform the arbitrator's decision.
    f. The arbitrator should be required to choose either the bid of the pharmaceutical manufacturer or the bid of the payer.
    g. The arbitration process should be used for pharmaceuticals that have insufficient competition; have high list prices; or have experienced unjustifiable price increases.
    h. The arbitration process should include a mechanism for either party to appeal the arbitrator's decision.
    i. The arbitration process should include a mechanism to revisit the arbitrator's decision due to new evidence or data.
2. Our AMA will advocate that any use of international price indices and averages in determining the price of and payment for drugs should abide by the following principles:
    a. Any international drug price index or average should not be used to determine or set a drug's price, or determine whether a drug's price is excessive, in isolation.

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   b. The use of any international drug price index or average should preserve patient access to necessary medications.
   c. The use of any international drug price index or average should limit burdens on physician practices.
   d. Any data used to determine an international price index or average to guide prescription drug pricing should be transparent and updated regularly.
3. Our AMA supports the use of contingent exclusivity periods for pharmaceuticals, which would tie the length of the exclusivity period of the drug product to its cost-effectiveness at its list price at the time of market introduction. (CMS Rep. 4, I-19; Reaffirmed: CMS Rep. 3, I-20; Modified: CMS Rep. 4, A-22)

Pharmaceutical Costs H-110.987

1. Our AMA encourages Federal Trade Commission (FTC) actions to limit anticompetitive behavior by pharmaceutical companies attempting to reduce competition from generic manufacturers through manipulation of patent protections and abuse of regulatory exclusivity incentives.
2. Our AMA encourages Congress, the FTC and the Department of Health and Human Services to monitor and evaluate the utilization and impact of controlled distribution channels for prescription pharmaceuticals on patient access and market competition.
3. Our AMA will monitor the impact of mergers and acquisitions in the pharmaceutical industry.
4. Our AMA will continue to monitor and support an appropriate balance between incentives based on appropriate safeguards for innovation on the one hand and efforts to reduce regulatory and statutory barriers to competition as part of the patent system.
5. Our AMA encourages prescription drug price and cost transparency among pharmaceutical companies, pharmacy benefit managers and health insurance companies.
6. Our AMA supports legislation to require generic drug manufacturers to pay an additional rebate to state Medicaid programs if the price of a generic drug rises faster than inflation.
7. Our AMA supports legislation to shorten the exclusivity period for biologics.
8. Our AMA will convene a task force of appropriate AMA Councils, state medical societies and national medical specialty societies to develop principles to guide advocacy and grassroots efforts aimed at addressing pharmaceutical costs and improving patient access and adherence to medically necessary prescription drug regimens.
9. Our AMA will generate an advocacy campaign to engage physicians and patients in local and national advocacy initiatives that bring attention to the rising price of prescription drugs and help to put forward solutions to make prescription drugs more affordable for all patients.
10. Our AMA supports:
    a. drug price transparency legislation that requires pharmaceutical manufacturers to provide public notice before increasing the price of any drug (generic, brand, or specialty) by 10 percent or more each year or per course of treatment and provide justification for the price increase;
    b. legislation that authorizes the Attorney General and/or the Federal Trade Commission to take legal action to address price gouging by pharmaceutical manufacturers and increase access to affordable drugs for patients; and
    c. the expedited review of generic drug applications and prioritizing review of such applications when there is a drug shortage, no available comparable generic drug, or a price increase of 10 percent or more each year or per course of treatment.
11. Our AMA advocates for policies that prohibit price gouging on prescription medications when there are no justifiable factors or data to support the price increase.
12. Our AMA will provide assistance upon request to state medical associations in support of state legislative and regulatory efforts addressing drug price and cost transparency.
13. Our AMA supports legislation to shorten the exclusivity period for FDA pharmaceutical products where manufacturers engage in anti-competitive behaviors or unwarranted price escalations.
14. Our AMA supports legislation that limits Medicare annual drug price increases to the rate of inflation. (CMS Rep. 2, I-15; Reaffirmed in lieu of: Res. 817, I-16; Appended: Res. 201, A-17; Reaffirmed in lieu of: Res. 207, A-17; Modified: Speakers Rep. 01, A-17; Appended: Alt. Res. 806, I-17; Reaffirmed: BOT Rep. 14, A-18; Appended: CMS Rep. 07, A-18; Appended: BOT Rep. 14, A-19; Reaffirmed: Res. 105, A-19; Appended: Res. 113, I-21; Reaffirmed in lieu of: Res. 810, I-22; Reaffirmed: Res. 801, I-23; Reaffirmed: Res. 801, I-23; Reaffirmed: CMS Rep. 04, I-24; Reaffirmed: CMS Rep. 06, A-25)

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Incorporating Value into Pharmaceutical Pricing H-110.986

1. Our American Medical Association supports value-based pricing programs, initiatives and mechanisms for pharmaceuticals that are guided by the following principles:
    a. value-based prices of pharmaceuticals should be determined by objective, independent entities;
    b. value-based prices of pharmaceuticals should be evidence-based and be the result of valid and reliable inputs and data that incorporate rigorous scientific methods, including clinical trials, clinical data registries, comparative effectiveness research, and robust outcome measures that capture short- and long-term clinical outcomes;
    c. processes to determine value-based prices of pharmaceuticals must be transparent, easily accessible to physicians and patients, and provide practicing physicians and researchers a central and significant role;
    d. processes to determine value-based prices of pharmaceuticals should limit administrative burdens on physicians and patients;
    e. processes to determine value-based prices of pharmaceuticals should incorporate affordability criteria to help assure patient affordability as well as limit system-wide budgetary impact; and
    f. value-based pricing of pharmaceuticals should allow for patient variation and physician discretion.

2. Our AMA supports the inclusion of the cost of alternatives and cost-effectiveness analysis in comparative effectiveness research.

3. Our AMA supports direct purchasing of pharmaceuticals used to treat or cure diseases that pose unique public health threats, including hepatitis C, in which lower drug prices are assured in exchange for a guaranteed market size. (CMS Rep. 05, I-16; Reaffirmed in lieu of: Res. 207, A-17; Reaffirmed: CMS-CSAPH Rep. 01, A-17; Reaffirmed: CMS Rep. 07, A-18; Reaffirmed: CSAPH Rep. 2, I-19; Reaffirmed: CMS Rep. 4, I-19; Reaffirmed: CMS Rep. 6, I-20; Reaffirmed: Res. 113, A-23)

Prescription Drug Prices and Medicare D-330.954

1. Our American Medical Association will support federal legislation which gives the Secretary of the Department of Health and Human Services the authority to negotiate contracts with manufacturers of covered Part D drugs.
2. Our AMA will work toward eliminating Medicare prohibition on drug price negotiation.
3. Our AMA will prioritize its support for the Centers for Medicare & Medicaid Services to negotiate pharmaceutical pricing for all applicable medications covered by CMS. (Res. 211, A-04; Reaffirmation I-04; Reaffirmed in lieu of Res. 201, I-11; Appended: Res. 206, I-14; Reaffirmed: CMS Rep. 2, I-15; Appended: Res. 203, A-17; Reaffirmed: CMS Rep. 4, I-19; Reaffirmed: CMS Rep. 3, I-20; Reaffirmed: Res. 113, I-21; Reaffirmed: CMS Rep. 4, A-22; Reaffirmed in lieu of: Res. 810, I-22)

Inappropriate Actions by Pharmacies and Pharmacy Benefit Managers D-120.988

Our AMA, in cooperation with pharmacy benefit managers, pharmacy companies, and other drug retailing organizations, shall develop model procedures that physicians may use when prescribing off-formulary pharmaceuticals that are medically indicated and that these procedures be in compliance with the Health Insurance and Portability and Accountability Act of 1996. (Res. 528, A-02; Reaffirmation I-04; Reaffirmation A-06; Reaffirmed: CSAPH Rep. 01, A-16)

Evaluating Actions by Pharmacy Benefit Manager and Payer Policies on Patient Care D-120.934

1. Our American Medical Association will take steps to implement AMA Policies H-120.947 and D-35.981 that prescriptions must be filled as ordered by physicians or other duly authorized/licensed persons, including the quantity ordered.
2. Our AMA will work with pharmacy benefit managers, payers, relevant pharmacy associations, and stakeholders to: (a) identify the impact on patients of policies that restrict prescriptions to ensure access to care and urge that these policies receive the same notice and public comment as any other significant policy affecting the practice of pharmacy and medicine; and (b) prohibit pharmacy actions that are unilateral medical decisions.
3. Our AMA will report back at the 2018 Annual Meeting on actions taken to preserve the purview of physicians in prescription origination. (Res. 233, I-17; Reaffirmed: CMS Rep. 05, A-23)

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6. STUDY OF PRACTICE MODELS FOR PHYSICIANS PERFORMING PROCEDURES ACROSS STATE LINES

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: REFERRED

Resolution 711, "Study of Practice Models for Physicians Working Across State Lines," was introduced by the Oklahoma delegation at the 2025 Annual Meeting and was referred. It asks the following:

> RESOLVED, that our American Medical Association (AMA) undertake a thorough review of the practice models for physicians relying on transfer agreements between corporate health care entities, rather than physician-to-physician backup agreements for backup coverage, their rates of expected and unexpected complications, the impact of this model on local patients and on local physician medical liability costs; and be it further
>
> RESOLVED, that our AMA should collect and analyze data regarding patient outcomes, complications, and continuity of care issues associated with licensed physicians who primarily practice out of state without appropriate backup agreements; and be it further
>
> RESOLVED, that our AMA's study should include an extensive review of the impact this practice model has on physicians thrust into cross coverage without adequate handoff or fore-knowledge of the patient, impact on physician malpractice costs, patient safety, and physician well-being in our country.

This report focuses on physicians traveling out of state or to another area distant from their home practice, performing a procedure in an ambulatory surgical center (ASC) or office-based laboratory (OBL) and subsequently leaving the area or state. The report recommends the adoption of a new set of related policy principles.

BACKGROUND

An itinerant surgeon travels to a distant site from their home practice, performs surgery, and departs after completing the procedure, often leaving the postoperative care of the patient to another physician or member of the care team. Many believe that in order for this practice to be ethical, a surgeon must perform appropriate preoperative assessments and postoperative follow-up care or delegate this care to a physician familiar with the patient and trained in the same specialty as the surgeon performing the procedure. It should be noted that patients in rural settings can benefit from services provided by itinerant surgeons, granting them access to specialists they would otherwise have to travel long distances to see. Recent data from peer reviewed sources was not available on the impact of itinerant surgeons on patient outcomes or physician liability and/or malpractice. Studies on surgical workforce in the United States almost always omitted the effect of itinerant surgeons. In cases where itinerant surgery was taken into account, data on the impact of this arrangement was inconclusive.

ASCs are regulated health care facilities providing outpatient surgical care for patients who do not require an overnight stay, including preventive and diagnostic treatments. ASC procedures are often paid at rates 35-50 percent lower than those for comparable procedures performed at hospital outpatient departments and thus may be considered more cost efficient.[1] Examples of procedures performed at ASCs include hemodialysis thrombectomy, arteriovenous fistula creation, iliac artery intervention, venous stents, ports, and pacemaker and defibrillator installations. OBLs are similar non-hospital outpatient facilities, typically offering less complex procedures, including endovascular procedures, diagnostic health catheterization, and peripheral angiograms and/or interventions.

ASCs account for over 60 percent of outpatient procedural care and represent a $30 billion market.[2] In recent years, ASCs have become an attractive target for private equity investment. The shift to outpatient surgical procedures presents lucrative opportunities for investors without having to directly acquire a hospital facility. Empirical evidence on quality of care in ASCs after private equity acquisition is still limited and relies on a small number of studies, which to date have not found significant changes in short-term quality metrics though they do show substantial changes in charges and payer mix.[3] A recent study found that private equity-owned ASCs do not increase surgical volume but do raise prices significantly – charging nearly 50 percent more per case within 4-5 years.[4]

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RELEVANT POLICY

Policy H-475.984 establishes Core Principles on Office-Based Surgery. Most relevant to this report is Core Principle #4, which states that physicians performing office-based surgery with moderate sedation/analgesia, deep sedation/analgesia, or general anesthesia must have admitting privileges at a nearby hospital, or a transfer agreement with another physician who has admitting privileges at a nearby hospital or maintains an emergency transfer agreement with a nearby hospital.

The AMA Code of Ethics discusses related issues in Opinions 2.3.6, Surgical Co-Management, 1.1.3, Patient Rights, and 11.2.3, Contracts to Deliver Health Care Services. Opinion 2.3.6 states that physicians engaging in the practice of surgical co-management should do so following all ethical and legal guidelines, working with the patient to designate one physician to be responsible for ensuring that care is delivered in a coordinated and appropriate manner, and obtaining patient consent for the surgical co-management arrangement. This consent should include the disclosure of significant aspects of the arrangement, such as qualifications of clinicians, services each clinician will provide, and billing arrangements. Opinion 1.1.3 states that patients should be able to expect that their physician will cooperate in coordinating medically indicated care with other health care professionals. Further, the physician will not discontinue treating them when further treatment is medically indicated without giving them sufficient notice and reasonable assistance in making alternative arrangements for care. Finally, Opinion 11.2.3 states that prior to entering into contracts to deliver health care services, physicians should consider the proposed contract to assure themselves that the terms do not create conflicts of interest or compromise their ability to fulfill their ethical and professional obligations to patients.

The American College of Surgeons (ACS) has its own policy and ethics statements regarding itinerant surgeons and surgical co-management.[6] Other surgical specialty societies such as the American Academy of Ophthalmology, American Society of Plastic Surgeons, and American Academy of Otolaryngology-Head and Neck Surgery also have policies or statements that outline situations where itinerant surgery may be permissible. While these vary, they all generally indicate that the ultimate responsibility for arranging an appropriate level of continuity of care falls upon the operating surgeon.[7,8,9]

DISCUSSION

The lack of available data on patient outcomes and physician liability and/or malpractice makes it difficult to accurately gauge the impact of itinerant surgeons and their work at ASCs across state lines. One can surmise that there may be negative impacts on patients who need follow-up care or burdens on physicians who may be required to provide that care, but there are no data to indicate that is the case.

There are varying opinions on the ethics of itinerant surgery. Despite some criticisms, it may be the most appropriate way to provide specialty surgical care in rural areas or other places with a shortage of specialty surgeons. Ethics statements from the AMA and ACS state that surgeons who perform elective surgery at a practice that is distant from their home have a professional obligation to also perform preoperative assessments and postoperative follow-up care. There is leeway, however, if perioperative care is designated to another physician who is equivalently qualified to continue caring for the patient, as long this arrangement is agreed to ahead of the procedure by all parties, including the patient.

While the original resolution mentioned corporate entities, the recommendations made by the Council are not specific to ownership type (e.g., private equity, physician-owned) as there is no evidence to date that ownership of an ASC has an impact on itinerant surgeon arrangements or outcomes for patients. When compared to non-private equity-owned ASCs, those owned by private equity did not have statistically significant differences in the probability of a patient having an unplanned hospital visit (i.e., complications during or post-surgery).[5]

The principles outlined in the recommendations below can be applied generally and highlight important considerations for those considering the practice of itinerant surgery. Of utmost importance is continuity of care for the patient and having both backup and transfer agreements in place with local physicians who are able to provide the necessary follow-up care, both in case of emergencies and to ensure proper healing and recovery. Itinerant surgery may not be appropriate in all cases, but the Council believes that it may be acceptable in certain circumstances, specifically providing planned specialty surgical care to areas of shortage. The Council concurs with the ethical standards reviewed

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and agrees that in cases where itinerant surgery is the best option, physicians should follow appropriate guidelines and ethical and legal standards.

As written, the original resolve clauses have challenges to their feasibility but raise an important concern. Additionally, recent data could not be found to quantify the impact of the concerns raised in the original resolution. However, the Council believes there is a gap in AMA policy regarding the practice of itinerant surgeons and thus presents a set of guidelines for physicians performing procedures across state lines, specifically at ASCs and OBLs, to address the issues raised in Resolution 711-A-25.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 711-A-25 and the remainder of the report be filed.

1. That our American Medical Association (AMA) supports the following principles for physicians employed by ambulatory surgical centers (ASC) or office-based laboratories (OBL) who may travel from their primary practice location to provide patient care:
    a. A transfer agreement with a physician or physician group licensed in the patient's state should be arranged to address in-person care needs that may arise from a patient receiving care from a physician who primarily practices out of state or out of the immediate area or from a physician with no admitting privileges to the local hospital.
    b. A referral system with a local physician, physician practice, or other facility for appropriate treatment should be established if a patient's conditions or symptoms are beyond the scope of services provided by the ASC or OBL.
    c. Transfer agreements and backup plans should be coordinated between physicians.
        i. In the event an institution coordinates these arrangements (i.e., a hospital system, an ASC, or an OBL), a physician that would be among those receiving the patient must give explicit consent to the agreement to provide follow-up care.
        ii. When patient transfer is required, a direct hand off of the patient and patient records should be completed.
        iii. Transfer and referral agreements should be evidence-based and risk-based to balance access to care and patient safety.
    d. Protocols for ensuring continuity of care with physicians in the local community should be established.
    e. Consent from the patient regarding preoperative assessment and postoperative care should be obtained prior to the provision of any procedure, with clarity on which physician will be providing care during each step of the process.
    f. Physicians entering into these arrangements should ensure that they are in keeping with ethical standards and legal requirements.
2. That our AMA reaffirm Policy H-475.984, which lists Core Principles for Office-Based Surgery Regulations, with a focus on Core Principle #4 which states that physicians performing office-based surgery with moderate sedation/analgesia, deep sedation/analgesia, or general anesthesia must have admitting privileges at a nearby hospitals or a transfer agreement with another physician who has admitting privileges at a nearby hospital, or to maintain an emergency transfer agreement with a nearby hospital.

Fiscal Note: Minimal

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[4]*Supra.* Note 2.
[5]Supra. Note 1.

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Council on Medical Service Report 6-A-26
Study of Practice Models for Physicians Working Across State Lines
Policy Appendix

Office-Based Surgery Regulation, H-475.984
Our American Medical Association supports the following Core Principles on Office-Based Surgery:

Core Principle #1: Guidelines or regulations for office-based surgery should be developed by states according to levels of anesthesia defined by the American Society of Anesthesiologists (ASA) excluding local anesthesia or minimal sedation. (American Society of Anesthesiologists. Continuum of depth of sedation. Available at: https://www.asahq.org/standards-and-guidelines/guidelines-for-office-based-anesthesia, https://www.asahq.org/standards-and-guidelines/continuum-of-depth-of-sedation-definition-of-general-anesthesia-and-levels-of-sedationanalgesia).

Core Principle #2: Physicians should select patients for office-based surgery using moderate sedation/analgesia, deep sedation/analgesia or general anesthesia by criteria including the ASA Physical Status Classification System and so document. (American Society of Anesthesiologists. ASA physical status classification system. Available at: https://www.asahq.org/standards-and-guidelines/asa-physical-status-classification-system).

Core Principle #3: Physicians who perform office-based surgery with moderate sedation/analgesia, deep sedation/analgesia, or general anesthesia should have their facilities accredited by The Joint Commission, Accreditation Association for Ambulatory Health Care (AAAHC), American Association for Accreditation of Ambulatory Surgical Facilities (AAAASF), American Osteopathic Association (AOA), or by a state recognized entity, such as the Institute for Medical Quality (IMQ), or be state licensed and/or Medicare certified.

Core Principle #4: Physicians performing office-based surgery with moderate sedation/analgesia, deep sedation/analgesia, or general anesthesia must have admitting privileges at a nearby hospital or a transfer agreement with another physician who has admitting privileges at a nearby hospital, or maintain an emergency transfer agreement with a nearby hospital.

Core Principle #5: States should follow the guidelines outlined by the Federation of State Medical Boards (FSMB) regarding informed consent. (Report of the Special Committee on Outpatient [Office-Based] Surgery. (Med. Licensure Discipline. 2002; 88:-160-174).

Core Principle #6: For office surgery with moderate sedation/analgesia, deep sedation/analgesia, or general anesthesia, states should consider legally privileged adverse incident reporting requirements as recommended by the FSMB and accompanied by periodic peer review and a program of Continuous Quality Improvement. (Report of the Special Committee on Outpatient (Office-Based) Surgery. https://www.fsmb.org/siteassets/advocacy/policies/outpatient-office-based-surgery.pdf).

Core Principle #7: Physicians performing office-based surgery using moderate sedation/analgesia, deep sedation/analgesia or general anesthesia must obtain and maintain board certification by one of the boards recognized by the American Board of Medical Specialties, American Osteopathic Association, or a board with equivalent standards approved by the state medical board within five years of completing an approved residency training program. The procedure must be one that is generally recognized by that certifying board as falling within the scope of training and practice of the physician providing the care.

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Core Principle #8: Physicians performing office-based surgery with moderate sedation/analgesia, deep sedation/analgesia, or general anesthesia may show competency by maintaining core privileges at an accredited or licensed hospital or ambulatory surgical center, for the procedures they perform in the office setting. Alternatively, the governing body of the office facility is responsible for a peer review process for privileging physicians based on nationally recognized credentialing standards.

Core Principle #9: For office-based surgery with moderate sedation/analgesia, deep sedation/analgesia, or general anesthesia, at least one physician who is credentialed or currently recognized as having successfully completed a course in advanced resuscitative techniques (e.g., ATLS, ACLS, or PALS), must be present or immediately available with age- and size-appropriate resuscitative equipment until the patient has met the criteria for discharge from the facility. In addition, other medical personnel with direct patient contact should at a minimum be trained in Basic Life Support (BLS).

Core Principle #10: Physicians administering or supervising moderate sedation/analgesia, deep sedation/analgesia, or general anesthesia should have appropriate education and training.
(BOT Action in response to referred for decision BOT Rep. 23, A-03; Modified: CMS Rep. 4, A-13; Modified: CCB/CLRPD Rep. 1, A-23)

E-2.3.6 Surgical Co Management
Surgical co-management refers to the practice of allotting specific responsibilities of patient care to designated clinicians. Such arrangements should be made only to ensure the highest quality of care.

When engaging in this practice, physicians should:
(a) Allocate responsibilities among physicians and other clinicians according to each individual's expertise and qualifications.
(b) Work with the patient and family to designate one physician to be responsible for ensuring that care is delivered in a coordinated and appropriate manner.
(c) Participate in the provision of care by communicating with the coordinating physician and encouraging other members of the care team to do the same.
(d) Obtain patient consent for the surgical co-management arrangement of care, including disclosing significant aspects of the arrangement such as qualifications of clinicians, services each clinician will provide, and billing arrangement.
(e) Obtain informed consent for medical services in keeping with ethics guidance, including provision of all relevant medical facts.
(f) Employ appropriate safeguards to protect patient confidentiality.
(g) Ensure that surgical co-management arrangements are in keeping with ethical and legal restrictions.
(h) Engage another caregiver based on that caregiver's skill and ability to meet the patient's needs, not in the expectation of reciprocal referrals or other self-serving reasons, in keeping with ethics guidance on consultation and referrals.
(i) Refrain from participating in unethical or illegal financial agreements, such as fee-splitting.

AMA Principles of Medical Ethics: I,II,IV,V,VI
The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law.
(Issued: 2016)

E-1.1.3 Patient Rights
The health and well-being of patients depends on a collaborative effort between patient and physician in a mutually respectful alliance. Patients contribute to this alliance when they fulfill responsibilities they have, to seek care and to be candid with their physicians, for example.

Physicians can best contribute to a mutually respectful alliance with patients by serving as their patients' advocates and by respecting patients' rights. These include the right:
(a) To courtesy, respect, dignity, and timely, responsive attention to his or her needs.
(b) To receive information from their physicians and to have opportunity to discuss the benefits, risks, and costs of appropriate treatment alternatives, including the risks, benefits and costs of forgoing treatment. Patients should be able

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to expect that their physicians will provide guidance about what they consider the optimal course of action for the patient based on the physician's objective professional judgment.
(c) To ask questions about their health status or recommended treatment when they do not fully understand what has been described and to have their questions answered.
(d) To make decisions about the care the physician recommends and to have those decisions respected. A patient who has decision-making capacity may accept or refuse any recommended medical intervention.
(e) To have the physician and other staff respect the patient's privacy and confidentiality.
(f) To obtain copies or summaries of their medical records.
(g) To obtain a second opinion.
(h) To be advised of any conflicts of interest their physician may have in respect to their care.
(i) To continuity of care. Patients should be able to expect that their physician will cooperate in coordinating medically indicated care with other health care professionals, and that the physician will not discontinue treating them when further treatment is medically indicated without giving them sufficient notice and reasonable assistance in making alternative arrangements for care.

AMA Principles of Medical Ethics: I,IV,V,VIII,IX
The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law.
(Issued: 2016)

E-11.2.3 Contracts to Deliver Health Care Services
Prioritizing profits over patients is incompatible with physicians' ethical obligations. No part of the health care system that supports or delivers patient care should place profits over such care. Physicians have a fundamental ethical obligation to put the welfare of patients ahead of other considerations, including personal financial interests. This obligation requires that before entering into contracts to deliver health care services, physicians consider carefully the proposed contract to assure themselves that its terms and conditions do not create untenable conflicts of interest or compromise their ability to fulfill their ethical and professional obligations to patients. Those physicians who enter into contracts with corporate entities, such as private equity firms, management service organizations, professional services corporations, insurance companies, or pharmaceutical benefit managers, who act within their capacity as a physician, even as administrators or intermediaries, also have a duty to uphold the ethical obligations of the medical profession.

Ongoing evolution in the health care system continues to bring changes to medicine, including changes in reimbursement mechanisms, models for health care delivery, restrictions on referral and use of services, clinical practice guidelines, and limitations on benefits packages. While these changes are intended to enhance quality, efficiency, and safety in health care, they can also put at risk physicians' ability to uphold professional ethical standards and can impede physicians' freedom to exercise independent professional judgment and tailor care to meet the needs of individual patients.

As physicians seek capital to support their practices or enter into various differently structured contracts to deliver health care services—with group practices, hospitals, health plans, investment firms, or other entities—they should be mindful that while some arrangements have the potential to promote desired improvements in care, other arrangements have the potential to put patients' interests at risk and to interfere with physician autonomy.

When contracting with entities, or having a representative do so on their behalf, to provide health care services, physicians should:

(a) Carefully review the terms of proposed contracts, preferably with the advice of legal and ethics counsel to assure themselves that the arrangement:
(i) minimizes conflict of interest with respect to proposed reimbursement mechanisms, financial or performance incentives, restrictions on care, or other mechanisms intended to influence physicians' treatment recommendations or direct what care patients receive, in keeping with ethics guidance;
(ii) does not compromise the physician's own financial well-being or ability to provide high-quality care through unrealistic expectations regarding utilization of services or terms that expose the physician to excessive financial risk;
(iii) ensures the physician can appropriately exercise professional judgment;
(iv) includes a mechanism to address grievances and supports advocacy on behalf of individual patients;

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(v) is transparent and permits disclosure to patients;
(vi) enables physicians to have significant influence on, or preferably outright control of, decisions that impact practice staffing;
(vii) prohibits the corporate practice of medicine.

(b) Negotiate modification or removal of any terms that unduly compromise physicians' ability to uphold ethical or professional standards.

When entering into contracts as employees, preferably with the advice of legal and ethics counsel, physicians should:

(c) Advocate for contract provisions to specifically address and uphold physician ethics and professionalism.

(d) Advocate that contract provisions affecting practice align with the professional and ethical obligations of physicians and negotiate to ensure that alignment.

(e) Advocate that contracts do not require the physician to practice beyond their professional capacity and provide contractual avenues for addressing concerns related to good practice, including burnout or related issues.

(f) Not enter into any contract that would require the physician to violate their professional ethical obligations.

When contracted by a corporate entity involved in the delivery of health care services, physicians should:

(g) Terminate any contract that requires the physician to violate their professional ethical obligations and report any known or suspected ethical violations through the appropriate oversight mechanisms.

AMA Principles of Medical Ethics: I,II,III,V,VI,VIII,IX
The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law.
(Issued: 2016)

7. PRIVATE INSURANCE COVERAGE OF ANTI-OBESITY MEDICATIONS

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: RECOMMENDATIONS ADOPTED
REMAINDER OF REPORT FILED
See Policies D-110.987, D-330.954, H-110.959, H-110.987, H-110.997 and H-150.953

Resolution 230-A-25, "Advocating to Expand Private Insurance Coverage of Anti-Obesity Medications," was introduced by the Endocrine Society, American Association of Clinical Endocrinology, American Society for Reproductive Medicine, American Society for Metabolic and Bariatric Surgery, Obesity Medicine Association, and American College of Physicians. The resolution asked that existing Policy H-440.801 be amended. Subclauses 1f and 1h were adopted, while Subclauses 1e and 1g were referred. These referred subclauses ask the following:

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

1. Our AMA will urge individual state delegations to directly advocate for their state insurance agencies and insurance providers in their jurisdiction to:
    e. Eliminate coverage exclusions for the pharmacologic treatment of obesity.
    g. Support and cover chronic treatment with anti-obesity medications to maintain weight loss.

This report discusses the persistence of obesity, the emerging marketplace and coverage of anti-obesity medications (AOMs), guidelines for the treatment of obesity, and includes several policy recommendations.

BACKGROUND

Defined by the World Health Organization (WHO) as a chronic, progressive, and relapsing disease, obesity is a global public health challenge affecting more than one billion people worldwide and contributing to millions in preventable deaths each year. In the United States (U.S.), the prevalence of obesity among adults increased from 34.7 million (19.3 percent) in 1990 to 107 million (42.5 percent) in 2022.[1,2] Adults with severe obesity accounted for 9.2 percent (over twenty-two million by total population) in 2020.[3] By 2035, an estimated 46.9 percent of the adult population (126 million) will be categorized as obese.[4] The percentage of U.S. children and adolescents affected by obesity has more than tripled from 1965 (5 percent) to 2018 (19 percent).[5] Obesity is costly to the U.S. health care system, with an

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estimated $172 billion annually attributed in medical costs, representing 5 to 7 percent of all health care expenditures.[6] Despite obesity being a significant chronic disease for all populations, prevalence varies by race and ethnicity. In 2022, non-Hispanic Black females were estimated to have the highest prevalence of obesity, at 56.9 percent followed by Hispanic females at 49.4 percent.[7] The increasing prevalence of obesity also varied by race and ethnicity. For instance, obesity has risen least for non-Hispanic Black males, with an increase in prevalence from 22.0 percent in 1990 to 40.4 percent in 2022.[8] Additionally, there are state-level differences, with prevalence highest in Midwestern and Southern states and variance by age, with obesity prevalence highest among middle-aged adults and large increases in the youngest adult ages, especially for females.[9]

While the WHO defines obesity as having a body mass index (BMI) of 30.0 or higher in adults, the Lancet Commission recently announced a new definition that moves beyond BMI to classify it as a chronic disease.[10] Obesity is associated with and can result in an increased risk of comorbidities such as hypertension, diabetes, hypercholesterolemia, coronary heart disease, gallbladder disease, osteoarthritis, certain cancers, and liver disease. Severe obesity, defined as having a BMI of 40 or higher, can shorten life expectancy by up to 14 years, similar to smoking.[11] Moderately obese and severely obese individuals are estimated to have 14 to 25 percent more visits to their physicians, respectively, with visits to primary physicians to be 38 percent higher for those who are obese.[12]

Previously, obesity was thought to be an imbalance between energy intake and expenditure. However, recent research has suggested that genetic, physiological, and behavioral factors play a significant role.[13] Variations in genes that affect metabolic processes, appetite regulation, body fat distribution, and environmental factors such as geography, food and physical activity environment, and socioeconomic status are consequential in the development of obesity.[14] While traditional strategies focused on individual behavior have been insufficient, prevention efforts targeting obesity-related noncommunicable diseases have never been more important. For instance, prevention efforts can include the promotion of healthy eating, active lifestyles, and early intervention to reduce risks of diabetes, heart disease, and cancer. People with obesity continue to face social stigma with weight bias and discrimination persisting as significant factors in understanding the impact of and providing treatment through pharmacological methods.[15] Additionally, weight bias has led to delays in diagnosis and treatment and contributes to poorer health outcomes leading to a profound effect on all aspects of patients' lives and those of their families.[16]

Multiple public health interventions, such as school nutrition and exercise programs, taxes on unhealthy foods, and health system requirements for nutritional counseling programs[17] have had limited success, requiring health care to evolve to meet the needs of the population more adequately. Currently, comprehensive care for obesity includes nutrition therapy, physical therapy, behavioral counseling, and pharmacotherapy.[18] There are multiple methods for treating obesity including lifestyle modifications (e.g., diet, physical activity, and behavioral modifications), medications, and bariatric surgery, usually in combination.[19]

ANTI-OBESITY MEDICATIONS

Initially developed for the treatment of type-2 diabetes, GLP-1 receptor agonist and glucose-dependent insulinotropic polypeptides (GIP)/GLP-1 dual agonist therapies have emerged as potential AOMs. By targeting mechanisms that reduce appetite and enhance satiety along with other physiological effects, GLP-1 medications provide a complementary treatment to traditional behavioral interventions and important innovations to address obesity.[20] Additionally, clinical benefits associated with GLP-1 therapies have demonstrated improvements for major cardiovascular events, heart failure with preserved ejection fraction, diabetes prevention, systolic blood pressure and low-density lipoprotein cholesterol, obstructive sleep apnea, peripheral artery disease, kidney disease, metabolic dysfunction-associated steatohepatitis, and neurodegenerative diseases.[21] Similar results can be seen for patients with diabetes: improved glycemic control, significant weight loss, cardiovascular risk reduction, renal and liver production, a reduced need for other medications, lowered blood pressure, and improved cholesterol profiles.[22] The pleiotropic effects are beneficial for patients with multiple chronic conditions, especially for older patients, because it can help reduce polypharmacy and increase adherence to pharmacological treatments.[23] There has also been emerging evidence to suggest their utility in treating neurodegenerative diseases, reducing stroke risk, liver disease, and substance use disorders.[24] However, there are potential unintended consequences through the long-term use of GLP-1 medications. For instance, there is emerging clinical and paraclinical evidence that suggests that the agents may contribute to a reduction in skeletal muscle mass, potentially exacerbating or precipitating sarcopenic obesity, particularly in older or frail individuals with limited muscular reserves.[25] Therefore, the preservation of muscular health through nutritional support, exercise, and pharmacological therapies are important supplementary treatments, especially for older patients.

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At the time this report was written, there were seven medications approved for weight loss by the Food & Drug Administration (FDA), with varying effectiveness and occurrences of side effects. Earlier generations of obesity medications had lower degrees of effectiveness with higher incidences of side effects. Appendix A highlights the FDA approved GLP-1 medications for the treatment of obesity. There may be potential benefits to prescribing and administering earlier generations of AOMs.[26] For instance, access to second generation AOMs remains limited because of restricted insurance coverage and high out-of-pocket costs. While Wegovy® and Zepbound® are listed at $16,188 and $12,720 per year, respectively, Qsymia and Contrave are $1,465 and $2,095, respectively.[27] Additionally, significant shortages of GLP-1 medications can make it difficult to prescribe the second generation of AOMs and further inhibit access for certain patients. Furthermore, some patients may be nonresponders to semaglutide (or tirzepatide) or have difficulty tolerating GLP-1 based medications.[28] Some patients may require multiple medications in addition to semaglutide or tirzepatide to achieve significant weight loss or second generation AOMs might be too powerful and result in too much weight loss, loss of lean muscle mass, and concern of increased frailty.[29]

The next generation of AOMs are set to enter the market within the next several years–with 40 manufacturers in the process of developing GLP-1 drugs and 16 AOMs expected to be approved from 2026 to 2029–and are considered more effective with fewer side effects.[30] Similarly, non-GLP-1 medications are part of this emerging market and include melanocortin-4 receptor agonists, amylin analogs, and mitochondrial uncouplers.[31] Non-GLP-1 medications can be appealing for patients who do not respond to GLP-1s or have specific metabolic needs. Some of these new medications provide an oral alternative targeting similar pathways without requiring injections, thereby improving accessibility and patient adherence. Further, the dosing schedule for some of these new medicines is easily adherable. The emergence of these medications, their efficacy, favorable effects on metabolism and obesity-related complications, and recognition of obesity as a chronic health condition, has led to a rapid expansion in their use. GLP-1-based prescriptions among people without diabetes have risen by 700 percent between 2019 to 2023.[32] Pervasive media attention has led some to theorize whether AOMs could be a potential solution to the obesity epidemic. In December 2025, Novo Nordisk released a pill version of Wegovy® and, in less than three weeks, 150,000 prescriptions were filled.[33] According to the manufacturer, most prescriptions are from new patients and 9 out of 10 paid out of pocket.[34]

Pervasive media attention has also led GLP-1s to being used off-label for non-obese patients to lose small amounts of weight.[35] While GLP-1s are being used off-label by individuals who do not meet obesity criteria, there are significant considerations required in prescribing an AOM. There is a marked difference between AOMs being prescribed for chronic, long-term use and for short-term use without the guidance of a medical professional. Compounded versions of the GLP-1 injectables were made available in early 2022 when brand name versions were in short supply. Under Section 503A and 503B of the Federal Food, Drug, and Cosmetic (FD&C) Act, compounded drugs are allowed when the brand-name drug is on the FDA's official Drug Shortages list. While the FDA provides some flexibility, the agency may act if an outsourcing facility continues to fill new orders for more than 60 days after the drug has been removed from the Drug Shortages list. In the case of GLP-1 medications, the FDA removed the injectables from the list in February 2025 but allowed a brief window for compounders to wind down operations with 503A pharmacies allowed to continue until April 22, 2025 and 503B outsourcing facilities until May 22, 2025.[36] Despite the timeline, and the FDA warning telehealth companies against illegal marketing of compounded GLP-1s, Hims & Hers™ was still offering its versions of injectable weight-loss drugs until March 2026 when it struck a deal with Novo Nordisk to sell Wegovy® at a discounted rate.[37,38]

Treatment discontinuation of tirzepatide and semaglutide remains high and is a significant issue as it is associated with increased risks of cardiovascular events and mortality. Randomized trials, such as SURMOUNT-4, demonstrate that discontinuation of pharmacotherapy leads to weight re-gain reinforcing the chronic nature of obesity treatment.[39] Cost or insurance-related (insurance denial, expiration of manufacturer discount coupon, or out-of-pocket cost) hurdles were cited as the most common reason, by half of respondents (47.6 percent).[40] Side effects were the second most cited reason with 14.6 percent of respondents. For comparison, side effects and efficacy are cited as the most common reason for treatment discontinuation of medication for chronic medical conditions.[41] In general, high-risk, non-oral medications for conditions like diabetes, asthma, and glaucoma often have higher initial discontinuation rates.[42] Furthermore, younger patients, those with comorbidities, and patients who are non-White may have higher rates of discontinuation.[43]

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COVERAGE OF ANTI-OBESITY MEDICATIONS

Despite an increasing body of evidence to suggest that emerging AOMs are effective treatments, coverage of GLP-1s for obesity treatment remains limited. Indeed, coverage is sparse for individuals through Medicaid, Affordable Care Act (ACA) Marketplace plans, and those who work in large employer firms, and coverage in Medicare for treatment of obesity is, for now, prohibited.[44,45,46] While all Medicaid programs cover GLP-1s for the treatment of diabetes, coverage is optional for the treatment of obesity. As of October 2025, 16 state Medicaid programs covered GLP-1s for obesity treatment, 11 states cover GLP-1s for weight loss under their state employee health plan, and five provide coverage under both programs.[47] Some of these Medicaid programs, however, have already announced they will discontinue coverage or restrict those who can qualify. North Carolina Medicaid, for example, ended coverage of GLP-1s for obesity in October 2025, citing shortfalls in state funding.[48] Additionally, California, New Hampshire and South Carolina will end coverage at the beginning of 2026.[49] Further, starting next year, Michigan Medicaid will limit coverage to people who are "morbidly obese," (BMI of 40 or higher).[50] Lastly, Pennsylvania, Rhode Island and Wisconsin are also considering new restrictions.[51]

Private insurance coverage is often based on the insurance plan or employer decision to include the benefit; even if the coverage is offered, its initial and continued coverage is restricted by stringent prior authorization criteria. As of 2025, 39.4 percent of individuals with private insurance and 45.1 percent of individuals with employee sponsored insurance had at least one GLP-1 medication covered by their plan.[52] Drugs solely approved to treat obesity have minimal to no coverage on most ACA Marketplace formularies. Among ACA Marketplace plans with these drugs on formulary, prior authorization is required by most plans (greater than 98 percent).[53] Step therapy, a utilization management tool that requires patients to try and fail lower cost medications before coverage is provided for more expensive medications, is less commonly used, with 1 in 4 marketplace plans requiring it.[54] Quantity limits are imposed in most plans among those including these drugs.[55] With such a high demand for and short supply of GLP-1 agonists, some patients have taken to procuring them from alternative sources, such as online vendors, medical spas, or compounding pharmacies selling products not evaluated by the FDA, some of which may contain different ingredients.[56] The FDA is increasing enforcement against compounded GLP-1 drugs, as many shortages have been resolved, removing the exemption that allowed pharmacies to create copies of branded drugs.[57] The agency is targeting companies, including telehealth providers, for selling non-FDA-approved, mass-marketed "copycat" versions that pose safety risks.[58]

Despite a notable increase in employers covering GLP-1 medications for weight loss, the high costs associated with obesity medications raise significant concerns. While recognizing their benefit, many employers are considering scaling back coverage due to their high cost and higher than expected use. Approximately 34 percent of non-elderly people with employer-sponsored health insurance (36.2 million) have a body mass that would medically qualify them for GLP-1 drugs.[59] The share of firms with 5,000 or more workers covering these medications for weight loss increased significantly (from 28 percent in 2024 to 43 percent in 2025).[60] However, only 19 percent of firms with 200 or more workers cover GLP-1 drugs for weight loss in their largest health plan in 2025.[61] Furthermore, for those firms that cover GLP-1s for weight loss, about a third require enrollees to meet with a dietician, case manager, therapist, or participate in a lifestyle program.[62]

While insurance coverage of GLP-1 medications for obesity remains lower than other medications, there is a roadmap to broader access with comparable treatments. Bariatric surgery coverage has evolved from a rarely covered, high-risk procedure in the early 1990s to a widely accepted, insurance-covered treatment for severe obesity. Driven by improved safety and proven metabolic benefits, a major milestone occurred when the Centers for Medicare & Medicaid Services (CMS) expanded Medicare coverage in 2006 for patients with specific comorbidities.[63] Currently, bariatric surgery is generally covered for obesity when deemed medically necessary, a specific BMI threshold is met with obesity-related comorbidities like diabetes and sleep apnea. Additionally, coverage requires documentation of failed, previous weight loss attempts, a supervised diet program, and mental health evaluations.[64]

Rebates for GLP-1 medications are widespread and, as of 2025, are estimated to be 40 percent or higher for major products like Wegovy® and Zepbound®.[65] They are most readily used by pharmacy benefit managers (PBMs) to secure formulary placement, reducing high list prices to lower net costs for payers. The rebates are a primary tool used to secure preferred coverage on insurer formularies, with some discounts at 50 percent.[66] Additionally, states received substantial rebates for brand-name GLP-1s, with usage growing and accounting for eight percent of Medicaid prescription drug spending before rebates in 2024.[67] However, these manufacturer-to-payer rebates do not always

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translate directly into lower out-of-pocket costs for individual users and frequently rely on copay assistance coupons to manage costs.

PBMs play a central, controversial role in the high cost of GLP-1 medications. By controlling access via formularies and negotiating large, often opaque rebates, PBMs are criticized for favoring higher-priced drugs for larger rebates and, therefore, keeping net costs high for employers.[68,69] PBMs argue their negotiating power is used to counterbalance high list prices set by manufacturers, sometimes securing lower out-of-pocket costs for members. However, limited transparency makes it difficult to distinguish how and if the discounts are passed on to employers or patients.[70] PBMs can also implement strict utilization controls including mandatory prior authorization, step therapy, and BMI requirements to limit access and manage costs.[71] While utilization controls can be useful, it is argued that PBMs may use unfair criteria or a patient facing restricted access despite it being a clinically appropriate treatment.

A study from 2025 showed that there was significant disparities in AOM prescription rates based on gender, race/ethnicity, age, insurance type, insurance carrier, and adjusted gross income (AGI).[72,73] For instance, Black patients, Hispanic individuals, and those of other racial or ethnic backgrounds had lower prescription rates, compared with white patients.[74] Furthermore, men had lower rates than women and, compared with privately insured individuals those with Medicaid, traditional Medicare, Medicare Advantage, self-paying, and other insurance types had lower rates of prescription.[75] Lastly, those with the highest level of income had the highest prescription rate compared to those with the lowest income.[76] Patients filling their prescription differed as well, though less significantly than those receiving an AOM prescription. While Hispanic patients were less likely to fill their prescription compared with White patients, Black patients had similar filling rates.[77] Patients who were older or women were more likely to fill their prescription higher odds of AOM fill.[78] Furthermore, Medicaid, traditional Medicare and Medicare Advantage insurance types were associated with lower odds of AOM fill, compared with private insurance category.[79] Interestingly, insurance carriers or AGI did not produce any significant difference in filling rates.[80]

WORLD HEALTH ORGANIZATION GUIDELINES ON THE USE OF GLP-1 THERAPIES[81]

In December 2025, and in response to requests from its member nations, the WHO published an evidence-informed guideline on the use of GLP-1 therapies in the treatment of obesity in adults. The guideline outlines a strategic foundation to help countries accelerate their response to the obesity crisis, brings together the current evidence base, details the development process, and distills the implications for expanding equitable access to these medications while shaping a more comprehensive ecosystem for obesity management. In the report, two practice statements were outlined with partnering recommendations. First, obesity was recognized as chronic, complex disease that requires lifelong care beginning in clinical assessment and early diagnosis. It was recommended that in adults living with obesity, GLP-1 receptor agonists or GIP/GLP-1 dual agonists may be used as long-term treatment for obesity. Second, people living with obesity should receive context-appropriate counselling on behavioral and lifestyle changes as an initial step toward more structured behavioral interventions. Thus, it was recommended that in adults living with obesity who are prescribed GLP-1 receptor agonists or GIP/GLP-1 dual agonists, intensive behavioral therapy may be provided as a co-intervention within a comprehensive multimodal clinical algorithm.

The guideline emphasizes the importance of fair access to GLP-1 therapies and preparing health systems for use of obesity medicines. Without deliberate policies, the WHO suggests access to GLP-1 therapies could exacerbate existing health disparities. Additionally, in September 2025, the WHO added GLP-1 therapies to its Essential Medicines List for managing type 2 diabetes in high-risk groups.[82] With the guideline, the WHO issues conditional recommendations for using therapies to support people living with obesity, as part of a comprehensive approach that includes healthy diets, regular physical activity, and support from health professionals.

INSTITUTE FOR CLINICAL AND ECONOMIC REVIEW REPORT: AFFORDABLE ACCESS TO GLP-1 OBESITY MEDICATIONS[83]

In April 2025, the Institute for Clinical and Economic Review (ICER) released the report Affordable Access to GLP-1 Obesity Medications: Strategies to Guide Market Action and Policy Solutions. In the report, ICER presented potential strategies to guide market action, policy solutions, and federal policy interventions to improve access to GLP-1 medications, and AOMs in general.

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Five market strategies were suggested, informed by ICER's interviews with different stakeholders and their advantages and limitations are outlined for each option in Appendix B. For instance, temporary coverage denial was a solution, suggesting that some purchasers and insurers have concluded that they do not have the budget flexibility to provide coverage for GLP-1s for treatment of obesity at current prices. For those that are seeking a more affordable and long-term way to provide coverage for expensive drugs, such as GLP-1s, purchasers and insurers may apply enhanced utilization and could include coverage criteria. Some coverage criteria included BMI and clinical comorbidities, additional clinical or genetic factors, and/or duration of coverage. Another suggestion was that managing the network of clinical providers may improve results while controlling costs. While some purchasers may consider temporary non-coverage of GLP-1 drugs, another solution may be to utilize alternative payment arrangements to help individuals afford treatment. The last market solution that the report outlined was carve-out programs. Many purchasers or payers are delegating obesity management to a comprehensive program offered by a PBM or to an independent obesity management company.

Five federal policy interventions were suggested as potential policy reforms that the federal government could enact to address access to GLP-1 medications and the overall cost of obesity treatment. One potential policy reform was increased access through coverage of obesity drugs in Medicare. While the Trump Administration announced the coverage of GLP-1 medications for the treatment of obesity, federal law still bans Medicare from covering weight-loss drugs and requires a pilot program to evaluate coverage. At a federal level, in lieu of Medicare coverage of GLP-1s for obesity, another way to broaden coverage would be to ask the United States Preventive Services Task Force to evaluate GLP-1s and deem them as preventive treatments worthy of a rating of "A" or "B" that creates a mandate for coverage by all private insurers with no patient cost sharing. The third cited policy reform was reducing costs through aggressive drug price negotiation by the federal government. The Trump Administration, as will be outlined, recently negotiated the price for GLP-1 medications covered through Medicare and Medicaid. Additionally, the federal government negotiated during its second round of Medicare's Drug Price Negotiation Program, created by the Inflation Reduction Act (IRA) of 2022, which included diabetes and obesity drugs Ozempic® and Wegovy®. The fourth reform was to reduce costs through federal subsidies for private insurance coverage of obesity treatments. The federal government, it is suggested, could negotiate significant price concessions like the affordable prices that were negotiated for COVID-19 vaccines and treatments during the pandemic in exchange for federal subsidies to private insurers. Along with negotiating lower prices through the IRA process, the fifth intervention is to require that drugmakers license GLP-1 drugs to generic manufacturers for the express purpose of providing more affordable versions for public payers, including state Medicaid programs and state employee health plans.

RECENT REGULATORY ACTIVITY

In May 2025, the Trump Administration issued Executive Order No. 14297, Delivering Most-Favored-Nation Prescription Drug Pricing to American Patients which instructed drug manufacturers to reduce the prices of brand-name drugs to match the lowest price among selected high-income countries as part of its aim to deliver its most-favored-nation (MFN) drug pricing.[84] In November 2025, the Trump Administration announced an agreement with pharmaceutical manufacturers Eli Lilly and Novo Nordisk to offer their weight-loss drugs for individuals receiving Medicare and Medicaid as part of its MFN policy.[85] As part of this plan, the Medicare price for Ozempic®, Wegovy®, Mounjaro®, and Zepbound® will be $245, with Wegovy® and Zepbound® covering patients with obesity and related comorbidities for the first time. Further, in December 2025, CMS published its voluntary Better Approaches to Lifestyle and Nutrition for Comprehensive hEalth (BALANCE) Model.[86] The BALANCE Model will allow CMS to negotiate drug pricing and coverage terms with manufacturers of GLP-1 medications on behalf of state Medicaid agencies and Medicare Part D plan sponsors. Medicaid agencies can join the model beginning in May 2026, and Part D plans in January 2027. However, as previously mentioned, federal law still bans Medicare from coverage of weight-loss drugs and will require demonstration programs and waivers to proceed. Furthermore, it is unclear whether states will find the model appealing. For instance, due to recent budget cuts, many states are facing tighter budget constraints. Additionally, it is unknown how the new lower costs compare to the net prices state Medicaid programs already pay after rebates. Lastly, state interest in expanding coverage of obesity drugs has been waning due to their significant budgetary impact and sustainability.

Legal challenges and negative feedback from stakeholders led to the withdrawal of prior proposals introduced during the first Trump Administration: International Pricing Index (IPI) Model and MFN Model. The IPI Model sought to lower drug costs and reduce out-of-pocket costs for patients. CMS solicited public comments on options considered for testing changes to payment for separately payable Medicare Part B drugs to align with international prices more closely. Similarly, the proposed MFN Model negotiated for the lowest price that drug manufacturers received in other

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similar countries for high-cost Medicare Part B drugs. While both were withdrawn, these policies provided the outline for the Trump Administration's second attempt to lower prescription drug costs.
While Novo Nordisk and Eli Lilly have committed to lowering the prices for private insurance and group health plans, it is unclear how the negotiated prices will affect them. The agreement does not include pricing obligations in the commercial market. Some experts suggest price reductions will transition over to group health plans and private insurance, while others believe manufacturers will make up the difference by lowering rebates or increasing prices. Others have expressed concern over MFN policies, suggesting that price controls trade short-term benefits for long-term risk. Further, while the Trump Administration has indicated its desire to codify MFN pricing, it is unclear if Congress will be agreeable citing concern potential threats to medical innovation, reduced access to new medicines, and increased government intervention in the health care market.

In November 2025, CMS announced the prices that the federal government negotiated during its second round of Medicare's Drug Price Negotiation Program (MDPNP), created by the IRA, which included Ozempic® and Wegovy®.[87] According to a spokesperson for CMS, MFN prices will supersede MDPNP prices and that MFN drug prices will supersede "maximum fair prices" negotiated under the IRA where there is a conflict.

Finally, the Trump Administration launched TrumpRx in February 2026 – a government run, direct to consumer website designed to deliver MFN prices directly from manufacturers. Not all medications will be available, with five manufacturers participating and 40 of the nation's highest-cost brand-name drugs listed on the website. For instance, not all AOM are available for purchase - Wegovy® and Zepbound® are listed while Saxenda® is not. Details are still emerging, and questions remain regarding who will benefit.

AMA POLICY

Policy H-110.997 supports programs whose purpose is to contain the rising costs of prescription drugs, most notably that: all patients have access to all prescription drugs necessary to treat their illnesses and physicians have the freedom to prescribe the most appropriate drug and method of delivery. Additionally, Policy H-110.997 encourages physicians to stay informed about the availability and therapeutic efficacy of generic drugs, to consider the prescribing of the least expensive drug product, and to become familiar with the price in their community of the medications they prescribe.

Policy H-110.959 supports efforts to ensure that patients have affordable access to medications and encourages all payers to establish a reasonable and affordable cap on patient out-of-pocket prescription costs.

Policy H-110.987 encourages prescription drug price and cost transparency among pharmaceutical companies, pharmacy benefit managers and health insurance companies, encourages the Federal Trade Commission actions to limit anticompetitive behavior by pharmaceutical companies attempting to reduce competition, and supports legislation to shorten the exclusivity period for biologics.

Policy D-110.987 supports the active regulation of PBMs under state departments of insurance, supports improved transparency of PBM operations, and details that the AMA will develop model state legislation addressing the state regulation of PBMs, which shall include provisions to maximize the number of PBMs under state regulatory oversight.

Policy H-150.953 urges physicians and managed care organizations and other third-party payers to recognize obesity as a complex disorder and all payers to ensure coverage parity for evidence-based treatment of obesity, including FDA-approved medications without exclusions or additional carve-outs.

Policy D-330.954 supports federal legislation which gives the Secretary of the Department of Health and Human Services (HHS) the authority to negotiate contracts with manufacturers of covered Part D drugs, works toward eliminating Medicare prohibition on drug price negotiation, and prioritizes the AMA's support for CMS to negotiate pharmaceutical pricing for all applicable medications covered by CMS.

Finally, Policy H-440.801, which is amended by Resolution 230, urges state delegations to directly advocate for their insurance agencies and insurance providers to, most notably: allow a patient's physician to prescribe anti-obesity medication and have it covered by insurance and reduce the prior authorization burden for the coverage of anti-obesity medications.

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DISCUSSION

The Council recognizes the changing landscape of AOMs, their role in the treatment of obesity, and the emergence of GLP-1s as a "game-changing" pharmacological treatment for patients with obesity, diabetes, and comorbid conditions. Their clinical efficacy is clear, but they are expensive. Although many employer-sponsored insurance or private insurance plans do not cover GLP-1 medications for the treatment of obesity, that could change in the future as there have been several developments toward improved affordability and access. Starting in July 2026, Medicare will significantly expand coverage for GLP-1 medications for patients with obesity and comorbid conditions. Patients will have access to these drugs with copays capped at $50 per month, supported by the short-term demonstration program acting as a bridge to the broader BALANCE model launching in 2027 which will also serve as a pilot program for state Medicaid programs. Moreover, the proliferation of direct-to-consumer marketplaces, which bypass traditional insurance and retail pharmacies, offer lower list prices and enhance medication access. Likewise, the recently approved pill versions of Wegovy® ¬and soon to be approved non-peptide GLP-1 called Orforglipron® ¬ enhance affordability. Additionally, the emergence of more effective AOMs set to enter the marketplace within the next few years will improve their affordability and access. Furthermore, while some states have rescinded coverage of GLP-1 medications for the treatment of obesity, the demand for AOMs and potential payment structures lessening variability may improve access organically.

Nonetheless, the Council recognizes the importance of more immediate coverage and the potential value of the market strategies and policy reforms outlined in the ICER report. Therefore, the Council recommends several new policies to supplement AOM affordability and access. The Council recommends support for innovative payment arrangements and pilot programs consistent with several recently announced Medicare and Medicaid demonstrations intended to increase the affordability of GLP-1 medications.

It also is becoming more evident that patients with chronic obesity may need to take these medications long-term. As such, the Council supports the long-term coverage of AOMs to maintain weight loss through consistent drug pricing, formulary tiers, and benefit structures. The Council also acknowledges pharmacological treatment may not be effective, in some cases, without concurrent disease management treatment which may not be accessible for all patients. With that in mind, the Council supports equitable access to comprehensive disease management, nutritional therapies, health promotion, and prevention interventions targeting the general population, those who are at elevated risk for obesity, and patients being treated for obesity.

Medication affordability and access continue to be significant concerns for many patients, including those that need AOMs for chronic obesity. As such, the Council recommends reaffirming Policy H-110.987, which supports efforts to ensure drug prices are affordable to patients, and Policy H-110.959, which encourages all payers to establish a reasonable and affordable cap on patient out-of-pocket prescription drug spending in a manner that does not increase patient premiums. The Council also recognizes the contribution of PBMs to high drug costs and their lack of clarity on rebate driven formularies. Therefore, the Council recommends reaffirming Policy D-110.987, which supports efforts to increase PBM transparency and regulation. Additionally, the Council notes that negotiating for Medicare drug prices is crucial to reducing high out-of-pocket costs for seniors and lowering government health care spending. Thus, the Council recommends reaffirming Policy D-330.954, which supports CMS negotiating pharmaceutical pricing for all applicable medications covered by CMS and indicates the AMA's support for federal legislation giving the Secretary of HHS the authority to negotiate contracts with manufacturers of covered Medicare Part D drugs. The Council appreciates the important role of the physician in the treatment of chronic obesity and, as such, recommends reaffirming Policy H-110.997, which supports programs whose purpose is to contain the rising costs of prescription drugs, physicians having the freedom to prescribe the most appropriate drug and method of delivery, and encourages all physicians to become familiar with the price in their community of the medications they prescribe.

Lastly, the Council recognizes the complexity, prevalence, and impact of obesity and, therefore, recommends reaffirming Policy H-150.953, which recognizes obesity as a complex health disorder, urges all payers to ensure coverage parity for evidence-based treatment of obesity, including FDA-approved medications without exclusions or additional carve-outs, and appropriate federal agencies work with organized medicine to develop coding and payment mechanisms for the evaluation and management of obesity.

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RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Subclauses 1e and 1g of Resolution 230-A-25, and the remainder of the report be filed:

1. That our American Medical Association (AMA) support:
    a. Potential innovative payment arrangements to help individuals afford treatment for emerging anti-obesity medications (AOMs);
    b. Pilot programs which allow for demonstration projects that cover emerging medications which aid in obesity management, such as glucagon-like peptide-1 and glucose-dependent insulinotropic polypeptide-based medications;
    c. The long-term coverage of AOMs to maintain weight loss through consistent drug pricing, formulary tiering, benefit structures, and coverage criteria in private insurance and employer-sponsored insurance to offset cost variability;
    d. Equitable access to comprehensive disease management, nutritional therapies, health promotion, and prevention interventions targeting the general population, those who are at elevated risk for obesity, and patients being treated for obesity.
2. That our AMA reaffirm Policy H-110.987, which supports efforts to ensure drug prices are affordable to patients.
3. That our AMA reaffirm Policy D-110.987, which supports efforts to increase PBM transparency and regulation.
4. That our AMA reaffirm Policy H-110.959, which supports efforts to ensure patients have affordable access to medications and encourages all payers to establish a reasonable and affordable cap on patient out-of-pocket prescription drug spending in a manner that does not increase patient premiums.
5. That our AMA reaffirm Policy H-110.997, which supports programs whose purpose is to contain the rising costs of prescription drugs, that all patients have access to all prescription drugs necessary to treat their illnesses, and physicians have the freedom to prescribe the most appropriate drug and method of delivery.
6. That our AMA reaffirm Policy D-330.954, which supports Centers for Medicare & Medicaid Services (CMS) negotiating pharmaceutical pricing for all applicable medications covered by CMS, AMA working toward the elimination Medicare prohibition on drug price negotiation, and indicates the AMA's support for federal legislation giving the Secretary of the Department of Health and Human Services the authority to negotiate contracts with manufacturers of covered Part D drugs.
7. That our AMA reaffirm Policy H-150.953, which recognizes obesity as a complex health disorder, urge all payers to ensure coverage parity for evidence-based treatment of obesity, including FDA-approved medications without exclusions or additional carve-outs, and appropriate federal agencies work with organized medicine to develop coding and payment mechanisms for the evaluation and management of obesity.

Fiscal Note: Minimal

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Appendix A
GLP-1 Obesity Medications Approved by the FDA

Drug	Effectiveness	FDA Approval Indication	Year Approved
Liraglutide (Saxenda®) GLP-1 Receptor Agonist Daily subcutaneous injection	63% lost at least 5% reduction of body weight	Adjunct to a reduced-calorie diet and increased physical activity for chronic weight management in: 1) Adult patients with an initial body mass index (BMI) of •30 kg/m2 or greater (obese), or •27 kg/m2 or greater (overweight) in the presence of at least one weight-related comorbid condition; 2) Pediatric patients aged 12 years and older with body weight above 60 kg and an initial BMI corresponding to 30 kg/m2 for adults (obese) by international cut-offs	2014
Semaglutide (Wegovy®) GLP-1 Receptor Agonist Weekly subcutaneous injection	80% lost at least 5% reduction of body weight	GLP-1 receptor agonist indicated in combination with a reduced calorie diet and increased physical activity: •to reduce the risk of major adverse cardiovascular events in adults with established cardiovascular disease and either obesity or overweight • to reduce excess body weight and maintain weight reduction long term in: 1) Adults and pediatric patients aged 12 years and older with obesity; 2) Adults with overweight in the presence of at least one weight-related comorbid condition	2021
Semaglutide (Wegovy®) GLP-1 Receptor Agonist Once-daily oral administration	76% lost at least 5% reduction of body weight	GLP-1 receptor agonist indicated in combination with a reduced calorie diet and increased physical activity: • chronic weight management in adults with obesity (BMI ≥ 30) or overweight (BMI ≥ 27) with weight-related conditions; • reduced calorie diet/exercise to lower cardiovascular risk in adults with established heart disease and to treat MASH	2025
Tirzepatide (Zepbound®) Combined GLP-1/GIP Receptor Agonist Weekly subcutaneous injection	85% lost at least 5% reduction of body weight	GIP receptor and GLP-1 receptor agonist indicated as an adjunct to a reduced-calorie diet and increased physical activity for chronic weight management in indicated in combination with a reduced-calorie diet and increased physical activity: • to reduce excess body weight and maintain weight reduction long term in adults with obesity or adults with overweight in the presence of at least one weight-related comorbid condition. • to treat moderate to severe obstructive sleep apnea (OSA) in adults with obesity.	2023

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Appendix B
Potential Strategies to Guide Market Action: Institute for Clinical and Economic Review (ICER) Report

1) Temporary Coverage Denial: Some purchasers and insurers have concluded that they do not have the budget flexibility to provide coverage for GLP-1s for treatment of obesity at current prices. Some purchasers believe that, within a year or two, providers will be more efficient and effective, more will be known about how to maintain long-term use of all AOMs, and competition may bring lower pricing.
    a. Advantages: For purchasers with high employee turnover and limited resources, this perspective can provide a compelling argument for holding off on providing coverage until the landscape changes. Additionally, individuals may be able and willing to bear the cost of GLP-1 drugs outside of insurance, although much of that access was made possible through far less expensive, and less reliable, compounded versions.
    b. Limitations: Clinical trials have demonstrated relatively rapid reductions in cardiac events among patients with existing cardiac conditions after treatment initiation and, therefore, temporary non-coverage may be untenable for those with serious medical conditions. Additionally, the broader societal goal of reducing disparities in access to effective treatments for obesity across socioeconomic and racial categories may make temporary non-coverage insupportable. Furthermore, there is an equity concern about requiring people with one medical condition to bear the financial burden alone when most costs of other conditions are covered by insurance.
2) Enhanced Prior Authorization and Formulary Management: For those seeking a more affordable and long-term way to provide coverage for expensive drugs, such as GLP-1s, purchasers and insurers may apply enhanced utilization and could include coverage criteria. Some coverage criteria included BMI and clinical comorbidities, additional clinical or genetic factors, and/or duration of coverage. Two additional formulary management options were suggested: covering only a single GLP-1 drug; or step therapy through earlier AOMs.
    a. Advantages: Using more restrictive BMI and comorbidity thresholds for coverage can be seen as a principled, evidence-based approach to targeting coverage to those individuals at highest risk for short-term adverse events and who therefore stand to benefit most from treatment.
    b. Limitations: Coverage criteria narrower than the FDA label language can be criticized by clinicians and patients as being inappropriately restrictive. For example, BMI, the main patient characteristic being used for limiting coverage eligibility, is an imperfect measure of obesity-related health risks. Additionally, data from clinical trials suggest that patients stopping GLP-1 treatment often regain much or all the weight lost. Furthermore, some patients who merit treatment will face delays or other barriers to effective care.
3) Network Management: Managing the network of clinical providers may improve results while controlling costs. Some options include - open prescribing with attendant tighter utilization management could allow all primary care providers to prescribe GLP-1 drugs as part of their practice, limiting prescribing by a curated expert network with lighter or no utilization management, or carve-out clinical care and prescribing to external weight loss management firms.
    a. Advantages: Open prescribing maximizes access to the most effective obesity treatment, thereby reducing disparities in access across socioeconomic, racial, and other categories. In addition, integrating GLP-1 prescribing into primary care helps keep medication use coordinated across other clinical conditions, such as diabetes and hypertension. Limited prescribing has the opposite advantages of an open prescribing model. Setting up a “Centers of Excellence” approach to obesity medication prescribing maximizes the likelihood of appropriate comprehensive care for patients with obesity, including the use of GLP-1 drugs.
    b. Limitations: The drawbacks of open prescribing begin with the likelihood that a certain proportion of GLP-1 drugs will be prescribed for patients who could do well with other, less expensive AOMs. Combining open prescribing with tight utilization management criteria is one way to try to provide wide access without producing high rates of inappropriate use. Negatives to limited prescribing are that there are nowhere near enough obesity specialists to manage the number of people seeking GLP-1 treatment and long waiting lists would result.
4) Innovative Payment Arrangements: While some purchasers may consider temporary non-coverage of GLP-1 drugs, another solution may be to utilize alternative payment arrangements to help individuals afford treatment. For instance, performance agreements by linking rebates to a weight goal, to a particular percentage weight loss target, or to adherence to treatment are an option. Other options include volume-based rebates and subscription models.

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a. Advantages: Performance agreements sometimes include aligned patient incentives to maintain adherence or to achieve clinical goals. Additionally, subscription models guarantee financial certainty for purchasers but also guarantee recurring revenue for manufacturers.
b. Limitations: There are many reasons that patients might not reach their goal, whether from lack of drug availability, ineffectiveness of the drug, side effects, or financial barriers. Furthermore, some performance agreements have little study on their efficacy.

5) Carve Out Programs: Many purchasers or payers are delegating obesity management to a comprehensive program offered by a PBM or to an independent obesity management company. The common features of these programs are a national network of clinical experts who engage with patients virtually, clinical algorithms that help identify patients for whom less expensive treatment options are appropriate, an integration of interventions on diet and activity as part of lifestyle management, and a per member per month payment model, often with guarantees on adherence to medication use and overall cost reductions.
    a. Advantages: Carve-out companies can bring not only clinical expertise but a more comprehensive approach to ensuring that all patients receive individualized care, including appropriate lifestyle management interventions
    b. Limitations: One challenge is the distribution of rebate dollars - rebates from GLP-1 manufacturers in many cases go directly to the carve-out program and not to the purchaser. Additionally, carving out obesity care runs the risk of creating a lack of coordination with the care for other conditions. Lastly, obesity carve-out companies have been using compounded versions of GLP-1 drugs as another way to achieve lower overall costs of care.

Council on Medical Service Report 7-A-26
Private Insurance Coverage of Anti-Obesity Medications
Policy Appendix

Advocacy Against Obesity-Related Bias by Insurance Providers H-440.801

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

(Res. 224, A-23; Appended: Res. 230, A-25)

Obesity as a Major Public Health Problem H-150.953

1. Our American Medical Association will urge physicians as well as managed care organizations and other third party payers to recognize obesity as a complex disorder involving appetite regulation and energy metabolism that is associated with a variety of comorbid conditions.
2. Our AMA will work with appropriate federal agencies, medical specialty societies, and public health organizations to educate physicians about the prevention and management of overweight and obesity in children and adults, including education in basic principles and practices of physical activity and nutrition counseling; such training should be included in undergraduate and graduate medical education and through accredited continuing medical education programs.
3. Our AMA will urge federal support of research to determine:
    a. the causes and mechanisms of overweight and obesity, including biological, social, and epidemiological influences on weight gain, weight loss, and weight maintenance;

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   b. the long-term safety and efficacy of voluntary weight maintenance and weight loss practices and therapies, including surgery;
   c. effective interventions to prevent obesity in children and adults; and
   d. the effectiveness of weight loss counseling by physicians.
4. Our AMA will encourage national efforts to educate the public about the health risks of being overweight and obese and provide information about how to achieve and maintain a preferred healthy weight.
5. Our AMA will urge physicians to assess their patients for overweight and obesity during routine medical examinations and discuss with at-risk patients the health consequences of further weight gain; if treatment is indicated, physicians should encourage and facilitate weight maintenance or reduction efforts in their patients or refer them to a physician with special interest and expertise in the clinical management of obesity.
6. Our AMA will urge all physicians and patients to maintain a desired weight and prevent inappropriate weight gain.
7. Our AMA will encourage physicians to become knowledgeable of community resources and referral services that can assist with the management of overweight and obese patients.
8. Our AMA will urge the appropriate federal agencies to work with organized medicine and the health insurance industry to develop coding and payment mechanisms for the evaluation and management of obesity.
9. Our AMA will urge all payers to ensure coverage parity for evidence-based treatment of obesity, including FDA-approved medications without exclusions or additional carve-outs.

(CSA Rep. 6, A-99; Reaffirmation A-09; Reaffirmed: CSAPH Rep. 1, A-09; Reaffirmation A-10; Reaffirmation I-10; Reaffirmation A-12; Reaffirmed in lieu of Res. 434, A-12; Reaffirmation A-13; Reaffirmed: CSAPH Rep. 3, A-13; Reaffirmation: A-19; Appended: Res. 806, I-23)

Prescription Medication Price Negotiation H-110.959

1. Our AMA supports efforts to ensure that patients have affordable access to medications.
2. Our AMA encourages all payers, both public and private, in efforts to establish a reasonable and affordable cap on patient out-of-pocket prescription drug spending in a manner that does not increase patient premiums.
3. Our AMA opposes drug payment methodologies that result in physician practices being paid at less than the cost of acquisition, inventory, storage, and administration of relevant drugs and other necessary related clinical services.

(CMS Rep. 06, A-25; Reaffirmed: CMS Rep. 04, I-25)

Cost of Prescription Drugs H-110.997

1. Our American Medical Association supports programs whose purpose is to contain the rising costs of prescription drugs, provided that the following criteria are satisfied:
   a. physicians must have significant input into the development and maintenance of such programs;
   b. such programs must encourage optimum prescribing practices and quality of care;
   c. all patients must have access to all prescription drugs necessary to treat their illnesses;
   d. physicians must have the freedom to prescribe the most appropriate drug(s) and method of delivery for the individual patient; and
   e. such programs should promote an environment that will give pharmaceutical manufacturers the incentive for research and development of new and innovative prescription drugs.
2. Our AMA reaffirms the freedom of physicians to use either generic or brand name pharmaceuticals in prescribing drugs for their patients and encourages physicians to supplement medical judgments with cost considerations in making these choices.
3. Our AMA encourages physicians to stay informed about the availability and therapeutic efficacy of generic drugs and will assist physicians in this regard by regularly publishing a summary list of the patient expiration dates of widely used brand name (innovator) drugs and a list of the availability of generic drug products.
4. Our AMA encourages expanded third party coverage of prescription pharmaceuticals as cost effective and necessary medical therapies.
5. Our AMA will monitor the ongoing study by Tufts University of the cost of drug development and its relationship to drug pricing as well as other major research efforts in this area and keep the AMA House of Delegates informed about the findings of these studies.
6. Our AMA encourages physicians to consider prescribing the least expensive drug product (brand name or FDA A-rated generic).

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7. Our AMA encourages all physicians to become familiar with the price in their community of the medications they prescribe and to consider this along with the therapeutic benefits of the medications they select for their patients.

(BOT Rep. O, A-90; Sub. Res. 126 and Sub. Res. 503, A-95; Reaffirmed: Res. 502, A-98; Reaffirmed: Res. 520, A-99; Reaffirmed: CMS Rep. 9, I-99; Reaffirmed: CMS Rep.3, I-00; Reaffirmed: Res. 707, I-02; Reaffirmation A-04; Reaffirmed: CMS Rep. 3, I-04; Reaffirmation A-06; Reaffirmed in lieu of Res. 814, I-09; Reaffirmed in lieu of Res. 201, I-11; Reaffirmed in lieu of: Res. 207, A-17; Reaffirmed: BOT Rep. 14, A-18; Reaffirmed: CMS Rep. 04, I-24)

Pharmaceutical Costs H-110.987

1. Our AMA encourages Federal Trade Commission (FTC) actions to limit anticompetitive behavior by pharmaceutical companies attempting to reduce competition from generic manufacturers through manipulation of patent protections and abuse of regulatory exclusivity incentives.
2. Our AMA encourages Congress, the FTC and the Department of Health and Human Services to monitor and evaluate the utilization and impact of controlled distribution channels for prescription pharmaceuticals on patient access and market competition.
3. Our AMA will monitor the impact of mergers and acquisitions in the pharmaceutical industry.
4. Our AMA will continue to monitor and support an appropriate balance between incentives based on appropriate safeguards for innovation on the one hand and efforts to reduce regulatory and statutory barriers to competition as part of the patent system.
5. Our AMA encourages prescription drug price and cost transparency among pharmaceutical companies, pharmacy benefit managers and health insurance companies.
6. Our AMA supports legislation to require generic drug manufacturers to pay an additional rebate to state Medicaid programs if the price of a generic drug rises faster than inflation.
7. Our AMA supports legislation to shorten the exclusivity period for biologics.
8. Our AMA will convene a task force of appropriate AMA Councils, state medical societies and national medical specialty societies to develop principles to guide advocacy and grassroots efforts aimed at addressing pharmaceutical costs and improving patient access and adherence to medically necessary prescription drug regimens.
9. Our AMA will generate an advocacy campaign to engage physicians and patients in local and national advocacy initiatives that bring attention to the rising price of prescription drugs and help to put forward solutions to make prescription drugs more affordable for all patients.
10. Our AMA supports:
    a. drug price transparency legislation that requires pharmaceutical manufacturers to provide public notice before increasing the price of any drug (generic, brand, or specialty) by 10% or more each year or per course of treatment and provide justification for the price increase;
    b. legislation that authorizes the Attorney General and/or the Federal Trade Commission to take legal action to address price gouging by pharmaceutical manufacturers and increase access to affordable drugs for patients; and
    c. the expedited review of generic drug applications and prioritizing review of such applications when there is a drug shortage, no available comparable generic drug, or a price increase of 10% or more each year or per course of treatment.
11. Our AMA advocates for policies that prohibit price gouging on prescription medications when there are no justifiable factors or data to support the price increase.
12. Our AMA will provide assistance upon request to state medical associations in support of state legislative and regulatory efforts addressing drug price and cost transparency.
13. Our AMA supports legislation to shorten the exclusivity period for FDA pharmaceutical products where manufacturers engage in anti-competitive behaviors or unwarranted price escalations.
14. Our AMA supports legislation that limits Medicare annual drug price increases to the rate of inflation.

(CMS Rep. 2, I-15; Reaffirmed in lieu of: Res. 817, I-16; Appended: Res. 201, A-17; Reaffirmed in lieu of: Res. 207, A-17; Modified: Speakers Rep. 01, A-17; Appended: Alt. Res. 806, I-17; Reaffirmed: BOT Rep. 14, A-18; Appended: CMS Rep. 07, A-18; Appended: BOT Rep. 14, A-19; Reaffirmed: Res. 105, A-19; Appended: Res. 113, I-21; Reaffirmed in lieu of: Res. 810, I-22; Reaffirmed: Res. 801, I-23; Reaffirmed: Res. 801, I-23; Reaffirmed: CMS Rep. 04, I-24; Reaffirmed: CMS Rep. 06, A-25)

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The Impact of Pharmacy Benefit Managers on Patients and Physicians D-110.987
1. Our AMA supports the active regulation of pharmacy benefit managers (PBMs) under state departments of insurance.
2. Our AMA will develop model state legislation addressing the state regulation of PBMs, which shall include provisions to maximize the number of PBMs under state regulatory oversight.
3. Our AMA supports requiring the application of manufacturer rebates and pharmacy price concessions, including direct and indirect remuneration (DIR) fees, to drug prices at the point-of-sale.
4. Our AMA supports efforts to ensure that PBMs are subject to state and federal laws that prevent discrimination against patients, including those related to discriminatory benefit design and mental health and substance use disorder parity.
5. Our AMA supports improved transparency of PBM operations, including disclosing:
- Utilization information;
- Rebate and discount information;
- Financial incentive information;
- Pharmacy and therapeutics (P&T) committee information, including records describing why a medication is chosen for or removed in the P&T committee's formulary, whether P&T committee members have a financial or other conflict of interest, and decisions related to tiering, prior authorization and step therapy;
- Formulary information, specifically information as to whether certain drugs are preferred over others and patient cost-sharing responsibilities, made available to patients and to prescribers at the point-of-care in electronic health records;
- Methodology and sources utilized to determine drug classification and multiple source generic pricing; and
- Percentage of sole source contracts awarded annually.
6. Our AMA encourages increased transparency in how DIR fees are determined and calculated.
(CMS Rep. 05, A-19; Reaffirmed: CMS Rep. 6, I-20; Reaffirmed: CSAPH Rep. 02, I-24; Reaffirmed: CMS Rep. 06, A-25; Reaffirmed: CMS Rep. 04, I-25)

Prescription Drug Prices and Medicare D-330.954
1. Our American Medical Association will support federal legislation which gives the Secretary of the Department of Health and Human Services the authority to negotiate contracts with manufacturers of covered Part D drugs.
2. Our AMA will work toward eliminating Medicare prohibition on drug price negotiation.
3. Our AMA will prioritize its support for the Centers for Medicare & Medicaid Services to negotiate pharmaceutical pricing for all applicable medications covered by CMS.

(Res. 211, A-04; Reaffirmation I-04; Reaffirmed in lieu of Res. 201, I-11; Appended: Res. 206, I-14; Reaffirmed: CMS Rep. 2, I-15; Appended: Res. 203, A-17; Reaffirmed: CMS Rep. 4, I-19; Reaffirmed: CMS Rep. 3, I-20; Reaffirmed: Res. 113, I-21; Reaffirmed: CMS Rep. 4, A-22; Reaffirmed in lieu of: Res. 810, I-22)

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8. RURAL HEALTH TRANSFORMATION PROGRAM UPDATE & WORKFORCE CHALLENGES

Reference committee hearing: see report of Reference Committee A.

HOUSE ACTION: RECOMMENDATIONS ADOPTED
REMAINDER OF REPORT FILED
See Policies D-200.980, D-465-993, H-464.988, H-465.971 and H-465.994

As a follow-up to CMS Report 3-I-25, Payment Models to Sustain Rural Hospitals, the Council on Medical Service initiated this report which provides an update on the federal Rural Health Transformation (RHT) program and discusses workforce recruitment and retention in rural settings. Further, this report reviews relevant American Medical Association (AMA) policy and offers recommendations to support the physician workforce in rural settings.

Given the complexity of rural health, the Council will continue to monitor and, as appropriate, initiate future reports on aspects of rural health which may include topics such as scope of practice, federal designation, Medicare Advantage, alternative payment models, immigration pathways for physicians intending to practice in rural settings, and/or educational pathways to bolster the rural physician workforce.

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BACKGROUND

While the vast majority of land in the United States (U.S.) is considered rural, only 20 percent of Americans live in these areas.[1] Vermont has the highest percentage of rural residents, with over 66 percent living in rural areas while California has the lowest percentage of rural residents, with just under six percent of the state residing in rural areas.[1,2] Rural communities tend to have older residents with higher rates of chronic illness, lower rates of adequate health insurance coverage, and less access to health care. Specifically, rural Americans have higher rates of heart disease, cancer, stroke, unintentional injury, suicide, maternal and infant mortality, and drug overdose mortality than non-rural Americans.[1,2] These issues are exacerbated by the fact that 80 percent of rural Americans live in communities that are considered medically underserved.[2] Rural communities face a number of demographic, environmental, economic, and social factors that often result in residents facing significant barriers to receiving health care.[1,2] For example, rural physicians/practices often do not receive adequate payment to sustain care, struggle to maintain or qualify for governmental support, lack the infrastructure to support potential solutions, and struggle to recruit and retain an adequate health care workforce.[1,2] Additional details on the state of rural health can be found in CMS Report 9-A-21, Addressing Payment and Delivery in Rural Hospitals, CMS Report 9-A-23, Federally Qualified Health Centers and Rural Health, and CMS Report 3-I-25, Payment Models to Sustain Rural Hospitals.

In rural settings, hospitals and medical practices face a unique challenge in that payments often do not cover the actual cost of care. Some federal programs do bolster Medicare payment rates to offset a portion of the discrepancy. However, these programs are primarily focused on hospitals that meet specific criteria, meaning that physician practices and non-designated hospitals are not eligible to receive these additional funds.[3] Moreover, even for those hospitals that are able to receive special designation, the increased Medicare payment rates are often not enough to cover the deficits from other payers.[3] Medicare Advantage (MA) plans have proven to be particularly problematic for those practicing in rural settings as protections found in traditional Medicare do not carry over to MA plans and issues with payment can be even worse than with other payers.[4,5] Importantly, Medicaid also makes up a relatively significant portion of the rural payer mix, with 41 states adopting some kind of Medicaid expansion program, decreasing the number of uninsured rural patients. To assist in mitigating the cost discrepancies, Medicaid provides supplemental payments to match Medicare payment rates.[6] However, this is not available in all practice settings nor enough to cover all deficits.[6] Additionally, these deficits are often exacerbated by uninsured or underinsured patients. More detailed information on rural payment and payer mix can be found in CMS Report 6-I-23 and CMS Report 3-I-25.

As previously mentioned, rural Americans are more likely than their urban or suburban counterparts to lack adequate health insurance coverage, meaning that rural providers are often faced with a greater amount of uncompensated care.[7] While this has been mitigated in many states that have chosen to implement Medicaid expansion, which with the inception of the Affordable Care Act (ACA) and after legal battles, allowed states to voluntarily expand the populations that qualify for Medicaid access. In states that chose to expand, the rates of uninsured individuals dropped sharply, with some research demonstrating nearly 15 percent lower rates of uninsured residents when compared to states that did not choose to expand Medicaid.[7] The impact on rural residents was even stronger as nearly one quarter of rural adults and almost half of rural children are enrolled in their state Medicaid program.[7] However, the recently passed H.R. 1 (or the "One Big Beautiful Bill Act") is anticipated to have a negative impact on Medicaid coverage eligibility, including expansion access, as well as other types of insurance and payment rates.[7,8]

Experts anticipate that over 10 million Americans will lose health insurance coverage as a result of the changes in H.R. 1 and that, across payer type, beneficiaries will face significant increases in premium costs.[8,9] It is projected that in a majority of states, this premium increase will be more significant for rural Americans. Specifically, analyses have shown that on top of the 18 percent increase for all private health plans, rural Americans will face a 107 percent premium increase compared to the 89 percent premium increase for urban residents.[8,9] Additionally, rural residents who utilize the ACA Health Insurance Marketplace Exchange ("Marketplace") to secure insurance coverage are anticipated to experience premium increases that are 28 percent higher than urban residents, primarily driven by the lack of extension of previously available tax credits designed to help make coverage affordable.[8,9] This is problematic as rural communities rely more heavily on affordable Marketplace plans to obtain health insurance.[8,9] Further, due to additional challenges around rural employment and coverage determination logistics in rural settings, it is anticipated that the Medicaid work requirements outlined in H.R. 1 will disproportionately impact rural communities.[9,10] According to the Centers for Medicare & Medicaid Services (CMS), there have not been actual cuts to Medicaid or other public coverage options, but rather that these expenditures were "slowed" and that any reduction in funding is focused on reductions of waste and/or fraud. However, rural health leaders and researchers have explained that these policy changes have already resulted in funding reductions negatively impacting rural health facilities and will likely

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continue to disproportionately impact rural providers and the communities they serve.[11] Experts, providers, and patients have voiced significant concern that these coverage losses have the potential to significantly worsen the landscape of rural health through increased financial stress on vulnerable rural hospitals and practices.

RURAL HEALTH TRANSFORMATION (RHT) PROGRAM UPDATE

In an attempt to address concerns around funding reductions, H.R. 1 included a one-time $50 billion program designated for rural health transformation.[10,12] While the RHT program is clearly a significant investment in rural health, it is anticipated that it will not make up for the projected losses to rural hospitals and providers as a result of policy changes due to H.R. 1. It is projected that changes made to the ACA, Medicare, and Medicaid will result in rural hospitals loosing $137 billion over the next 10 years, meaning that even with the rural health fund, rural hospitals are anticipated to lose $87 billion over the next decade due to patients who will lose coverage through Medicare, Medicaid, and/or Marketplace plan changes.[10,12,13] The deficit created by the cuts resulting from the passage of H.R. 1, and other policy decisions such as the expiration of the enhanced ACA tax credits, is likely to cause financial problems for rural hospitals and other health care providers beyond what is potentially solved by the dollars dispersed through the RHT program.[10,13]

The RHT program has been launched, and all 50 states have applications that have been preliminarily approved by CMS. Three-quarters of the funds in this program are designated to be divided between all states, with half distributed equally across states that have approved applications and a quarter allocated based on CMS-evaluated state need.[10,12,13] The final one quarter of funding, $12.5 billion, will be distributed based on CMS scoring of state policy, state initiatives, and other factors yet to be released.[13,14] CMS has indicated that $8 billion of these funds, distributed in the first few years of the program, will be based on a qualitative review of the proposed initiatives in the RHT program applications. Thirty percent of these funds will be distributed later based on state policies, or progress towards state policies, that align with the "Make America Healthy Again" (MAHA) agenda.[13,14] The final $750 million will be distributed based on other factors that have not yet been announced but may include the quality of Medicaid data reporting or dual eligible integrated care plans.[12,13,14,15] While the actual formula has not been released, the notice of funding for this program outlines discretion for CMS to award states higher levels of funding if policies align with the federal administration's priorities. As a result, some states are pledging to implement policies that align with MAHA stated goals in an attempt to garner a greater amount of the discretionary portion of the RHT program funds. Of concern, a number of RHT program applications include specific reference for movement toward licensure expansion for non-physician practitioners.[14] For example, some applications expand the ability of pharmacists to test and treat and/or allow for non-physician advanced practice providers to practice independently. While it is likely that these programs could have some positive impacts on the communities they serve, it remains important that the provision of medical services occur within the purview of a physician-led team.

At the end of 2025, CMS announced initial RHT program awards for Fiscal Year 2026 (FY26). State awards ranged from $154,249,106 for Connecticut to $281,319,361 for Texas. A full list of state funding awards for FY26 can be found in Appendix A. The assessment of more subjective elements of applications, such as state alignment with the "MAHA agenda" or the "quality" of reporting, has not been made public. As a result, the full picture of actual funding for states is yet to be seen. Should awards be evenly distributed across states, each would receive $750 million over five years. However, as was evidenced by the FY26 funding announcement, experts anticipate there will be significant variance in awards.[13,14] Researchers project that actual awards could range from $550 million in Rhode Island to over $1 billion in Texas. This discrepancy could be further exacerbated by the discretionary $12.5 billion portion of the fund that will be determined by CMS assessment of state policy and legislation.[12,13,14,15] It is anticipated that Texas, California, New Mexico, Montana, and Alaska will receive the largest portions of the needs-based funding. Since rural population numbers are not fully taken into account, payment per rural resident is anticipated to vary greatly across states.[12,13,14,16] For example, although it is anticipated to receive a high proportion of funding, Texas is projected to receive only $240 per rural resident while Rhode Island is projected to receive over $22,000 per rural resident -- both of which are significant deviations from the nationwide projected average of $590 per rural resident.[13,14,15]

In addition to potential significant funding discrepancies between states, the ambiguity of the fund allocation may mean that rural health care providers may not receive the full allocated funds.[10,12,13,14] For example, states are given the ability to direct funding towards urban and suburban settings with the approval of CMS.[10,12,13,14] Further, the administration has outlined intentions to "claw back" funding dispersed via the RHT program should states not successfully implement the intended program(s) in the allotted timeline. The program grants state a limited timeline, at most five years, to implement the initiatives outlined in applications. States and national rural health advocacy

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organizations have voiced significant concerns that this timeline is not reasonable and, as a result, funding that is given to many states may end up being taken back by the federal government.[17] Not only do states have a limited timeline to implement these policies, the program's notice of funding outlined a potential risk to state funding beyond the first year if states do not demonstrate outcomes deemed sufficient by CMS. For many states this means that new policies will need to be implemented that align with stated MAHA/administration goals and should these policies not be implemented, funding beyond the first year may be limited or reduced. Further, the funding from this program is limited to the next five years, but the reductions in Medicare, Medicaid, and ACA funding or coverage are ongoing. As a result, after the RHT program is finished, the impacts of the cuts are likely to remain and rural health providers/facilities will be without additional support to mitigate the cuts.[18] While the RHT program will likely help mitigate some of the funding reductions faced in rural settings, the level of compensation may be inadequate and the potential for politicization of available funds may result in many rural residents loosing access to crucial health care.

RURAL WORKFORCE CHALLENGES

As shrinking funding and payment has stretched hospitals and health care providers across the country, the United States is facing a growing physician shortage that it is exacerbated in rural communities. Specifically, research suggests that in the next decade rural communities may face a 23 percent decline in physicians compared to just nine percent in non-rural settings.[19] Further, studies show that rural communities have, on average, 236 fewer physicians per 100,000 people when compared to urban areas.[20] These shortages are not due to any single factor, but rather a combination of hospital/practice closures, lack of new physicians, practice challenges, and issues with infrastructure. Further, despite programs designed to support rural hospitals, many are struggling to stay open as challenges continue to grow.[22,23] In recent years, the number of rural hospitals operating at a deficit has grown nearly seven percent.[22] Today, half of all rural hospitals are operating at a deficit. In some states, such as Kansas and Wyoming, the problem is even worse with over 80 percent of rural hospitals operating in a deficit.[22,23] Even among rural hospitals that have chosen to affiliate with larger health systems, 42 percent are operating at a deficit.[22,23,24] More than 140 rural hospitals have closed since 2010 and a third of the remaining rural hospitals are financially vulnerable, placing access to emergency and inpatient care at risk for millions of rural residents. This is leading to many rural hospitals being forced to close or reduce services. For example, between 2011 and 2021, nearly 25 percent of all rural obstetric and gynecologic units were closed and access to chemotherapy decreased at a similar rate.[25,26] While not exclusively responsible, these hospital closures have increased the rural physician shortage.

Infrastructure

Beyond hospital closures, the chronic lack of investment in rural infrastructure has resulted in many rural communities lacking basic infrastructure necessary to support community growth or maintain an adequate physician workforce. These communities often lack resources such as updated roads, utilities, broadband access, schools, and sanitation necessary to attract and retain businesses and bolster economies.[27] As infrastructure becomes less maintained, businesses close or reduce employee hours, and as a result, communities shrink in size. The issue is often cyclical; a community economy is not enough to sustain a physician and/or hospital, but when a physician or hospital leaves a community, it hurts the economy as well.[28,29] This remains true for physician practices as evidence shows that each physician supports, on average, 17.1 jobs and generates approximately $3.2 million in economic output across their full career.[28] Across physician offices and hospitals, residents of rural census tracts, rural residents live three to four times further away from hospitals than those in urban or suburban areas.[30] When patients do travel these greater distances, they often encounter roads that are difficult to pass due to poor upkeep, difficult terrain, and/or dangerous weather. Additionally, poor system infrastructure, like faulty sanitation systems or lack of clean water, can lead to poorer health outcomes for rural residents.[27] For example, for some towns in Mississippi, estimates show that nearly 40 percent of children have chronic stomach problems due to parasitic infections linked to raw sewage in drinking water from failing infrastructure.[31]

Not only do these issues of infrastructure directly impact patient health and health outcomes, but they also indirectly impact physician workforce. Communities that do not have adequate infrastructure are less likely to be attractive for new physicians and can be detrimental in retaining the existing physician workforce.[27,32,33] Additionally, the lack of infrastructure often makes potential solutions, to mitigate the rural health crisis nearly impossible to implement. For example, telehealth has promise to bolster rural health care networks; however, nearly a quarter of rural Americans lack access to high-speed internet, compared to only 1.5 percent of urban Americans.[27] Further, rural practices and hospitals may be less likely to be able to offer competitive pay and/or benefits exacerbating challenges to both recruit and retain workforce.[27,31,32,34]

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Physician Recruitment and Retention

Data suggest that the vast majority of medical students and trainees do not intend to practice in rural communities.[35] While research has demonstrated that students who are from a rural community are more likely to return to a rural setting to practice, the number of rural medical students has been declining. Estimates show that less than five percent of medical students report they are from a rural background, meaning that this cannot be the single solution to bolstering the rural physician workforce.[35] Along with rural-born trainees, international medical graduates (IMGs) can be an important element in the rural physician workforce. In addition to obtaining the appropriate visa to practice in the United States, these physicians must obtain an Education Commission on Foreign Medical Graduates certification, pass appropriate exams, and complete their residency in the United States. IMGs are essential to meeting the health care needs of Americans across the country, but especially in underserved and rural communities.[36] Research shows that IMGs make up nearly a quarter of all practicing physicians in America and represent a disproportionate amount of physicians in rural and underserved settings.[37]

While states vary widely in proportions of practicing IMGs, likely due to differing visa legislation and regulation, nationwide estimates continually demonstrate that IMGs are vital to ensuring that rural Americans have access to physicians.[38] This became a greater challenge for many hiring facilities with the implementation of a new H-1B visa fee and changes to the visa lottery process. Historically, the visa lottery process was randomized, but the Department of Homeland Security (DHS) recently implemented a weighting system based on higher skill and pay positions. Further, a $100,000 fee is now attached to all H-1B petitions, which for many rural facilities is an insurmountable and/or unsustainable figure. A number of health care advocacy organizations, including the AMA, have urged DHS and the Trump administration to implement a fee exemption for health care professionals. In March 2026, a bipartisan bill (H.R. 7961; H-1Bs for Physicians and the Healthcare Workforce Act) was introduced and if passed would exempt physicians and health care professionals from the aforementioned $100,000 filing fee attached to new H-1B petitions. However, at the time that this report was written, this legislation has not passed Congress and no such exception has been put in place.[38,39]

With physician burnout rate at a high across the nation, it is no surprise that rural physicians also face burnout.[36] Rural physicians are frequently the only, or one of the few physicians in their area and as a result they are often asked to do more with fewer resources.[27,40] Heavier clinical workloads and professional isolation in rural practice environments may contribute to physician burnout and can make recruitment and retention more difficult for rural communities.[27,40] Further, physicians practicing in rural areas may find it more challenging to complete continuing professional development (CPD) requirements.[41] While neither physician burnout nor the challenges around certification and CPD requirements is solely responsible for rural physician shortages, each contributes to the challenges that rural health employers have in both recruiting and retaining physicians.

POTENTIAL SOLUTIONS

While there is no single solution that will solve the health care problems faced by rural communities, there are some actions that could be taken to work toward improvement. One promising element toward progress is the support and expansion of telehealth services.[42] Telehealth and associated remote patient care could be a lifesaving stopgap while the larger access issues are being addressed.[41,42] Telehealth has been associated not only with better patient outcomes, both in health and satisfaction, but also with shorter wait times and reductions in delays of care and diagnosis/treatment.[44] Research shows that patients treated by rural hospitals utilizing telehealth are more likely to receive stroke care within the crucial “golden hour” for treatment. Additionally, physician satisfaction is higher and physicians, particularly specialists, are less likely to report burnout when their practice utilizes telehealth.[42,44] However, for telehealth implementation to be successful in rural areas, there would need to be an increase in access to reliable high-speed broadband in rural communities.[43] Another challenge related to the implementation of telehealth is the cost for hospitals and practices. Estimates for initial startup costs in rural hospitals range from $17,000 to $50,000 with annual subscription fees over $50,000. For many rural hospitals and practices, this is an insurmountable amount of money.[42] While many of the applications submitted to the RHT program include an element of telehealth, it is yet to be seen if the funds distributed by the program will be sufficient to implement and/or sustain telehealth programs in these communities.[14]

Experts agree that in addition to encouraging rural-born medical students to return to rural practice as physicians, it is equally important to expose non-rural-born medical students to these communities. For example, the University of Washington School of Medicine’s Rural Underserved Opportunities Program allows medical students to rotate

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through rural care settings in five states during their first two years of medical education. This program has shown that their students who train in rural sites are twice as likely to return to practice as physicians in rural areas.[45] Other programs, such as the Family Medicine Rural Residency Program, can be found across the country and are designed to expose physicians to a variety of rural practice settings during their residency. Specifically, this program includes both inpatient and outpatient rotations at a hospital which is the only one in the county.[46] These programs, sometimes referred to as "Grow Your Own Doctor" programs, can be instrumental in ensuring that medical students and residents are more likely to return to rural medical practice for their career.

Further, loan forgiveness programs continue to provide an incentive for physicians to practice in rural communities.[43,47] The Health Resources and Services Administration (HRSA) offers a number of funding programs designed to attract new physicians to rural areas. For example, the State Loan Repayment Program and the National Health Service Corps (NHSC) both provide loan repayment and scholarships to physicians providing primary care in provider shortage areas. The Indian Health Service (IHS) Loan Repayment Program offers similar benefits to physicians/trainees who commit to practicing in IHS settings. Further, many states allocate funds designed to expand these programs and/or provide additional incentives to physicians.[48] Research shows that loan repayment/forgiveness-based retention programs are generally successful for health care workers.[49] For example, as many as two-thirds of physicians who committed to working in these communities as a result of a loan repayment or forgiveness program are still practicing in the community more than eight years later.[50] However, some research suggests that if a physician's overall loan amount is too high, the repayment or forgiveness programs may not be as attractive. In total, experts proport these types of programs as a promising aspect to mitigate the rural physician shortage, but not the single solution.[51]

To facilitate the success of these programs, it also is essential that there are a sufficient number of residency slots in rural areas. Notably, the Rural Residency Planning and Development Program has introduced over 500 new residency slots in rural areas, allowing repayment programs to have the space to function and more physicians to be trained in rural settings.[52] Beyond loan-based programs, general recruitment strategies have been shown to be successful in recruiting physicians to rural communities. For example, programs such as housing assistance, relocation support, flexible scheduling, and mentorship/peer support can be impactful in both attracting and retaining physicians. Specifically, experts posit that providing rural physicians with creative staffing solutions can not only attract physicians but support them in remaining in rural communities.[53] Locum tenens programs, or programs that fill open positions via temporary contract, can provide a stop-gap measure to ensure that rural hospitals have the staffing necessary to remain open.[53]

As previously mentioned, IMGs are an essential component to reducing physician shortages. However, in order for these physicians to practice in the United States, they must be able to secure the appropriate visa and/or waivers.[54] Often this means that physicians must secure a J-1 or H-1 visa and/or a Conrad 30 waiver. Research demonstrates that more IMGs practice in states with more relaxed Conrad 30 requirements, such as an expanded visa cap. This can be incredibly beneficial in reducing the physician shortage faced in rural communities as IMGs are also more likely to practice in rural settings.[36,54] Further, studies show no evidence of U.S.-trained physicians being "crowded out" of jobs as little to no changes in the proportion of domestically trained physicians were found.[36] This research seems to suggest that the expansion of slots for these visa and waiver programs may allow for IMGs to help meet the health needs of rural communities. Further, it is important to not only attract physicians to rural settings, but to support those who have chosen to practice there. Specifically, to ensure that physicians are able to meet licensure and CPD requirements, programs like the Interstate Medical Licensure Compact are working to streamline licensure.[55,56] This program ensures that physicians are able to expedite licensure requirements in order to practice in underserved areas. These kinds of programs are helpful in ensuring that physicians can also be available to practice telehealth and promote the aforementioned benefits of those programs.[55,56]

To further support and attract rural-practicing physicians the federal government created the Health Professional Shortage Area (HPSA) designation and assigned particular benefits. While HPSAs are not exclusive to rural settings, there is frequent overlap. HPSAs are a geographic, population, and/or facility that has a shortage of primary, dental, or mental health care providers.[57] Geographic HPSAs, most common for rural settings, are areas where the entire population is experiencing a shortage of providers. Population HPSAs are defined as a shortage of providers for a specific population in a geographic area. For example, unhoused or migrant farm workers in a set area. Facility defined HPSAs include set facilities that serve a population or geographic area facing a provider shortage.[57] While not an exhaustive list, Federally Qualified Health Centers, Indian Health Facilities/Hospitals, and Rural Health Clinics often meet the criteria to be defined as a facility HPSA. Currently, there are just under 8,500 primary care HPSA

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designations across type, which is inclusive of over 92 million people.[58] Physicians practicing in HPSAs are able to access a number of incentives, the most significant of these incentives are related to scholarships/loans, immigration, and payment bonuses. Specifically, physicians are able to access NHSC scholarships and loan repayment, the J-1 visa waiver program which expedites the immigration process, and, assuming the physician serves Medicare beneficiaries, a quarterly Medicare bonus payment. While research has not demonstrated an improvement in physician workforce across all types of HPSAs, it has shown that this designation seems to make significant improvements in rural settings, demonstrating more favorable patient-physician ratios.[58,59] Specifically, after a HPSA designation significant increases in primary care physicians were shown resulting in, rural HPSAs having an average of 5.4 more primary care physicians than non-HPSA rural settings.[59] While primary care is essential to overall health, it is also important that rural communities have access to specialty physicians when the need arises. Further, for a rural hospital to remain fully functional, there must be an ability to attract and retain physicians beyond primary care. The success of the HPSA designation in rural primary care could indicate that an expansion to other specialties may similarly bolster the rural physician workforce. While none of these solutions alone will solve the health care problems faced by rural communities, the solutions mentioned above have been shown to have an impact and are specific, practical, and realistically achievable.

AMA POLICY AND ADVOCACY

The AMA has an extensive body of policy related to rural health, with some policies specifically focused on physician workforce. Broadly, Policies H-465.997 and H-465.978 outline the AMA's stance on rural health disparities and efforts to work toward improvement in access and quality of rural health care both independently and in conjunction with relevant state medical associations and national medical specialty societies. Policy H-465.994 outlines AMA efforts to plan and promote improvements in rural health through private and public support. Beyond policies designed to generally promote rural health improvements there is a large group of policies dedicated to bolstering the rural physician workforce. Policies, H-465.988, H-200.972, and H-300.983 outline efforts centered in education to not only encourage physicians to consider rural care but also to ensure they are able to continue their training once practicing in these settings. Policies H-200.945, D-465.997, and H-330.864 address the physician workforce shortage in general, but also specific strategies to recruit and retain physicians in rural areas. Policies H-465.980, H-465.994, H-420.946, and H-350.937 outline strategies to advocate for better access to rural health care generally and with a specific focus on OB/GYN care through the implementation of networks, and focusing on minorities in rural communities. Further, Policy H-465.981 outlines AMA efforts to support rural physician practices and to begin to address limits on HPSA benefits, supports the expansion of the associated Medicare payment bonus to rural counties that meet a set poverty threshold beyond formal HPSA designation.

While telehealth is mentioned in a number of the aforementioned policies related to rural health, Policy H-478.980 specifically outlines AMA advocacy to support access to broadband services in rural communities. Policy H-480.937 outlines the AMA's stance and advocacy efforts related to the implementation of telehealth and related health technologies. In addition to telehealth, the AMA has policy, D-200.982, related to the implementation of educational programs designed to create and support pathways for students who intend to practice in rural settings. The AMA has been active in this area and successfully advocated for extensions of telehealth flexibilities that were initially implemented during the COVID-19 pandemic.[43]

To address physician workforce, Policy H-200.949 details support for physician and trainee incentives to practice in underserved rural areas while Policy H-200.954 outlines AMA efforts to work to alleviate the overall physician shortage. The AMA policy is clear in support of expanded residency slots. Specifically, aforenoted Policies H-200.949 and H-200.954 outline support within the context of the physician workforce while Policies H-310.943 and D-305.967 focus more specifically on the residency program structure and sustainability. Finally, Policies H-255.965, H-255.961, and D-255.969 all outline AMA advocacy and support for IMGs and visa processes for international physicians to be able to practice in the United States. Related, the AMA has voiced supported for recently introduced legislation that would remove the increased J-1 visa fee. Importantly, the AMA also has a robust body of policy related to prevention of scope creep and the promotion of care within a physician-led team. Specifically, Policies H-35.966 and D-160.995 call out protection of physician licensure and medical care within a physician-led team.

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DISCUSSION

Rural Americans deserve high-quality and readily accessible health care; however, due to a complex combination of factors, including workforce challenges, rural access to care is in crisis. The RHT program was designed as an infusion of funds into rural settings but comes with a number of challenges and restrictions that may limit the positive impact of the program. Further, the dollars designated for the RHT program may not offset the projected losses that rural providers face due to cuts to Medicare, Medicaid, and the ACA. As a result, hospitals and rural physicians have voiced significant concern regarding their ability to continue to provide care for their rural patients. To address these concerns, the Council recommends the adoption of new policy that supports ongoing AMA efforts to monitor the RHT program and similar initiative to educate physicians and legislators on the associated opportunities and challenges. While the AMA has supported and developed educational materials, Council reports, and, informational sessions on the RHT, the adoption of this policy will enshrine theses these efforts and ensure their continuance. Further, the Council recommends the reaffirmation of Policy H-465.994, which outlines efforts to work towards improvements in rural health. Specifically, this policy outlines efforts to improve funding, develop evidence-based action plans, and to support innovative care models.

Rural communities also face significant challenges in recruiting and retaining a physician workforce large enough to meet population needs. The cause of workforce challenges is not monolithic, as many factors including a lack of infrastructure investment and certification/training opportunities, complicate physician workforce in rural communities. Many of the solutions that could contribute to remedying this problem are also complicated by the intricate nature of the issue. For example, while telehealth has been promoted as a part of the solution to improving access to physicians in rural communities, rural communities are less likely to have access to the reliable broadband necessary for successful telehealth implementation. Additionally, rural practices and hospitals are less likely to have the necessary capital to establish or continue these programs. In order to address this, the Council recommends the adoption of new policy supporting funding for telehealth implementation and improvement in rural settings. Further, the Council notes recently reaffirmed Policy H-478.980 outlines AMA advocacy for reliable broadband in rural settings to address health disparities.

Internationally trained physicians could also serve to improve rural health workforces, yet the solution faces barriers to success. Although IMG physicians have been shown to be more likely to practice in rural settings, the complicated immigration and certification process in the U.S. can introduce barriers to this solution. Another promising potential solution is educational pathways that promote rural health practice. Through medical school and residency experiences in rural communities, physicians are introduced to the benefits of practice in these settings and are more likely to return. Similarly, programs that help to pay off or forgive student loans have shown to be successful in attracting and retaining talent. In order to both support IMG's ability to practice in the rural United States and to promote U.S.-trained physicians in rural practice, the Council recommends the reaffirmation of Policy D-200.980 which outlines support for scholarship, loan repayment or forgiveness programs, and the expansion of visas for IMGs. Specifically, this policy supports collaborative efforts to secure funding and advocate for the retention and expansion of relevant programs such as the NHSCs and the Conrad 30 visa. Further, the Council recommends the reaffirmation of Policy H-465.988 which outlines educational strategies to attract and retain physicians to rural settings. This policy details efforts to ensure that appropriate training slots are available for medical students and residents, that education is delivered in a manner that is accessible, and that funding is maintained or expanded to secure these program efforts.

In order to ensure that physicians who choose to practice in rural settings are able to continue, opportunities to meet licensure and CPD requirements in rural settings must be enhanced. Therefore, the Council recommends new policy designed to ensure that practicing rural physicians have accessible opportunities to meet continuing education and CPD requirements. Finally, the promise shown by both defining and incentivizing rural practice via the HPSA in bolstering the rural primary care physician workforce could indicate an area of advocacy to expand the success to physician specialties. Thus, the Council recommends the adoption of new policy that indicates AMA support for the expansion of programs that define and support physician shortage areas to include specialties in an effort to ensure that rural medical practices and hospitals can attract the full spectrum of physicians necessary.

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RECOMMENDATIONS

The Council on Medical Service recommends that the following recommendations be adopted and the remainder of the report be filed:

1. That our American Medical Association (AMA) monitor legislative and regulatory proposals related to the rural health transformation program or similar rural health initiatives to educate physicians and policymakers regarding the potential opportunities and challenges associated with such programs.
2. That our AMA support the development of funding avenues designated to support costs associated with telehealth in rural hospitals and medical practices.
3. That our AMA support the development and implementation of programs that ensure physicians practicing in rural settings have access to opportunities to meet continuing medical education and continuing professional development requirements.
4. That our AMA encourage the expansion of programs designed to define physician shortage areas and support physicians working in these areas to include specialties necessary to the functioning of a rural medical practice or hospital.
5. That our AMA reaffirm Policy H-465.994, which details efforts to support, promote, and innovate solutions to improve rural health.
6. That our AMA reaffirm Policy D-200.980, which outlines support for various strategies to bolster the physician workforce in underserved areas, including rural communities.
7. That our AMA reaffirm Policy H-465.988, which specifies strategies and efforts to improve the physician workforce that focus on education and practice solutions.

Fiscal Note: Minimal

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Council on Medical Service Report 8-A-26
Rural Health Transformation Fund Update & Workforce Challenges
Policy Appendix

Improving Rural Health H-465.994

1. Our American Medical Association (AMA):
    a. supports continued and intensified efforts to develop and implement proposals for improving rural health care and public health,
    b. urges physicians practicing in rural areas to be actively involved in these efforts, and
    c. advocates widely publicizing AMA's policies and proposals for improving rural health care and public health to the profession, other concerned groups, and the public.
2. Our AMA will work with other entities and organizations interested in public health to:
    a. Encourage more research to identify the unique needs and models for delivering public health and health care services in rural communities.
    b. Identify and disseminate concrete examples of administrative leadership and funding structures that support and optimize local, community-based rural public health.
    c. Develop an actionable advocacy plan to positively impact local, community-based rural public health including but not limited to the development of rural public health networks, training of current and future rural physicians and public health professionals in core public health techniques and novel funding mechanisms to support public health initiatives that are led and managed by local public health authorities.
    d. Advocate for adequate and sustained funding for public health staffing and programs
3. Our American Medical Association will work with relevant stakeholders to develop a national strategy to eliminate rural cancer disparities in screening, treatment, and outcomes and achieve health equity in cancer outcomes across all geographic regions.
4. Our AMA calls for increased federal and state funding to support research on rural cancer disparities and equity in care, access, and outcomes and development of interventions to address those disparities.
5. Our AMA advocates for evidence-based collaborative models for innovative telementoring/ teleconsultation between health care systems, academic medical centers, and community physicians to improve access to cancer screening, diagnosis, treatment, rehabilitation, and patient services in rural areas. (Sub. Res. 72, I-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmed: CEJA Rep. 06, A-18; Appended: Res. 433, A-19; Modified: CSAPH Rep. 2, A-22; Reaffirmed: CMS Rep. 09, A-23; Reaffirmed: Res. 724, A-23; Appended: Res. 919, I-24)

Educational Strategies for Meeting Rural Health Physician Shortage H-465.988

1. In light of the data available from the current literature as well as ongoing studies being conducted by staff, our American Medical Association (AMA) recommends that:
    a. Our AMA encourage medical schools and residency programs to develop educationally sound rural clinical preceptorships and rotations consistent with educational and training requirements, and to provide early and continuing exposure to those programs for medical students and residents.

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b. Our AMA encourage medical schools to develop educationally sound primary care residencies in smaller communities with the goal of educating and recruiting more rural physicians.
c. Our AMA encourage state and county medical societies to support state legislative efforts toward developing scholarship and loan programs for future rural physicians.
d. Our AMA encourage state and county medical societies and local medical schools to develop outreach and recruitment programs in rural counties to attract promising high school and college students to medicine and the other health professions.
e. Our AMA urge continued federal and state legislative support for funding of Area Health Education Centers (AHECs) for rural and other underserved areas.
f. Our AMA continue to support full appropriation for the National Health Service Corps Scholarship Program, with the proviso that medical schools serving states with large rural underserved populations have a priority and significant voice in the selection of recipients for those scholarships.
g. Our AMA support full funding of the new federal National Health Service Corps loan repayment program.
h. Our AMA encourage continued legislative support of the research studies being conducted by the Rural Health Research Centers funded by the National Office of Rural Health in the Department of Health and Human Services.
i. Our AMA continue its research investigation into the impact of educational programs on the supply of rural physicians.
j. Our AMA continue to conduct research and monitor other progress in development of educational strategies for alleviating rural physician shortages.
k. Our AMA reaffirm its support for legislation making interest payments on student debt tax deductible.
l. Our AMA encourage state and county medical societies to develop programs to enhance work opportunities and social support systems for spouses of rural practitioners.

2. Our AMA will work with state and specialty societies, medical schools, teaching hospitals, the Accreditation Council for Graduate Medical Education (ACGME), the Centers for Medicare and Medicaid Services (CMS) and other interested stakeholders to identify, encourage and incentivize qualified rural physicians to serve as preceptors and volunteer faculty for rural rotations in residency.
3. Our AMA will:
    a. work with interested stakeholders to identify strategies to increase residency training opportunities in rural areas with a report back to the House of Delegates; and
    b. work with interested stakeholders to formulate an actionable plan of advocacy with the goal of increasing residency training in rural areas.
4. Our AMA will encourage ACGME review committees to consider adding exposure to rural medicine as appropriate, to encourage the development of rural program tracks in training programs and increase physician awareness of the conditions that pose challenges and lack of resources in rural areas.
5. Our AMA will encourage adding educational webinars, workshops and other didactics via remote learning formats to enhance the educational needs of smaller training programs. (CME Rep. C, I-90; Reaffirmation A-00; Reaffirmation A-01; Reaffirmation I-01; Reaffirmed: CME Rep. 1, I-08; Reaffirmed: CEJA Rep. 06, A-18; Appended: Res. 956, I-18; Appended: Res. 318, A-19; Modified: CME Rep. 3, I-21; Reaffirmation: I-22; Reaffirmed: BOT Rep. 11, A-23; Reaffirmed: Res. 215, I-24; Reaffirmed: BOT Rep. 07, I-24)

Rural Health Physician Workforce Disparities D-465.997
Our AMA will monitor the status and outcomes of the 2020 Census to assess the impact of physician supply and patient demand in rural communities. (CME Rep. 3, I-21)

Improving Rural Health H-465.994
1. Our American Medical Association:
    a. supports continued and intensified efforts to develop and implement proposals for improving rural health care and public health,
    b. urges physicians practicing in rural areas to be actively involved in these efforts, and
    c. advocates widely publicizing AMA's policies and proposals for improving rural health care and public health to the profession, other concerned groups, and the public.
2. Our AMA will work with other entities and organizations interested in public health to:
    a. Encourage more research to identify the unique needs and models for delivering public health and health care services in rural communities.

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   b. Identify and disseminate concrete examples of administrative leadership and funding structures that support and optimize local, community-based rural public health.
   c. Develop an actionable advocacy plan to positively impact local, community-based rural public health including but not limited to the development of rural public health networks, training of current and future rural physicians and public health professionals in core public health techniques and novel funding mechanisms to support public health initiatives that are led and managed by local public health authorities.
   d. Advocate for adequate and sustained funding for public health staffing and programs
3. Our American Medical Association will work with relevant stakeholders to develop a national strategy to eliminate rural cancer disparities in screening, treatment, and outcomes and achieve health equity in cancer outcomes across all geographic regions.
4. Our AMA calls for increased federal and state funding to support research on rural cancer disparities and equity in care, access, and outcomes and development of interventions to address those disparities.
5. Our AMA advocates for evidence-based collaborative models for innovative telementoring/ teleconsultation between health care systems, academic medical centers, and community physicians to improve access to cancer screening, diagnosis, treatment, rehabilitation, and patient services in rural areas. (Sub. Res. 72, I-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmed: CEJA Rep. 06, A-18; Appended: Res. 433, A-19; Modified: CSAPH Rep. 2, A-22; Reaffirmed: CMS Rep. 09, A-23; Reaffirmed: Res. 724, A-23; Appended: Res. 919, I-24)

Improving Healthcare of Minority Communities in Rural Areas H-350.937

1. Our AMA encourages health promotion, access to care, and disease prevention through educational efforts and publications specifically tailored to minority communities in rural areas.
2. Our AMA encourages enhanced understanding by federal, state and local governments of the unique health and health-related needs, including mental health, of minority communities in rural areas in an effort to improve their quality of life.
3. Our AMA encourages the collection of vital statistics and other relevant demographic data of minority communities in rural areas.
4. Our AMA will advise organizations of the importance of minority health in rural areas.
5. Our AMA will channel existing policy for telehealth to support improved broadband internet access in minority communities in rural areas to increase the availability of telemedicine where clinically appropriate.
6. Our AMA supports minority health in rural areas through programming, equity initiatives, and other representation efforts.
7. Our AMA encourages the development of strategies and mechanisms for communities to share resources and best practices to serve their rural minority populations. (Res. 433, A-24; Modified: CSAPH Rep. 07, A-25)

Addressing Equity in Telehealth and Health Technology H-480.937

1. Our American Medical Association recognizes access to broadband internet as a social determinant of health.
2. Our AMA encourages initiatives to measure and strengthen digital literacy, with appropriate education programs, and with an emphasis on programs designed with and for historically marginalized and minoritized populations.
3. Our AMA encourages telehealth solution and service providers to implement design functionality, content, user interface, and service access best practices with and for historically minoritized and marginalized communities, including addressing culture, language, technology accessibility, and digital literacy within these populations.
4. Our AMA supports efforts to design and to improve the usability of existing electronic health record (EHR) and telehealth technology, including voice-activated technology, with and for those with difficulty accessing technology, such as older adults, individuals with vision impairment and individuals with other mental or physical disabilities.
5. Our AMA encourages hospitals, health systems and health plans to invest in initiatives aimed at designing access to care via telehealth with and for historically marginalized and minoritized communities, including improving physician and non-physician provider diversity, offering training and technology support for equity-centered participatory design, and launching new and innovative outreach campaigns to inform and educate communities about telehealth.
6. Our AMA supports expanding physician practice eligibility for programs that assist qualifying health care entities, including physician practices, in purchasing necessary services and equipment in order to provide telehealth services to augment the broadband infrastructure for, and increase connected device use among historically marginalized, minoritized and underserved populations.

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7. Our AMA supports efforts to ensure payers allow all contracted physicians to provide care via telehealth.
8. Our AMA opposes efforts by health plans to use cost-sharing as a means to incentivize or require the use of telehealth or in-person care or incentivize care from a separate or preferred telehealth network over the patient's current physicians.
9. Our AMA will advocate that physician payments should be fair and equitable, regardless of whether the service is performed via audio-only, two-way audio-video, or in-person.
10. Our AMA encourages the development of improved solutions to incorporate structured advance care planning (ACP) documentation standards that best meet the requisite needs for patients and physicians to easily store and access in the EHR complete and accurate ACP documentation that maintains the flexibility to capture unique, patient-centered details.
11. Our AMA encourages hospitals, health systems, and physician practices to provide a method other than electronic communication for patients who are without technological proficiency or access. (CMS Rep. 7, A-21; Reaffirmation: A-22; Reaffirmed: Res. 213, A-23; Reaffirmation: A-23; Modified: BOT Rep. 06, I-24)

Closing of Residency Programs H-310.943

1. Our American Medical Association:
    a. encourages the Accreditation Council for Graduate Medical Education (ACGME) to address the problem of non-educational closing or downsizing of residency training programs.
    b. reminds all institutions involved in educating residents of their contractual responsibilities to the resident.
    c. encourages the ACGME and the various Residency Review Committees to reexamine requirements for "years of continuous training" to determine the need for implementing waivers to accommodate residents affected by non-educational closure or downsizing.
    d. will work with the American Board of Medical Specialties Member Boards to encourage all its member boards to develop a mechanism to accommodate the discontinuities in training that arise from residency closures, regardless of cause, including waiving continuity care requirements and granting residents credit for partial years of training.
    e. urges residency programs and teaching hospitals be monitored by the applicable Residency Review Committees to ensure that decreases in resident numbers do not place undue stress on remaining residents by affecting work hours or working conditions, as specified in Residency Review Committee requirements.
    f. opposes the closure of residency/fellowship programs or reductions in the number of current positions in programs as a result of changes in GME funding.
    g. will work with the Centers for Medicare and Medicaid Services (CMS), ACGME, and other appropriate organizations to advocate for the development and implementation of effective policies to permit graduate medical education funding to follow the resident physician from a closing to the receiving residency program (including waivers of CMS caps), in the event of temporary or permanent residency program closure.
2. Our AMA will work with the Centers for Medicare and Medicaid Services (CMS) to establish regulations that protect residents and fellows impacted by program or hospital closure, which may include recommendations for:
    a. Notice by the training hospital, intending to file for bankruptcy within 30 days, to all residents and fellows primarily associated with the training hospital, as well as those contractually matched at that training institution who may not yet have matriculated, of its intention to close, along with provision of reasonable and appropriate procedures to assist current and matched residents and fellows to find and obtain alternative training positions that minimize undue financial and professional consequences, including but not limited to maintenance of specialty choice, length of training, initial expected time of graduation, location and reallocation of funding, and coverage of tail medical malpractice insurance that would have been offered had the program or hospital not closed.
    b. Revision of the current CMS guidelines that may prohibit transfer of funding prior to formal financial closure of a teaching institution.
    c. Improved provisions regarding transfer of GME funding for displaced residents and fellows for the duration of their training in the event of program closure at a training institution.
    d. Protections against the discrimination of displaced residents and fellows consistent with H-295.969.

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3. Our AMA will work with the Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, National Resident Matching Program, Educational Commission for Foreign Medical Graduates, Centers for Medicare and Medicaid Services, and other relevant stakeholders to identify a process by which displaced residents and fellows may be directly represented in proceedings surrounding the closure of a training hospital or program.
4. Our AMA will work with the Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, National Resident Matching Program, Educational Commission for Foreign Medical Graduates, Centers for Medicare and Medicaid Services, and other relevant stakeholders to:
    a. Develop a stepwise algorithm for designated institutional officials and program directors to assist residents and fellows with finding and obtaining alternative training positions;
    b. Create a centralized, regulated process for displaced residents and fellows to obtain new training positions; and
    c. Develop pathways that ensure that closing and accepting institutions provide liability insurance coverage to residents, at no cost to residents. (Sub. Res. 328, A-94; Appended by CME Rep. 11, A-98; Reaffirmed: CME Rep. 7, A-06; Appended: Res. 926, I-12; Modified: CME Rep. 1, A-15; Appended: Res. 310, I-19; Modified: CME Rep. 3, I-20; Reaffirmed: CME Rep. 01, I-22)

International Medical Graduate Employment H-255.965
Our American Medical Association will support federal legislation that reduces the administrative burden and streamlines the process of hiring International Medical Graduates. (Res. 203, I-22)

Expedited H-1B Pathways for International Medical Graduate Physicians in the USA H-255.961
Our American Medical Association supports the continuance of premium processing and other mechanisms that expedite H-1B visa applications and renewals for International Medical Graduate physicians. (Res. 222, A-25)

Urgent Advocacy to Restore J-1 Visa Processing for International Medical Graduate Physicians D-255.969
1. Our American Medical Association publicly advocates to resume the scheduling of new J-1 visa appointments affecting International Medical Graduates.
2. Our AMA will issue urgent advocacy communications to Congress, the Department of Homeland Security, the Department of State, and other relevant agencies, calling for the immediate resumption of J-1 visa processing for International Medical Graduates.
3. Our AME will collaborate with key parties, including program directors, Designated Institutional Officers, medical schools, and healthcare organizations to monitor the impact of visa appointment suspensions on patient care and physician workforce stability.
4. Our AMA will work proactively and transparently to reverse policies harmful to IMGs and mitigate future disruptions, emphasizing the essential contributions of International Medical Graduates to healthcare delivery in the United States. (Res. 237, A-25)

Recognizing and Remedying Payment System Bias As a Factor in Rural Health Disparities H-465.978
1. Our American Medical Association recognizes that systemic bias in healthcare financing has been one of many factors leading to rural health disparities and will advocate for elimination of these biases through payment policy reform to help reduce the shortage of rural physicians and eliminate health inequities in rural America.
2. Our AMA will, as part of our current advocacy for telehealth reform, specify that geographic payment equity be required in any telehealth legislation. (Res. 20, I-21, Reaffirmed: CMS Rep. 6, I-23)

Diversity in the Physician Workforce and Access to Care D-200.982
1. Our American Medical Association will continue to advocate for programs that promote diversity in the US medical workforce, such as pipeline programs to medical schools.
2. Our AMA will continue to advocate for adequate funding for federal and state programs that promote interest in practice in underserved areas, such as those under Title VII of the Public Health Service Act, scholarship and loan repayment programs under the National Health Services Corps and state programs, state Area Health Education Centers, and Conrad 30, and also encourage the development of a centralized database of scholarship and loan repayment programs.
3. Our AMA will continue to study the factors that support and those that act against the choice to practice in an underserved area, and report the findings and solutions at the 2008 Interim Meeting. (CME Rep. 7, A-08; Reaffirmation A-13; Reaffirmation: A-16; Reaffirmed: CME Rep. 5, A-21; Reaffirmation: Res. 240, A-24; Reaffirmed: Res. 308, I-25)

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Increasing Access to Broadband Internet to Reduce Health Disparities H-478.980
Our American Medical Association will advocate for the expansion of broadband and wireless connectivity to all rural and underserved areas of the United States while at all times taking care to protecting existing federally licensed radio services from harmful interference that can be caused by broadband and wireless services. (Res. 208, I-18; Reaffirmed: CMS Rep. 7, A-21; Reaffirmation: A-22; Reaffirmed: CMS Rep. 2, A-22; Reaffirmed: CSAPH Rep. 2, A-22; Reaffirmed: Res. 112, A-25)

Appendix A
Rural Health Transformation Program FY26 Funding

State	FY26 Award Amount
Alabama	$203,404,327
Alaska	$272,174,856
Arizona	$166,988,956
Arkansas	$208,779,396
California	$233,639,308
Colorado	$200,105,604
Connecticut	$154,249,106
Delaware	$157,394,964
Florida	$209,938,195
Georgia	$218,862,170
Hawaii	$188,892,440
Idaho	$185,974,368
Illinois	$193,418,216
Indiana	$206,927,897
Iowa	$209,040,064
Kansas	$221,898,008
Kentucky	$212,905,591
Louisiana	$208,374,448
Maine	$190,008,051
Maryland	$168,180,838
Massachusetts	$162,005,238
Michigan	$173,128,201
Minnesota	$193,090,618
Mississippi	$205,907,220
Missouri	$216,276,818
Montana	$233,509,359
Nebraska	$218,529,075
Nevada	$179,931,608
New Hampshire	$204,016,550
New Jersey	$147,250,806
New Mexico	$211,484,741
New York	$212,058,208
North Carolina	$213,008,356
North Dakota	$198,936,970
Ohio	$202,030,262
Oklahoma	$223,476,949
Oregon	$197,271,578
Pennsylvania	$193,294,054
Rhode Island	$156,169,931
South Carolina	$200,030,252
South Dakota	$189,477,607
Tennessee	$206,888,882
Texas	$281,319,361
Utah	$195,743,566
Vermont	$195,053,740
Virginia	$189,544,888
Washington	$181,257,515
West Virginia	$199,476,099
Wisconsin	$203,670,005
Wyoming	$205,004,743

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9. NONPROFIT STATUS

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS
REMAINDER OF REPORT FILED
See Policy H-155.954

Resolution 221, "Nonprofit Status," was introduced by the New York delegation at the 2025 Interim Meeting and was referred. It asks the following:

> RESOLVED, that our American Medical Association advocate that the granting and maintenance of health care entities not-for-profit status be reassessed by both the state legislature and the U.S. Congress.

Resolution 221-I-25 was referred largely due to concerns about vague language and the potential for unintended consequences. The Reference Committee report noted that technical questions regarding federal and state tax law should be considered to ensure that the American Medical Association (AMA) does not advocate for an outcome with harmful consequences. This report provides a review of the topic and recommendation to modify current AMA policy.

BACKGROUND

Nonprofit hospitals account for 58 percent of community hospitals in the United States and most of these hospitals are part of a larger health system.[1] Tax-exempt nonprofit hospitals operate as 501(c)(3) organizations, which by definition must be organized and operated exclusively for specific tax-exempt purposes and must have the following characteristics determined by the Internal Revenue Service (IRS): 1) no part of their net earnings is allowed to benefit any private shareholder or individual; 2) no substantial part of their activities can consist of carrying on propaganda or otherwise attempting to influence legislation; and 3) the organization should not participate or intervene in any political campaign on behalf of (or in opposition to) any candidate for public office.[2]

Additional requirements were added following the passage of the Affordable Care Act and are codified in Section 501(r) of the Internal Revenue Code. To retain 501(c)(3) tax-exempt status, nonprofit entities must:

- Establish a financial assistance policy (FAP) that describes who is eligible for charity care, the level of assistance provided, and how patients can apply. The FAP must be easily accessible to patients and translated into the languages commonly spoken in the community served by the hospital or health care organization.
- Cap charges to patients eligible for charity care based on fee-for-service Medicare rates, Medicaid rates, and/or commercial plan rates.
- Conduct a community health needs assessment (CHNA) every three years and adopt an implementation strategy to address those needs.
- Make reasonable efforts to determine if a patient is eligible for charity care before engaging in certain debt collection practices, including selling the patient's debt to third parties, reporting the debt to credit agencies, and taking legal action to control a patient's financial assets.[3]

Furthermore, to qualify as a 501(c)(3) tax-exempt organization, a nonprofit hospital must demonstrate that it has provided benefits to a class of people that is broad enough to benefit the community and operate to serve a public rather than a private interest. The IRS requires a tax-exempt hospital to annually file Form 990 Schedule H to provide the public with information on its policies and activities and the community benefits that its facilities provide. Schedule H broadly categorizes community benefit spending as charity care, unreimbursed costs for providing services to patients insured by government programs (Medicare and Medicaid), subsidized health services, community health improvement services and community benefit operations, research, health professions education, and financial and in-kind contributions to community groups.[4]

The IRS does not currently define specific types of services and activities that a hospital must undertake to qualify for a tax exemption. Instead, the IRS provides guidance on the types of activities that can demonstrate community benefits. IRS implementation of the Internal Revenue Code can give tax-exempt hospitals broad latitude to determine the nature and amount of community benefits they provide. Representatives from tax-exempt hospitals have shared that this provides needed flexibility in demonstrating community benefits. For example, a hospital located in a rural community may be the only hospital within hundreds of miles, making its existence the primary benefit to the

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community.[5] However, that lack of clarity also creates a challenge for the IRS in administering tax law. For example, a hospital could, in theory, maintain a tax exemption by operating an emergency room open to all and accepting patients on Medicare and Medicaid, which are common among hospitals while spending little to no money on charity care or other community benefits. As a result, reporting is inconsistent on many community benefit factors. Several years ago, the Government Accountability Office recommended that the IRS update Form 990 to ensure that the information demonstrating which community benefits a hospital is providing is clear and easily understood by Congress and the public. While the IRS has made minor adjustments to the form, it continues to allow hospitals to describe their community benefits in narrative form. Additionally, according to IRS officials, hospitals with little to no community benefit expenses may warrant an audit; however, the IRS was unable to provide evidence that it conducted reviews specifically related to hospital's community benefits.[6]

Because there is no explicit definition of what constitutes a community benefit, policymakers and others can reach different conclusions on whether a nonprofit hospital meets the requirements to maintain tax-exempt status or fails to do so. According to one 2024 study, 24 percent of nonprofit hospitals received more tax benefits than they spent on community benefits, but noted that the characteristics and location of nonprofit hospitals influenced the provision and composition of community benefits.[7] Some analyses on nonprofit hospital community benefits omit spending on Medicaid shortfall which can significantly impact the total amount of hospital-reported spending on community benefits. The IRS includes Medicaid shortfall as a community benefit on Form 990 Schedule H; therefore, many hospitals continue to report this amount and include it in calculations on community benefit spending. However, the calculation of Medicaid shortfall may not be reported in a standardized manner. Shortfall could be calculated using a hospital's charge master file, which may not accurately represent the actual cost of care.

Conversely, the lack of an explicitly defined list of appropriate community benefit activities can provide flexibility for nonprofit hospitals to report activities and spending based on their individual communities' needs or the focus of the hospital itself. For example, a nonprofit academic medical center may report higher spending on medical education and research, while a children's hospital may report higher spending on Medicaid shortfall due to serving many patients on Medicaid and/or the Children's Health Insurance Program. Those advocating for more stringent guidelines from the IRS argue that the vague requirements allow for reporting of activities and spending that do not show clear community benefit. However, when interviewed, hospital executives argue that the lack of clarity leads many of their organizations to omit spending because they are not sure it would qualify under the IRS guidelines, which can result in underreporting on community impact. Examples of excluded spending include hiring local contractors, increasing supplier diversity, or building a new office or facility to improve health care access.[8]

The estimated value of tax exemption for nonprofit hospitals is estimated to be $28 billion, split between $14.4 billion from exempted federal taxes and $13.7 billion from exempted state and local taxes. According to KFF, the $28 billion total estimated value of tax exemption exceeded the total estimated charity care costs of $16 billion for nonprofit hospitals.[9] Twenty-eight states mandate some form of reporting on community benefit spending by nonprofit hospitals, although this varies significantly from state to state and the impacts on spending and community health outcomes are mixed. While states with reporting requirements often saw increases in total spending on community benefits from nonprofit hospitals, there was less spending on charity care specifically, as spending was spread across several different categories. Nonprofit hospitals in states with reporting requirements spent 0.95 percent more on total community benefits (including Medicaid shortfall) than nonprofit hospitals in states without reporting requirements.[10]

AMA POLICY

Council on Medical Service Report 1-I-24, Nonprofit Hospital Charity Care Policies, addressed a similar request to the one made in Resolution 221-I-25. CMS Report 1-I-24 generated Policy H-155.954, which states that the AMA advocates: 1) that all nonprofit hospitals be required to screen patients for charity care eligibility and other financial assistance program eligibility prior to billing; 2) to encourage debt collectors to ensure a patient has been screened for financial assistance eligibility before pursuing that patient for outstanding debt, provide an appeals process for those patients not screened previously or deemed ineligible, and require the hospital to reassume the debt account if an appeal is successful; 3) for the development of minimum standards for nonprofit hospital financial assistance eligibility programs which are publicly accessible; 4) for a standardized definition of what is considered a "community benefit" when evaluating community health improvement activities; 5) for the development of transparent, publicly available, standardized data set on community benefit including consideration of charity care-to-expense ratios; and 6) for governmental oversight of nonprofit hospitals and enforcement of federal and/or state guidelines and standards for community benefit requirements including the ability to enact penalties and/or loss of tax-exempt status.

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Policy H-215.975 states that the AMA supports the concept that all hospitals be held to the same standards of care, community service, professional education and commitment to their respective communities.

DISCUSSION

The Council believes that nonprofit hospitals are not interchangeable, as each is part of a community with unique needs. For example, a large nonprofit health system that operates hospitals in multiple states is very different from a critical access hospital in a small rural town. While both are technically 501(c)(3) nonprofit hospitals, it should not be expected that these entities have the same resources to manage additional reporting requirements or other administrative burdens that may result from increased scrutiny on maintaining tax-exempt status. Furthermore, as they likely serve distinct communities, they may have different interpretations of what constitutes a community benefit tailored to the needs of their respective communities. Some studies the Council reviewed questioned the inclusion of Medicaid shortfall as a category for community benefit spending. However, reimbursement for Medicaid shortfall can have a huge impact on small critical access hospitals, and in some cases may allow the hospital to stay open to provide care to a community that may not have access to another hospital nearby.

The Reference Committee heard mixed, but largely negative testimony on Resolution 221-I-25 and recommended referral of this item due to concerns about vague language and the potential for unintended consequences. Reference Committee testimony on Resolution 221-I-25 cautioned that requiring new federal or state documentation mandates could divert limited resources from patient care to compliance activities, force safety-net institutions to consider reductions in force or service closures, and/or accelerate conversion or acquisition by for-profit or private equity-backed systems, leading to greater market consolidation and diminished local control. The Council agrees with this assessment and, thus, is not recommending a definition of what should be considered a community benefit. In addition to being beyond the scope of the AMA, it is a nuanced issue where more flexibility is likely beneficial, especially for smaller nonprofit hospitals that may have limited resources. Instead, the Council recommends advocating for consistency and transparency when defining these benefits to allow policymakers and the public to assess nonprofit hospital spending on community benefits more clearly.

Physician employment by hospitals and health systems has been rising steadily in recent years. In 2024, 47 percent of physicians were directly employed by a hospital, contracted directly with a hospital, or employed by a hospital-owned practice.[11] Given that physicians employed by hospitals or health systems comprise nearly one-half of the medical community, finding a balanced solution for addressing the level of community benefits provided by nonprofit hospitals is crucial. As the AMA represents all physicians, the Council does not want to unintentionally burden those employed by hospitals or health systems by placing additional mandates on their employers. However, the Council does understand the importance of holding nonprofit hospitals accountable for faithfully maintaining their tax-exempt status.

Accordingly, the Council continues to support the recommendations in CMS Report 1-I-24 and offers amendments to Policy H-155.954, which are intended to clarify and strengthen the AMA's position on this issue. The amendments offered call for increased transparency and consistency in governmental oversight of nonprofit hospitals, so physicians and the public are better aware of efforts undertaken by nonprofit hospitals and health systems to improve the health of their communities and justify their tax-exempt status as 501(c)(3) organizations. In addition, the Council recommends adding a new clause that encourages nonprofit hospitals to share results from their federally-required CHNA, including progress that has been made since the previous assessment and areas in need of improvement. This recommendation aims to achieve transparency and consistency regarding benefits nonprofit hospitals provide their communities. It also provides an opportunity for nonprofit hospitals to work with other individuals and/or organizations in their community on projects where progress can be furthered. AMA policy supports efforts to reduce administrative burdens in health care; therefore, although the Council does not recommend increasing the level of mandated reporting by nonprofit hospitals on community benefit efforts, it does encourage nonprofit hospitals to share accomplishments within their communities, including but not limited to CHNA results.

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RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 221-I-25 and the remainder of the report be filed.

1. That our American Medical Association amend Policy H-155.954 by addition and deletion to read as follows:

NONPROFIT HOSPITAL ~~CHARITY CARE~~ POLICIES, H-155.954

1. Our American Medical Association (AMA) advocates that all nonprofit hospitals be required to screen patients for charity care eligibility and other financial assistance program eligibility prior to billing.
2. Our AMA advocates to encourage debt collectors to ensure a patient has been screened for financial assistance eligibility before pursuing that patient for outstanding debt, provide an appeals process for those patients not screened previously or deemed ineligible, and require the hospital to reassume the debt account if an appeal is successful.
3. Our AMA advocates for the development of minimum standards for nonprofit hospital financial assistance eligibility programs which are publicly accessible.
4. Our AMA advocates for a standardized definition of what is considered a "community benefit" that includes addressing social drivers of health and population health when evaluating community health improvement activities and eligibility for nonprofit status.
5. Our AMA advocates for the development of ~~a~~ transparent, publicly available, standardized data sets and/or reports on nonprofit hospital community benefit spending, including consideration of charity care-to-expense ratios.
6. Our AMA advocates for transparency and consistency regarding ~~the expansion of~~ governmental oversight of nonprofit hospitals, ~~and~~ enforcement of federal and/or state guidelines, and standards for community benefit requirements and reporting, including the ability to enact penalties and/or loss of tax-exempt status.
7. Our AMA encourages nonprofit hospitals to publicly share the results from assessments, such as the Community Health Needs Assessment (CHNA), including progress that has been made since the previous assessment, as well as areas where there is room for improvement.

Fiscal Note: Minimal

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Council on Medical Service Report 9-A-26
Nonprofit Status
Policy Appendix

Nonprofit Hospital Charity Care Policies, H-155.954
1. Our American Medical Association (AMA) advocates that all nonprofit hospitals be required to screen patients for charity care eligibility and other financial assistance program eligibility prior to billing.
2. Our AMA advocates to encourage debt collectors to ensure a patient has been screened for financial assistance eligibility before pursuing that patient for outstanding debt, provide an appeals process for those patients not screened previously or deemed ineligible, and require the hospital to reassume the debt account if an appeal is successful.
3. Our AMA advocates for the development of minimum standards for nonprofit hospital financial assistance eligibility programs which are publicly accessible.
4. Our AMA advocates for a standardized definition of what is considered a "community benefit" when evaluating community health improvement activities.
5. Our AMA advocates for the development of a transparent, publicly available, standardized data set on community benefit including consideration of charity care-to-expense ratios.
6. Our AMA advocates for the expansion of governmental oversight of nonprofit hospitals and enforcement of federal and/or state guidelines and standards for community benefit requirements including the ability to enact penalties and/or loss of tax-exempt status.
(CMS Rep. 01, I-24)

Uniform Standards for Not-For-Profit and For-Profit Hospitals, H-215.975
The AMA supports the concept that all hospitals be held to the same standards of care, community service, professional education and commitment to their respective communities.
(Res. 705, A-96; Reaffirmed: CMS Rep. 8, A-06; Reaffirmed: CMS Rep. 01, A-16)

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